No. 11-2636

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

HENRY PASHBY; ANNIE BAXLEY; MARGARET DREW; DEBORAH FORD; MELISSA GABIJAN; MICHAEL HUTTER; JAMES MOORE; LUCRETIA MOORE; AYLEAH PHILLIPS; ALICE SHROPSHIRE; SANDY SPLAWN; ROBERT JONES; REBECCA PETTIGREW

Plaintiffs – Appellees,

v.

ALBERT DELIA, in his official capacity as Acting Secretary of the North Carolina Department of Health and Human Services

Defendant – Appellant.

On Appeal from the United States District Court
for the Eastern District of North Carolina
Western Division

DEFENDANT-APPELLANT'S OPENING BRIEF

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UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT
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No. 11-2363 Caption: Pashby, et al. (plaintiffs-appellee) v. Cansler (defendant-appellant)

Pursuant to FRAP 26.1 and Local Rule 26.1,

LANIER M. CANSLER, In his official capacity as Secretary of the N.C. Department of Health and Human
(name of party/amicus)

Services

who is appellant, makes the following disclosure:
(appellant/appellee/amicus)

1. Is party/amicus a publicly held corporation or other publicly held entity? ☐ YES ☑ NO

2. Does party/amicus have any parent corporations? ☐ YES ☑ NO
If yes, identify all parent corporations, including grandparent and great-grandparent corporations:

3. Is 10% or more of the stock of a party/amicus owned by a publicly held corporation or other publicly held entity? ☐ YES ☑ NO
If yes, identify all such owners:

4. Is there any other publicly held corporation or other publicly held entity that has a direct financial interest in the outcome of the litigation (Local Rule 26.1(b))? ☐ YES ☑ NO
If yes, identify entity and nature of interest:

5. Is party a trade association? (amici curiae do not complete this question) ☐ YES ☑ NO
If yes, identify any publicly held member whose stock or equity value could be affected substantially by the outcome of the proceeding or whose claims the trade association is pursuing in a representative capacity, or state that there is no such member:

6. Does this case arise out of a bankruptcy proceeding? ☐ YES ☑ NO
If yes, identify any trustee and the members of any creditors' committee:

CERTIFICATE OF SERVICE

****

I certify that on 12/21/11 the foregoing document was served on all parties or their counsel of record through the CM/ECF system if they are registered users or, if they are not, by serving a true and correct copy at the addresses listed below:

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STATEMENT OF JURISDICTION

Defendant-Appellant, Acting Secretary Albert Delia (hereinafter "Secretary Delia" or "defendant"), appeals from the District Court's 8 December 2011 Order ("the Order") granting plaintiffs' motions for preliminary injunction, class certification, and leave to file additional declarations. (Joint Appendix 1446) This Court has jurisdiction over defendant's appeal pursuant to 28 U.S.C. §1292(a), which grants jurisdiction to the courts of appeal of interlocutory orders of the district courts of the United States "granting, continuing, modifying, refusing or dissolving injunctions." An appeal brought under 28 U.S.C. §1292(a) "brings before the appellate court the entire order, not merely the propriety of injunctive relief." *Allstate Ins. Co. v. McNeill*, 382 F.2d 84, 88 (4th Cir. 1967).

STATEMENT OF THE ISSUES

1. Did the District Court properly apply the higher standard necessary for the grant of a mandatory injunction?

2. Did the District Court properly apply the preliminary injunction standard set forth in *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 129 S. Ct. 365 (2008)?

    a. Did the District Court abuse its discretion in granting the injunction because plaintiffs failed to demonstrate any real or immediate threat of irreparable injury?

    b. Did the District Court abuse its discretion in granting the injunction because plaintiffs did not meet their burden of demonstrating that the balance of equities tilts in their favor or that the injunction was in the public interest?

c. Did the District Court give appropriate deference to the decision of the federal Centers for Medicare and Medicaid Services ("CMS") to approve the State Plan Amendment ("SPA") complained of by the plaintiffs?

d. Did the District Court abuse its discretion in granting the injunction because plaintiffs did not show a likelihood of success on the merits of any of their claims?

3. Does the Order comply with the requirements for an injunction set out in Rule 65 of the Federal Rules of Civil Procedure?

4. Did the District Court err in certifying a class because plaintiffs lack standing, the class is not identifiable, and because plaintiffs cannot represent the class as to the due process claims?

5. Should plaintiffs' claims be dismissed for lack of subject matter jurisdiction?

STATEMENT OF THE CASE

Plaintiffs filed a complaint and motion for preliminary injunction on 31 May 2011 seeking to prohibit defendant from implementing revised eligibility requirements for optional in-home Medicaid services known as personal care services ("PCS"). (J.A. 17) Plaintiffs filed a motion for class certification on 6 June 2011 (J.A. 425), and an amended complaint on 11 July 2011. (J.A. 937) Essentially, plaintiffs contend that alleged differences between PCS provided to recipients living in the community and PCS provided to recipients residing in licensed Adult Care Homes constitute violations of the Americans with Disabilities Act ("ADA"), Section 504 of the Rehabilitation Act, and the Social

Security Act. Plaintiffs further contend that notices sent to the plaintiffs were insufficient under the Fourteenth Amendment to the United States Constitution.

The District Court did not entertain argument on the motions until 17 November 2011. A week prior to the scheduled hearing, plaintiffs filed a third motion for leave to file supplemental declarations based on "recently discovered" information. (J.A. 1381) The District Court entered the Order on 8 December 2011. (J.A. 1446) On 9 December 2011, defendant gave notice of appeal to this Court. (J.A. 1462) In accordance with Fed. R. App. P. 8(a), defendant sought a stay of the Order from the District Court, which was denied on 27 January 2012. (J.A. 1468) Defendant filed a motion for stay of the Order with this Court on 15 February 2012 (Document 24), plaintiffs filed a response to the motion on 22 February 2012 (Document 26), and defendant filed a reply on 29 February 2012 (Document 29).

STATEMENT OF FACTS

The Medicaid program, established in 1965 in Title XIX of the Social Security Act, 42 U.S.C. §§1396 *et seq.*, is a cooperative federal-state program that provides federal financial assistance to participating states to furnish medical assistance "as far as practicable under the conditions in such State." 42 U.S.C. §1396-1. In North Carolina, the Department of Health and Human Services ("Department" or "DHHS") is the single state agency designated to administer the

State's Medicaid program. 42 U.S.C. §1396a(a)(5); N.C. Gen. Stat. §108A-54. For a state to qualify for federal funds, CMS must approve the State's Medicaid plan and any amendments. Before approving a plan or amendments, CMS reviews the submission for compliance with federal requirements. *See* 42 U.S.C. §1316(a)(1),(b); §1396a(a),(b); 42 C.F.R. §430.10 *et seq.*; *Douglas v. Independent Living Center of So. Cal.*, No. 09-658, 565 U.S. ____, (February 22, 2012).

Certain services are mandated for all State Medicaid Plans, while others are optional for the State. 42 U.S.C. §§1396a(a)(10)(A), 1396a(a)(24). North Carolina's State Plan includes coverage for optional PCS, which pays for an aide to provide assistance with activities of daily living ("ADLs") such as bathing, toileting, dressing, eating and mobility. (J.A. 684, 916) "The [Medicaid] Act gives the States substantial discretion to choose the proper mix of amount, scope, and duration limitations on coverage." *Alexander v. Choate*, 469 U.S. 287, 303 (1985). Therefore, Medicaid recipients are subject to substantial governmental discretion about the mix and duration of the medical services for which the government will pay. *Beal v. Doe*, 432 U.S. 438, 444 (1977). States may place appropriate limits on services based on "utilization control procedures." 42 C.F.R. §440.230(d). States "can review the medical necessity of treatment prescribed by a doctor on a case by case basis." *Rush v. Parham*, 625 F.2d 1150, 1155 (5th Cir. 1980).

In 2010, responding to concerns about abuse of the PCS program as well as fiscal realities caused by the national economic crisis, the North Carolina General Assembly ("General Assembly") mandated the Department to "no longer provide services under PCS" and to implement a new service for recipients in the community with stricter eligibility criteria, which was to be called In-Home Care for Adults ("IHCA"). (J.A. 686, 751) IHCA is not applicable to recipients in Adult Care Homes. Beginning 1 May 2012 the State intends to cover all personal care services, regardless of whether provided in the community or a licensed Adult Care Home, under the authority of Section 1915(i) of the Social Security Act. (J.A. 688) Accordingly, CMS has terminated coverage for all types of State Plan personal care services, including IHCA, effective 30 April 2012. (D.E. # 29) The proposed 1915(i) waiver will utilize the same or similar eligibility criteria as Policy 3E and will thus eliminate any purported comparability issues. Implementation of IHCA is a critical step towards implementation of the 1915(i) waiver. (J.A. 688)

DHHS spent more than twelve months preparing to implement IHCA. It submitted a SPA to CMS on 25 October 2010. (J.A. 171, 686) It also made significant programmatic and operational changes involving multiple information technology systems, and communicated implementation instructions to a complex network of vendors, medical providers and recipients. (J.A. 915-931, 1557-1567) Counsel for the plaintiffs preemptively objected to approval of the SPA in a letter

to CMS dated 8 September 2010, raising the same issues complained of in this lawsuit. (J.A. 686, 759) Notwithstanding plaintiffs' objections, CMS approved the SPA by letter dated 18 April 2011. (J.A. 169)

DHHS began to implement the SPA as soon as it was approved. The Department promulgated Clinical Coverage Policy ("Policy 3E"), which implemented the eligibility criteria set forth in the SPA. (J.A. 918, 926) Policy 3E took effect on 1 June 2011 and does not apply to PCS provided in Adult Care Homes. *Id.* Plaintiffs have not alleged that Policy 3E contains different criteria than those approved by CMS.

A Department contractor also reviewed the clinical assessments for each of the more than 27,000 Medicaid recipients authorized to receive PCS. (J.A. 924-926) Clinical assessments for each PCS recipient were on file because the State Plan requires that an independent entity conduct an assessment of medical stability and ADL needs as part of the prior approval process. (J.A. 917) The contractor then notified approximately 2,405 recipients that they did not meet IHCA criteria. (J.A. 924) The notices included the reason for the decision and detailed instructions on how to file a request for a hearing, including an appeal form. (J.A. 508-682)

Each of the thirteen named plaintiffs was found ineligible for IHCA services and received notice of this determination. *Id.* All thirteen subsequently filed a

request for a fair hearing at the N.C. Office of Administrative Hearings ("OAH") contesting the termination of their PCS. *Id.* During the pendency of these appeals, each plaintiff continued to receive maintenance of service ("MOS") at the same level that was authorized prior to the notification, as required by N.C.G.S §108A-70.9A.(d). Ten of the named plaintiffs dismissed their state appeals prior to the 17 November hearing because they were approved for IHCA hours. (J.A. 947-963) Two of the named plaintiffs are still in the hearing process and continue to receive MOS (J.A.1059-61); one plaintiff voluntarily dismissed his appeal. (J.A. 1005)

Plaintiffs filed this action just before midnight on 31 May 2011. They neither sought a temporary restraining order nor attempted to expedite a hearing on their motion for preliminary injunction, despite their draconian predictions of injury, institutionalization, and even death to "thousands" of recipients who were no longer eligible for PCS as a result of the program changes. (J.A. 406) In the meantime, the Department relied on CMS's approval of the SPA and implemented the stricter eligibility criteria. (J.A. 918) Nearly six months after filing their motion, plaintiffs have yet to identify anyone who suffered harm as a result of losing PCS, let alone the "thousands" they predicted in their motion.

SUMMARY OF ARGUMENT

The Order is an unprecedented decision to disregard the express approval of a SPA by the federal agency charged with overseeing the Medicaid program. Allowing the Order to stand "threaten[s] to defeat the uniformity that Congress intended by centralizing administration of the federal program in the agency and to make superfluous or to undermine traditional APA review." *Independent Living*, 565 U.S. ___, ___ (2012) (slip op., at 8). The District Court failed to properly consider the factors required for a preliminary injunction, let alone those required for the extraordinary remedy of a mandatory injunction. Instead, despite the successful six-month record of implementation at the time of the hearing and the plaintiffs failure to show any real injury, the District Court concluded that the interest of the individual plaintiffs outweighed the administrative actions of CMS, the fiscal concerns of the State, and the negative impact of the Order on other Medicaid recipients who will lose services as a result of the redirection of limited Medicaid funds. Moreover, the District Court erred in certifying the class, the plaintiffs lack standing to bring this lawsuit and the Medicaid claims should be dismissed for lack of subject matter jurisdiction.

ARGUMENT

I. STANDARD OF REVIEW.

Although this Court must review the grant or denial of a preliminary injunction for abuse of discretion, cases are "replete with references to the particularly exacting application of standards that apply to that discretion." *Sun Microsystems, Inc. v. Microsoft Corp.*, 333 F.3d 517, 524 (4th Cir. 2003). The abuse of discretion standard "is not a rule of perfunctory appellate review but one of careful scrutiny." *Direx Israel, Ltd. v. Breakthrough Medical Corp.*, 952 F.2d 802, 815 (4th Cir. 1992). "Particularly where the appeal is from a grant of preliminary injunction, which represents the exercise of a very far-reaching power, never to be indulged in except in a case clearly demanding it[,] the standard of appellate review must not be reduced to the largely meaningless ritual of the typical 'abuse of discretion' standard." *Id.* at 815. The *Sun Microsystems* court further held that the "application of this exacting standard of review is even more searching when the preliminary injunctive relief ordered by the district court is mandatory rather than prohibitory in nature." *Id., citing Taylor v. Freeman*, 34 F.3d 266, 270 n.2 (4th Cir. 1994) ("Mandatory preliminary injunctive relief in any circumstance is disfavored, and warranted only in the most extraordinary circumstances").

II. THE DISTRICT COURT FAILED TO PROPERLY APPLY THE HEIGHTENED STANDARD REQUIRED FOR A MANDATORY INJUNCTION.

The Order is a mandatory injunction which forces defendant to take affirmative action to dismantle a program mandated by the General Assembly in June 2010 and approved by CMS in April 2011. Accordingly, it should be subjected to the strict scrutiny of *Sun Microsystems*. Plaintiffs contend the injunction is not mandatory because the Order preserves the status quo. Plaintiffs define this as "the last uncontroverted status preceding the pending litigation." (J.A. 981) This argument fails for at least three reasons.

First, there are three types of disfavored injunctions requiring a heightened standard of review: "(1) preliminary injunctions that alter the status quo; (2) mandatory preliminary injunctions; (3) and preliminary injunctions that afford the movant all the relief that it could recover at the conclusion of a full trial on the merits." *O Centro Espirita Beneficiente Uniao Do Vegetal v. Ashcroft*, 389 F.3d 973, 975 (10th Cir. 2004). An injunction is mandatory if the requested relief "affirmatively require[s] the nonmovant to act in a particular way, and as a result … place[s] the issuing court in a position where it may have to provide ongoing supervision to assure the nonmovant is abiding by the injunction." *Id.* at 979. In other words, the mandatory nature of injunctive relief is an independent issue that transcends the status quo. Although the "distinction between mandatory and

prohibitory injunctions is not without ambiguities or critics," *Tom Doherty Associates, Inc. v. Saban Entertainment, Inc.*, 60 F.3d 27, 34 (2d Cir. 1995), and "determining whether an injunction is mandatory as opposed to prohibitory can be vexing," *O Centro*, 389 F.3d at 1006 (Seymour, J., dissenting in part), in this case the answer is clear because the Order affirmatively requires the defendant to dismantle a program which was in effect for nearly six months, in order to satisfy the demands of plaintiffs who did not show harm and who waited until after federal approval was obtained before filing their lawsuit.

Second, plaintiffs' delay in filing a complaint and their failure to seek a temporary restraining order or to expedite a hearing on their motion should not inure to their benefit. Plaintiffs made no attempt to seek an injunction until after federal approval was in place and defendant had spent over a year preparing to implement the SPA. This Court has recognized the importance of a plaintiff's burden to prosecute his action diligently in order to avail himself of the court's equitable power to issue a preliminary injunction. *See Quince Orchard Valley Citizens Assoc. v. Hodel*, 872 F.2d 75 (4th Cir. 1989). In *Quince*, this Court upheld a district court's denial of a motion for preliminary injunction, noting that the plaintiffs had delayed in bringing their action until six months after all necessary federal approvals for the project had been granted and finding that "[l]ack of diligence, standing alone, may … preclude the granting of preliminary injunctive

relief[.]" *Id.* at 80 (internal quotations omitted). Similarly, the plaintiffs in this case delayed in bringing their action until more than a month after CMS approved the SPA, and nearly a year after the General Assembly mandated the stricter eligibility criteria.

Third, the last uncontested status prior to the lawsuit is that defendant was required by state law and authorized by CMS to implement stricter PCS eligibility criteria. This was the status quo. By the time the District Court entertained oral arguments on plaintiffs' motions, the SPA had been in effect for over seven months. At any point after the General Assembly mandated the new criteria or the SPA was approved, Plaintiffs could have sought immediate injunctive relief and taken steps to expedite a hearing. Instead, plaintiffs waited until the eve of implementation to file their action, and no hearing on injunctive relief was scheduled until November 2011. Plaintiffs' lack of urgency vividly illustrates the absence of any real risk of injury to class members.

In any event, the Order is clearly erroneous, because it fails to undertake the necessary inquiry on this point or to recognize the mandatory nature of the injunction. The Order simply does not address the higher standard required when a preliminary injunction "seeks to force one party to act." *Mercedes-Benz U.S. Int'l, Inc. v. Cobasys, LLC*, 605 F. Supp. 2d 1189, 1196 (N.D. Ala. 2009) (citations omitted); *see also Harris v. Wilters*, 596 F.2d 678, 680 (5th Cir. 1979); *Wetzel v.*

Edwards, 635 F.2d 283, 286 (4th Cir. 1980); *Cornwell v. Sachs*, 99 F. Supp. 2d 695, 704 (E.D. Va. 2000). Plaintiffs failed to meet this higher burden, and the District Court abused its discretion by ordering defendant to halt implementation of Policy 3E.

III. THE DISTRICT COURT FAILED TO PROPERLY APPLY THE *WINTER* STANDARD FOR A PRELIMINARY INJUNCTION.

The District Court failed to properly apply the test for a preliminary injunction set forth in *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7 (2008). Plaintiffs were required to demonstrate conclusively that they are likely to suffer irreparable harm; that the balance of the hardships tips in their favor; that the injunction is in the public interest; and that they are likely to succeed on the merits. *Winter*, 555 U.S. at 20. They failed to do so. This Court has clarified that there no longer exists any flexible interplay between the factors, and all four elements of the test must be independently satisfied. *The Real Truth About Obama, Inc. v. F.E.C.*, 575 F.3d 342, 347 (4th Cir. 2009), *vacated on other grounds*, *The Real Truth About Obama, Inc. v. Federal Election Com'n*, __ U.S. __, 130 S. Ct. 2371, 176 L. Ed. 2d 764 (2010), *reaffirmed by The Real Truth About Obama, Inc. v. FEC*, 607 F.3d 355 (4th Cir. 2010). Although the Order includes several pages analyzing whether plaintiffs demonstrated a likelihood of success on the merits of their claims, it addresses the remaining three factors in only a cursory fashion, contrary

to the Supreme Court's instruction in *Winter* and this Court's direction in *Real Truth*.

A. Plaintiffs Failed to Demonstrate Any Real or Immediate Threat of Irreparable Injury.

The District Court concluded that plaintiffs demonstrated a threat of irreparable harm because they "risk" re-evaluation and a lack of PCS "could" result in serious injury. (J.A. 1459) Neither of these findings is supported by the record, and the mere possibility of harm suggested by the word "could" is not sufficient to meet the strict standard for injunctive relief under *Winter*, particularly when the relief requested is mandatory in nature. The District Court's conclusions are textbook examples of harm that does not meet the standard because it is "merely feared." *Newdow v. Bush*, 355 F. Supp. 2d 265, 291 (D.C. Cir. 2005).

1. Plaintiffs failed to meet the strict test for harm under *Winter* and *Real Truth*.

A plaintiff must make a clear showing that he will likely be irreparably harmed absent preliminary relief. *Real Truth*, 575 F.3d at 347. That the plaintiff's harm might simply outweigh the defendant's harm is insufficient. *Id*. The showing of irreparable injury is mandatory even if the plaintiff demonstrates a strong showing on the probability of success on the merits. *Id*. The harm "must be concrete and immediate to warrant extraordinary injunctive relief, and vague or speculative injury will not suffice." *Newdow*, 355 F. Supp. 2d at 291, *citing*

Wisconsin Gas Co. v. Fed. Regulatory Comm'n, 244 U.S. App. D.C. 349, 758 F.2d 669, 674 (D.C. Cir. 1985) ("the injury must be both certain and great; it must be actual and not theoretical"); *see also E.A. Hawse Health Center v. West Virginia*, 2011 U.S. Dist. LEXIS 111206 (S.D. W.Va. September 28, 2011). In short, "the threatened injury must be of such imminence that there is a clear and present need for equitable relief to prevent irreparable harm, because injunctions are not intended 'to prevent injuries neither extant nor presently threatened, but only merely feared.'" *Newdow*, 355 F. Supp. 2d at 291, *quoting Comm. in Solidarity v. Sessions*, 289 U.S. App. D.C. 149, 929 F.2d 742, 745-46 (D.C. Cir. 1991) (citations omitted). Nothing in the record, including the last-minute declarations filed on 8 November 2011, supports a finding of concrete or immediate harm.

Winter rejected a standard that allowed the plaintiff to demonstrate only a "possibility" of irreparable harm because that standard was "inconsistent with our characterization of injunctive relief as an extraordinary remedy that may only be awarded upon a clear showing that the plaintiff is entitled to such relief." 555 U.S. at 22. The amended complaint alleged that as a result of the changes to the State Medicaid Plan and the implementation of IHCA, "thousands of individuals relying upon PCS will be unable to survive in their homes." (J.A. 918) Yet six months after filing their motion for preliminary injunction, plaintiffs were unable to demonstrate that any plaintiff had been institutionalized or hospitalized, that

institutionalization rates had risen, that any plaintiff's health had worsened, or that any plaintiff was unable to survive in their home. They offered no evidence whatsoever to support their dramatic allegations.

Plaintiffs contend that numerous courts have found that denial of necessary Medicaid services constitutes irreparable harm. (J.A. 408-09) First, nothing in the record before the District Court supports a finding that PCS is a "necessary" medical service, particularly in light of plaintiffs' specific factual circumstances. Second, the District Court below was not shown evidence of harm. For example, in *M.R. v. Dreyfus*, 663 F.3d 1100 (9th Cir. 2011), the court was presented with "evidence that [plaintiff's] condition had deteriorated since her July 2010 CARE assessment." *Id.* at 1114-15. In this case, no medical evidence or physician testimony was presented to the District Court that would support similar findings as to any of the named plaintiffs.

Unlike cases involving challenges to other State Medicaid programs such as *V.L. v. Wagner*, 669 F. Supp. 2d. 1106 (9th Cir. 2009) or *Brantley v. Maxwell-Jolly*, 656 F. Supp. 2d 1161, 1175 (N.D. Cal. 2009), where federal courts entered injunctions *prior* to contested Medicaid programs going into effect, the District Court had the opportunity to review a six-month record of implementation. That record belies plaintiffs' predictions. Instead, the District Court relied on

speculative assertions which simply did not materialize in the five months between the filing of the complaint and the hearing date.

2. The evidence failed to show harm to any of the named plaintiffs.

Where plaintiffs seek injunctive relief for a proposed class, at least one of the named representatives of the class must establish that he or she is personally subject to a real and immediate threat of harm from the defendant's challenged conduct. *See Golden v. Kelsey-Hayes*, 73 F.3d 648, 657 (6th Cir. 1996). None of the named plaintiffs met that requirement. Instead, each of the named plaintiffs filed practically identical declarations stating that without the help of a personal care assistant they "might" have no choice but to enter a facility. (J.A. 21-72) Ten of the named plaintiffs did not lose services at all, because they were found to meet IHCA criteria prior to the hearing date. (J.A. 947-963) Two other plaintiffs are still in the appeal process and will continue to receive MOS until a final decision is reached. (J.A. 1059-61) One plaintiff voluntarily dismissed his appeal at mediation and did not unequivocally allege that he would be institutionalized or otherwise harmed in the absence of PCS. (J.A. 1005) None of the named plaintiffs' declarations support a conclusion that they are at risk of institutionalization in the absence of PCS.

The other declarations offered by plaintiffs were equally speculative and, in several cases, were produced by individuals with a direct financial interest as providers of PCS. For example, Brenda Hutchens, a nurse for the agency that provides services to plaintiff Sandy Splawn, filed a declaration speculating that without assistance with bathing, dressing, cooking, exercise and light household tasks, Ms. Splawn "*may* have to be institutionalized." (J.A. 77, emphasis added) This statement does not show imminent danger of irreparable harm. In any event, Ms. Splawn was later found eligible for IHCA and faced no risk of harm, speculative or otherwise, on the hearing date. (J.A. 1059-61)

The declaration of Margaret Webb, the Chief Operating Officer for Interim Healthcare, another provider of PCS services, is also suspect. By her own admission, Ms. Webb's company stands to lose 15 percent of its business as a result of the implementation of IHCA. (J.A. 81) She does not indicate her professional background or qualifications for the numerous unsubstantiated medical opinions expressed in her declaration. Lastly, the declaration of Kathie Smith with the Association for Home and Hospice Care of North Carolina, Inc., is yet another declaration by a person whose stated purpose is to lobby for the very providers whose profits and income are negatively impacted by the state's decision to implement stricter eligibility criteria. (J.A. 204)

Plaintiffs did not submit the opinion of any medical doctor that would support a specific finding that any of the named plaintiffs are at risk of institutionalization, or even a generalized finding that an entire class of recipients is at risk of institutionalization. There was no support for the speculative claims that plaintiffs "may" fall or "might" require institutionalization. Scheduled PCS visits cannot prevent the risk that an individual may fall. (J.A. 918) None of the declarations explained why the plaintiffs "might" need to enter a nursing facility if they do not continue to receive PCS for the limited number of hours per month each was receiving prior to implementation of the SPA and Policy 3E. (J.A. 494, 505) None of the declarations explained how, if the plaintiffs' conditions are so unstable, they are able to safely live in the home the hundreds of hours per month they do not have the services of an in-home aide. (J.A. 491)

No declaration contained any assertion by a disinterested, unbiased medical professional (or even by any plaintiff's treating physician) that any of the named plaintiffs were at any risk of their health conditions worsening, let alone suffering irreparable injury, if the District Court failed to enter the injunction. No declaration demonstrated a "clear and present need for equitable relief to prevent irreparable harm" or that any harm was "presently threatened." *Newdow*, 355 F. Supp. 2d at 291. Plaintiffs' declarations utterly failed to support a finding of irreparable harm, and it was error for the District Court to hold otherwise.

3. The declarations concerning other individuals also failed to show harm.

Lacking evidence of harm to the named plaintiffs, counsel presented new declarations a week prior to the scheduled hearing concerning an individual who was not a named plaintiff (Bobby Hall) and three other individuals identified only by their initials. (J.A. 1381-1425) Admission of the declarations was an abuse of discretion, because plaintiffs failed to demonstrate any good cause for their untimely filing and because they did not concern any of the named plaintiffs. (J.A.1426-37) In any event, the untimely declarations were insufficient to support the Order.

By plaintiffs' own admission, Mr. Hall received less than one hour of PCS per day prior to the changes approved by CMS. (J.A. 1409) Sometime after 31 May 2011, Mr. Hall allegedly fell and was placed in a nursing home. (J.A. 1410) *No declaration states that his fall resulted from his loss of PCS.* In any event, PCS was never intended to assist individuals who are so unsteady on their feet that they could potentially fall any moment of the day. (J.A. 491, 505-06, 918) Plaintiffs presented no evidence that having a PCS aide visit Mr. Hall's home for less than an hour a day would have prevented him from falling. Moreover, Mr. Hall was later approved to receive the maximum number of IHCA hours per month (J.A. 1411), once again showing that, like the named plaintiffs, Mr. Hall was not harmed by Policy 3E.

Another untimely declaration concerns individuals who were not identified by name and who do not appear to have consented to participate in this lawsuit. (J.A. 1417-1420) Counsel did not identify on what basis they were permitted to disclose confidential medical information about these unnamed individuals, and defendant was unable to investigate the allegations because of this lack of identification. It was error for the District Court to admit this declaration or to rely on it as evidence of harm. The declarant identifies himself as the owner of a home care agency, not as a medical professional, but nonetheless expresses numerous medical opinions, all of which are unsupported by evidence from a physician. *Id.* He claims that one individual, C.R., is living in a less congregate setting (but which is not described as an institution), another individual, K.E., remains at home but her "safety is in danger" and a third, S.W., has received in-patient and out-patient behavioral health services after her PCS services were terminated. *Id.* This declaration also fails to support a finding that plaintiffs demonstrated irreparable harm in the absence of injunctive relief.

The State Plan requires recipients to have a physician referral before they can even be assessed for PCS. And yet plaintiffs were unable to produce any medical evidence, *or a statement from a single treating physician*, in support of their claims that individuals would be institutionalized in the absence of PCS or that any specific plaintiff's condition had deteriorated. None of the declarations

provided the District Court with a plain statement that a single plaintiff would be or was institutionalized as a result of the changes to the PCS program. Dr. Best, the only physician to provide evidence in this case, stated that there is no causal link between the absence of minimal PCS hours and potential institutionalization. (J.A. 494) For these reasons, plaintiffs failed to demonstrate a likelihood of irreparable harm, and it was an abuse of discretion for the District Court to find otherwise.

B. PLAINTIFFS DID NOT MEET THEIR BURDEN OF DEMONSTRATING THAT THE BALANCE OF EQUITIES TILTS IN THEIR FAVOR OR THAT THE INJUNCTION WAS IN THE PUBLIC INTEREST.

This Court has admonished District Courts to give "particular regard" to the "public consequences" of any relief granted. *Real Truth*, 575 F.3d at 347. The District Court failed to do so. Specifically, the District Court "did not give serious consideration to the public interest factor" and "failed properly to defer to [defendant's] specific, predictive judgments about how the preliminary injunction would" result in harm to the State and Medicaid recipients. *Winter*, 555 U.S. at 26-27 (citations omitted).

Former DHHS Secretary Cansler offered specific, predictive and *uncontroverted* judgments about how the preliminary injunction would force the State to "make other reductions to make up for the extra spending, including the potential elimination of optional Medicaid services." (J.A. 1367) The District

Court failed to pay "particular regard" to those judgments. Instead, the Order cites to a pre-*Winter* decision comparing the relative merits of financial harm versus harm to health and life. (J.A. 1460) It ignores the likelihood of harm to other Medicaid recipients if the State is forced to eliminate optional services as a result of the Order. The Order then finds that that an injunction is in the public interest because plaintiffs "have shown a likelihood of success on the merits." *Id.* This finding is directly contrary to this Court's instruction that each element of the injunction standard must be *independently* satisfied, and is clearly erroneous. *Real Truth*, 575 F.3d at 347. In any event, the Order fails to make separate findings as to the balance of equities and the public interest factors, violating the requirement to make independent findings on each of the four factors.

The District Court chose to disregard the specific statements of Secretary Cansler and Medicaid Chief Clinical Operations Officer Tara Larson concerning the precarious fiscal situation facing the State Medicaid program (J.A. 689, 1367), instead finding that "fiscal concerns cannot be held to outweigh harm to Plaintiffs' safety and well-being," which was clear error. (J.A. 1460) The Order simply failed to properly balance the equities, and did not give due regard to defendant's uncontradicted evidence concerning harm to the State.

Secretary Cansler explained that North Carolina is constitutionally required to have a balanced budget and specifically stated that the preliminary injunction

would force the State to "make other reductions to make up for the extra spending." (J.A. 1367) Medicaid Chief Business Operations Officer Steve Owen outlined the Department's current budget deficit and estimated that the financial costs to the State of implementing the Order are more than $40 million dollars in State Fiscal Years 2012 and 2013. (D.E. #24) Plaintiffs did not present any evidence to rebut this evidence of fiscal harm and harm to other Medicaid recipients. The fact that the Department has not yet made any specific reductions while it waits for this Court to rule on the motion for stay does not change the fact that the Secretary's statement remains uncontradicted or that cuts will have to be made.

When revenue is insufficient to support State programs, the State has no alternative but to make reductions to those programs. The mere fact that some recipients will no longer be entitled to PCS does not automatically tip the balance of equities in plaintiffs' favor. It is a false dichotomy to cast the competing claims of equity as the risk of institutionalization for Medicaid recipients who lost PCS versus defendant's budgetary need to establish stricter eligibility requirements. Instead, the real balance of equities here pits the PCS program against other optional Medicaid programs that serve other Medicaid recipients, including other recipients with disabilities. The Order simply awards Medicaid funds to one group of recipients at the expense of others.

The General Assembly and DHHS thoughtfully determined that stricter eligibility for PCS was far preferable to cuts in more critical programs. This determination was supported and approved by CMS. The Order did not consider all of the State's programs and recipients and thus failed to meet the Supreme Court's instruction to pay "particular regard" to the public consequences of injunctive relief. For example, the Sixth Circuit has recognized this principle in connection with even more drastic changes in Tennessee's Medicaid program and concluded:

> [I]t is not lost on us that the implementation of the State's disenrollment process will cause hardship for numerous Tennesseans. When a State to its credit achieves the status of becoming one of the most generous providers of Medicaid services in the nation, it may occasionally happen that the zero-sum fiscal realities of administering a state budget will prohibit the State from sustaining that level of support. If that should happen, it is not for the federal courts to compel the State to maintain non-mandatory Medicaid programs that it can no longer support.

Rosen v. Goetz, 410 F.3d 919, 927, 932-33 (6th Cir. 2005).

The relief granted to the plaintiffs in the Order constitutes a fundamental, systemic alteration of the State Medicaid Plan. It requires the State to make expensive and difficult changes to a program affecting over 20,000 enrolled Medicaid recipients. The District Court abused its discretion by concluding that the balance of equities tips in plaintiffs' favor when the injunction requested is mandatory in nature, ignores CMS approval to the contrary, and forces a state

agency to provide particular funding at the expense of other disabled persons. Moreover, because 42 C.F.R. §431.250(b)(2) requires CMS to provide federal financial participation for services provided in accordance with a court order, the mandatory injunction effectively enjoins CMS itself. Because of the demonstrated likelihood of harm to other Medicaid recipients, the State and the federal government, the Order is contrary to the public interest.

C. PLAINTIFFS DID NOT SHOW A LIKELIHOOD OF SUCCESS ON THE MERITS OF THEIR CLAIMS.

Plaintiffs did not make a clear showing that they are likely to succeed on any of their causes of action, for at least six reasons: (1) they cannot prevail on their Medicaid "comparability" or "reasonableness" claims because CMS' approval of the SPA was entitled to deference; (2) they cannot prevail on their "comparability" claim brought under 42 U.S.C. §1396a(a)(10) because the State is engaged in a comprehensive plan to resolve any alleged comparability issues and plaintiffs presented no evidence that the needs of those in the community and in adult care homes are the same; (3) there is no private right of action under §1983 to enforce the "reasonableness" provision in 42 U.S.C. §1396a(a)(17) and plaintiffs cannot bring this claim under the Supremacy Clause; (4) mere risk of institutionalization is insufficient to establish a claim under the ADA, and there has been no showing that any plaintiff is actually at risk of institutionalization; (5) the Order forces a

fundamental alteration of the State Medicaid plan and will result in cuts to services for other disabled individuals; and (6) the plaintiffs cannot prevail on their due process claims because the right to a fair hearing is not enforceable under § 1983 and because no plaintiff was deprived of anything without due process of law.

1. The District Court failed to give appropriate deference to the federal agency's decision to approve the SPA.

CMS's determination that the SPA complies with the Social Security Act was entitled to substantial deference under the principles espoused in *Chevron U.S.A. Inc. v. NRDC*, 467 U.S. 837 (1984). *See Independent Living*, 565 U.S. ___, ___ (2012) (slip op., at 6) ("The Medicaid Act commits to the federal agency the power to administer a federal program. And here the agency has acted under this grant of authority. That decision carries weight."); *Pharm. Research and Mfrs. of Am. v. Walsh*, 538 U.S. 644, 671 (2003) (Breyer, J., concurring) ("[The federal agency] is better able than a court to assemble relevant facts (e.g., regarding harm caused to present Medicaid patients) and to make relevant predictions (e.g., regarding furtherance of Medicaid-related goals) … the law grants significant weight to any legal conclusion by the [HHS] Secretary as to whether a program … is consistent with Medicaid's objectives.").

In order to prevail on their Medicaid claims, plaintiffs must show that CMS's approval of the SPA was arbitrary, capricious, an abuse of discretion, or

not in accordance with the law. 5 U.S.C. §706(2)(A). They failed to do so, and the District Court did not even consider this standard. Instead, the District Court found that "[a]lthough CMS approved Policy 3E, it did so while simultaneously approving stricter criteria for ACH PCS" and that "[i]rrespective of the plan approved by CMS, Plaintiffs have made a showing that, as currently implemented, Defendant has violated Medicaid's comparability requirement by treating differently recipients with similar levels of need." (J.A. 1457) The record does not support the District Court's finding, because the plaintiffs' own declarations do not show that recipients in adult care homes have "similar levels of need" to those in the community. (J.A. 112, 149-53) In any event, the District Court is not free to disregard the SPA. It is solely up to CMS to enforce any failure to comply with a SPA by withholding federal funds. *See* 42 C.F.R. Part 430, Subpart C.

Plaintiffs have since argued that the SPA is not entitled to deference because "CMS did not approve what Defendant actually implemented," and because defendant "took no action" to impose the stricter PCS limits on recipients living in Adult Care Homes, citing *Nebraska Pharmacists Ass'n v. Nebraska Dep't. of Social Servs.*, 863 F. Supp. 1037 (D. Neb. 1994). (D.E. # 26) In *Nebraska Pharmacists*, the court declined to allow Nebraska to use the approval of an *unrelated* SPA for support of their position that its action, which was not included or described in the amendment, was entitled to deference. *Id.* at 1047. In this case,

there is no question that the SPA at issue specifically approved the three ADL eligibility requirement complained of by the plaintiffs. (J.A. 171) Moreover, no CMS requirement or federal law or regulation mandates defendant to implement the SPA on any particular timetable, particularly where the SPA is part of a long-term plan designed to resolve the alleged comparability issues about which plaintiffs complain.

In their briefs before the District Court, plaintiffs further argued that if CMS knowingly approved the SPA, the approval was inconsistent with previous stated positions of the agency. (J.A. 412) As is clear from the timeline of events, CMS approved the SPA after receiving the same objections made by plaintiffs in this action, with full knowledge of its scope and ramifications and with knowledge that the State was in the process of developing and implementing a 1915(i) option that would resolve any alleged comparability issues. It must be presumed that the federal agency responsible for overseeing the Medicaid program would not knowingly approve a SPA that violates the Social Security Act or the ADA.

Well-settled Supreme Court and Fourth Circuit caselaw, as well as caselaw from nearly every other Circuit, holds that *Chevron* deference specifically applies to Medicaid state plan approvals. For example, in reviewing a challenge brought by the State of Maryland, this Court held that "even if we agreed that Maryland's [SPA] is more reasonable, CMS would still prevail because we must defer to its

interpretation." *Maryland Department of Health and Mental Hygiene v. CMS*, 542 F.3d 424, 436 (4th Cir. 2008), relying on *Chevron*, 467 U.S. at 842-43.

The Second Circuit also held that CMS interpretations are entitled to considerable deference, stating that "we take care not lightly to disrupt the informed judgments of those who must labor daily in the minefield of often arcane policy, especially given the substantive complexities of the Medicaid statute." *Community Health Center v. Wilson-Coker*, 311 F.3d 132 (2d Cir. 2002); accord, *Georgia v. Shalala*, 8 F.3d 1565 (11th Cir. 1993); *Pharm. Research and Mfgrs. of America v. Thompson*, 362 F.3d 817 (D.C. Cir. 2004); *Harris v. Olszewski*, 442 F.3d 456 (6th Cir. 2006); *Minnesota Pharmacists Ass'n v. Pawlenty*, 690 F. Supp. 2d 809, 826 (D. Minn. 2010) (There is "no persuasive, much less controlling, authority permitting [a court] to substitute its assessment of whether a State Plan complies with [The Social Security Act] for that of the federal agency that Congress expressly authorized to review and approve such plans").

Here, unlike the majority of cases cited by the plaintiffs (J.A. 408-09), defendant waited for federal approval of the SPA and relied on that approval to make expensive and difficult changes to the Medicaid program. The Order, a mandatory preliminary injunction, now forces defendant to undo those changes at considerable expense and harm to other recipients. Such a result equates to regulation by litigation, or worse, "government by injunction," which the Supreme

Court cautioned against in *Schlesinger v. Reservists Comm. to Stop the War*, 418 U.S. 208, 222 (1974).

The Order is inconsistent with Congress's decision to centralize enforcement authority in CMS and disregards the administrative process created by Congress for resolution of these issues. *See* 42 C.F.R. Part 430, Subpart D; *see also Astra USA, Inc.* v. *Santa Clara County*, 131 S.Ct. 1342, 1346 (2011). It undermines the key benefits of a centralized administrative enforcement scheme: national uniformity, consistency, and predictability in interpretation and administration of federal law. Indeed, the Order makes it virtually impossible for the State to plan and budget its Medicaid obligations because defendant is now subject to judicially created requirements contrary to those imposed by CMS. This is the antithesis of how the system is supposed to work. *Gonzaga Univ.* v. *Doe*, 536 U. S. 273, 292 (2002) (Breyer, J., concurring) (contrasting "the expertise, uniformity, wide-spread consultation, and resulting administrative guidance that can accompany agency decisionmaking" with the "comparative risk of inconsistent interpretations and misincentives that can arise out of an occasional inappropriate application of the statute in a private action").

In *Independent Living*, the Supreme Court specifically found that there was no reason not to apply the "ordinary standards of deference" once CMS has approved a SPA. 565 U.S. ___, ___ (2012) (slip op., at 7). The same holds true in

this case. There was no basis for the District Court to ignore the well-settled *Chevron* rule giving substantial deference to CMS's approval of the North Carolina SPA, and thus the District Court erred in finding that plaintiffs had shown a likelihood of success on the merits of their comparability and reasonableness claims.

2. The District Court erred in finding that plaintiffs were likely to prevail on their "comparability" claim brought under 42 U.S.C. §1396a(a)(10).

Prior to the lawsuit, defendant applied to CMS for a home and community based services waiver under Section 1915(i) of the Act that will establish new eligibility requirements for personal care services across the State, regardless of where provided. (J.A. 686) As the first step towards approval of the Section 1915(i) waiver, defendant submitted a SPA terminating coverage of all State Plan PCS, including IHCA. (J.A. 688) On 28 February 2012, CMS approved this SPA, which terminates all PCS effective 30 April 2012. (D.E. #29) The injunction only prolongs and delays implementation of the 1915(i) waiver across the State and further exacerbates the very comparability issues about which plaintiffs complain. Where defendant has applied to CMS for a waiver that will resolve the State's alleged comparability issues, an injunction will not lie. *Lankford v. Sherman,* 451 F.3d 496, 502 (8th Cir. 2006).

Moreover, plaintiffs admit that the comparability requirement "mandates

comparable services when recipients have comparable needs" and it is only violated "when some recipients are treated differently from other recipients where each has the same level of need." [1] (J.A. 409) The bare-bones allegations of the complaint do not support a generalized finding that residents of Adult Care Homes and other PCS recipients have the same level of need and plaintiffs submitted no medical evidence in support of such a finding. For example, individuals are admitted into Adult Care Homes only upon certification from a physician that they need the supervision or monitoring provided by licensed adult care home professionals and are not able to safely live at home. (J.A. 149-153) An individual receiving PCS community must be able to safely live at home. (J.A. 493-94, 503, 921) The needs and service requirements of the two populations are necessarily different. Defendant has not conceded otherwise, and plaintiffs did not show a likelihood of success on this argument.

3. The District Court erred in finding that plaintiffs were likely to prevail on their "reasonableness" claim brought under 42 U.S.C. §1396a(a)(17).

There is no private right of action under §1983 to enforce the "reasonableness" provision found at 42 U.S.C. §1396a(a)(17). *See Watson v.*

[1] It is also worth noting that under the plaintiffs' definition, services were not comparable under the program requirements in effect on 31 May 2011, yet plaintiffs are apparently content with a remedy that is equally incomparable.

Weeks, 436 F.3d 1152, 1162 (9th Cir. 2006); *Lankford*, 451 F.3d at 509. Recognizing this hurdle, plaintiffs attempted a secondary argument that because the SPA and Policy 3E violate the Medicaid reasonable standards requirement, they are "therefore preempted pursuant to the Supremacy Clause of the U.S. Constitution, art. IV." (J.A. 975) The Supreme Court recently addressed this precise Supremacy Clause argument in *Independent Living*. Although the majority opinion declined to answer the general question as to whether providers or recipients can maintain a cause of action under the Supremacy Clause to enforce a federal Medicaid law, the decision strongly indicates that they certainly cannot do so once CMS has approved the SPA at issue. *Independent Living*, 565 U.S. ___, ___ (2012) (slip op., at 7-8) ("[T]o allow a Supremacy Clause action to proceed once the agency has reached a decision threatens potential inconsistency or confusion. … the Supremacy Clause challenge is at best redundant.").

The Supremacy Clause is "not a source of any federal rights." *Chapman v. Houston Welfare Rights Organization*, 441 U. S. 600, 613 (1979); accord, *Dennis v. Higgins*, 498 U. S. 439, 450 (1991) (contrasting, in this regard, the Supremacy Clause and the Commerce Clause). As Chief Justice Roberts stated in his dissent to *Independent Living*:

> Saying that there is a private right of action under the Supremacy Clause would substantively change the federal rule established by Congress in the Medicaid Act. … Indeed, to say that there is a federal

> statutory right enforceable under the Supremacy Clause, when there is no such right under the pertinent statute itself, would effect a complete end-run around this Court's implied right of action and 42 U. S. C. §1983 jurisprudence. We have emphasized that "where the text and structure of a statute provide no indication that Congress intends to create new individual rights, there is no basis for a private suit, whether under §1983 or under an implied right of action." *Gonzaga Univ.* v. *Doe*, 536 U. S. 273, 286 (2002). This body of law would serve no purpose if a plaintiff could overcome the absence of a statutory right of action simply by invoking a right of action under the Supremacy Clause to the exact same effect. Cf. *Astra USA, Inc.* v. *Santa Clara County*, 563 U. S. ___, ___ (2011) (slip op., at 7).

565 U.S. ___, ___ (2012) (Roberts, J., dissenting op. at 3-5). Because there is no private right of action under either the Medicaid Act or the Supremacy Clause to enforce the reasonableness provision, the District Court erred as a matter of law in finding that plaintiffs showed a likelihood of success on this claim.

4. Mere risk of institutionalization is insufficient to establish a claim under the ADA and the Order forces a fundamental alteration of the State Medicaid Plan.

The Supreme Court has expressly disavowed a construction of the ADA that would require States to "provide a certain level of benefits to individuals with disabilities," and has acknowledged that individuals may have to seek institutional services from time to time. *Olmstead v. L.C. by Zimring*, 527 U.S. 581, 605-06 (1999). States are not required to provide any specific community-based placement desired or preferred by qualified disabled persons. *Id.* In any event, plaintiffs' proposed standard – that a state has discriminated against any individual

who is "at risk of institutionalization" (J.A. 414) – has no foundation in the ADA and is inconsistent with the *Olmstead* decision. For example, the ADA's prohibition of "unjustified isolation of individuals with disabilities," is limited to cases of "continued confinement in a segregated environment," *Olmstead*, 527 U.S. at 593, 597. Plaintiffs' leap from "unjustified institutionalization" to "at risk of institutionalization," is simply another means of arguing that the statute requires a minimum level of services, a conclusion that the *Olmstead* plurality expressly declined to make.

Tellingly, federal ADA regulations address this point, and specifically do not require "a public entity to provide to individuals with disabilities personal devices, such as wheelchairs; individually prescribed devices, such as prescription eyeglasses or hearing aids; readers for personal use or study; or *services of a personal nature including assistance in eating, toileting, or dressing*." 28 C.F.R. §35.135 (2010) (emphasis added). This provision "serves as a limitation on all of the requirements of the regulation," 56 Fed. Reg. 35,694, 35,707 (July 26, 1991), and expressly applies to the rule requiring reasonable service modifications, 28 C.F.R. §35.130(b)(7). Plaintiffs contend that a state "discriminates" when it fails to provide sufficient PCS to eliminate a speculative risk that an individual living at home will require institutional care at some nebulous point in the future. This is not what Congress intended when it prohibited discrimination against individuals

with disabilities.

Even if plaintiffs could show they have a claim for discrimination based on "risk of institutionalization," they did not show that the Order can be "reasonably accommodated" by defendant. *Olmstead*, 527 U.S. at 602. "The State's responsibility, once it provides community-based treatment to qualified persons with disabilities, is not boundless." *Id.* at 603. The governing federal regulation "allows States to resist modifications that entail a 'fundamental alteration' of the States' services and programs." *Id.*, citing 28 C.F.R. §35.130(b)(7)(1998). In *Olmstead*, the Supreme Court explained that the fundamental alteration defense gives States "more leeway" than the courts below allowed, 527 U.S. at 605, and that any construction of the defense that "would leave the State virtually defenseless" is "unacceptable." *Id.* at 603. The First Circuit has stated that "in no event is the [State] required to undertake measures that would pose an undue financial or administrative burden … or effect a fundamental alteration in the nature of the service." *Toledo v. Sanchez*, 454 F.3d 24, 39 (2006), *cert. denied*, *Univ. of P.R. v. Toledo*, 549 U.S. 1301 (2007); *see also Boyd v. Steckel*, 753 F. Supp. 2d 1163, 1176 (M.D. Ala. 2010). This principle is even more applicable to the instant case, in which the plaintiffs are neither institutionalized nor at any significant risk of institutionalization.

The Order constitutes an abuse of discretion because it requires defendant to

dismantle an existing program and provide services that are no longer approved in the State's Medicaid Plan, fundamentally alters the nature of the service as mandated by the General Assembly and approved by CMS, and places a roadblock on the State's path to develop a 1915(i) waiver program.

5. Plaintiffs failed to demonstrate a likelihood of success on their due process claims.

Due process simply requires that recipients receive "timely and adequate notice" of the reduction or termination of their benefits, and be given a reasonable opportunity to challenge the reduction or termination. *Goldberg v. Kelly*, 397 U.S. 254, 262-69 (1970); *Garrett v. Puett*, 707 F.2d 930, 931-932 (6th Cir. 1983) (notices that identified intended action, reason for the action, citation to relevant statute, and notice of right to appeal "satisfy due process and statutory requirements"). Each plaintiff received such notice and opportunity.

Arguably implicit in the concept of a fair hearing is the right to reasonable notice of the State's intended action so that a recipient can adequately prepare for hearing. On their face, the notices in the record easily comply with this requirement. (J.A. 506-682) Each notice of termination was three pages long (plus a pre-printed appeal form), included the specific reason for the termination, and cited the relevant state and federal laws, regulations and policies. *Id.* Moreover, defendant provided each recipient who appealed with a copy of their

assessment results (J.A. 924), and each of the plaintiffs understood the notices sufficiently to file an appeal. (J.A. 508-682)

Here, plaintiffs have alleged two separate due process causes of action. The first claim is that defendant's alleged practices and procedures violate Section 1396a(a)(3) of the Act and thus entitle them to relief under §1983. The second claim is that defendant's alleged practices and procedures violate the Fourteenth Amendment of the U.S. Constitution and entitle plaintiffs to relief under that Amendment and under §1983. Both claims must fail because each received their due process right to a fair hearing. In any event, the right to a fair hearing is not enforceable under §1983 and no plaintiff was deprived of anything without due process of law.

a. Section 1396a(a)(3) does not create an enforceable substantive right.

In order to seek redress through §1983, a plaintiff must assert the violation of a federal right, not merely a violation of federal law. *Blessing v. Freestone*, 520 U.S. 329, 340-41 (1997). To determine whether a particular statutory provision gives rise to a federal right enforceable under §1983, the initial step in the analysis requires a determination of Congressional intent to create a federal right. *Bio-Med. Applications of N.C. v. Elec. Data Sys. Corp*., 412 F. Supp. 2d 549, 555 (E.D.N.C. 2006) (finding as a matter of law that in enacting 42 U.S.C. §§1396a(4)(a),

1396a(8), 1396a(37)(A), and 1396a(30)(A) Congress did not create rights enforceable under §1983). The second consideration is whether the "right" claimed is not so "vague and amorphous" that its enforcement would strain judicial competence. *Blessing*, 520 U.S.at 340-41. The third consideration is whether the statute unambiguously imposes a binding obligation on the States. *Id.* At a minimum, the statutory provision giving rise to the asserted right must be couched in mandatory terms. *Id*.

In applying this test, courts are required to identify with particularity the rights claimed to arise under a specific statutory provision. *Blessing*, 520 U.S. at 342-43. The statute must create new rights in "clear and unambiguous terms – no less and no more than what is required for Congress to create new rights enforceable under an implied private right of action." *Gonzaga*, 536 U.S. at 290. Section 1396a(a)(3) provides, in pertinent part, that a state plan for medical assistance must provide "an opportunity for a fair hearing … to any individual whose claim for medical assistance is denied or is not acted upon with reasonable promptness."

In this case, plaintiffs do not allege constitutional inadequacies with the fair hearing itself. Instead, plaintiffs claim that defendant's notices do not provide an adequate explanation of the reasons for the decision and/or that the notices do not cite the relevant legal authority, policy or regulations supporting the decision.

(J.A. 972) The Order found that defendant's notice "contained verbatim language that failed to provide detailed reasons for the proposed termination." (J.A. 1459) Regardless of the nature of the due process violation alleged, §1396a(a)(3) simply does not give rise to any rights under §1983. As the First Circuit has explained:

> [S]ection 1396a(a)(3) merely guarantees a fair hearing to Medicaid beneficiaries. It neither offers any detail as to how states must conduct such hearings nor erects any ancillary remedial structures ... the Medicaid fair hearing reference is a *standardless generality*, open to interpretation by the states.

Rosie D. v. Swift, 310 F.3d 230, 236-37 (2002)(emphasis added). A "standardless generality" is hardly the type of statute of which enforceable rights are made.

Similarly, this Court has found that nearly identical language in 42 U.S.C. §8624(b)(13) does not create a private substantive right. *Hunt v. Robeson County Dep't of Soc. Servs.*, 816 F.2d 150 (4th Cir. 1987); *Boyland v. Wing*, 487 F. Supp. 2d 161 (2007). A right to a fair hearing is merely procedural, not substantive, and it is not enforceable under §1983. Regulations promulgated under §1396a(a)(3) also do not create enforceable §1983 rights not "already implicit in the enforcing statute." *Smith v. Kirk*, 821 F.2d 980, 984 (4th Cir. 1987); *Alexander v. Sandoval*, 532 U.S. 275 (2001); accord, *Peters v. Jenney*, 327 F.3d 307, 316 n. 9 (4th Cir. 2003); *Brinkley v. Hill*, 981 F. Supp. 423 (S.D. W. Va. 1997).

Accordingly, the regulations referenced by plaintiffs (J.A. 945-45) cannot and do not create any enforceable right not implicit in that standardless generality,

§1396a(a)(3), itself. *See Prestera Ctr. for Mental Health Servs. v. Lawton*, 111 F. Supp. 2d 768 (S.D. W. Va. 2000) (holding that regulations promulgated pursuant to the Medicaid Act are not enforceable via §1983). As in *Prestera*, plaintiffs' claims herein stand or fall on the statute itself, and plaintiffs have no claims enforceable through §1983 under any of the regulations they cite. However, even if the opportunity for a fair hearing constituted an enforceable substantive right, plaintiffs have not alleged this right was violated or that any plaintiff was deprived of anything as a result of any violation.

b. Plaintiffs failed to show any violation of procedural due process.

To establish a claim for violation of constitutional procedural due process, a plaintiff must show (1) that a protected property interest was taken, and (2) that the procedural safeguards surrounding the deprivation were inadequate. *See Board of Regents v. Roth*, 408 U.S. 564, 568-69 (1972). The deprivation of a property interest is only unconstitutional if it is effected without due process of law. *Zinermon v. Burch*, 494 U.S. 113, 125-26 (1990). Therefore, to determine whether defendant violated plaintiffs' due process rights, the District Court should have analyzed what pre-deprivation and post-deprivation process was provided and whether it was constitutionally adequate. *Id.*; *see also Fields v. Durham*, 909 F.2d 94, 97 (4th Cir. 1990) (to determine whether a procedural due process violation has

occurred, a court must consult the entire panoply of process provided). In this case, the District Court failed to undertake the appropriate due process analysis, and the Order's conclusion that plaintiffs demonstrated a likelihood of success on the merits on this claim was an error of law.

i. Plaintiffs have no property right.

The first inquiry is whether the plaintiffs have been deprived of a protected interest in "property." *Mathews v. Eldridge*, 424 U.S. 319, 332 (1976). Only if there has been the deprivation of a protected property interest does the court examine whether the State's procedures comport with due process. *Id*., 424 U.S. at 332. "The Fourteenth Amendment's procedural protection of property is a safeguard of the security of interests that a person *has already acquired in specific benefits*." *Roth*, 408 U.S. at 576 (emphasis added).

Absent an absolute entitlement, there is no property right. *Guilford County Cmty. Action Program, Inc. v. Wilson*, 348 F. Supp. 2d 548 (M.D.N.C. 2004). For example, in *Roth*, when employment was to terminate on a fixed date, with no provision for contract renewal, the employee did not have a *property* interest sufficient to require the authorities to give him a hearing when they declined to renew his contract. 408 U.S. at 578 (emphasis in original). Once an individual has been found eligible for Medicaid, that status is a property interest that cannot be withdrawn without giving the recipient notice and an opportunity to be heard. *See*

O'Bannon v. Town Court Nursing Ctr., 447 U.S. 773, 787 (1980); *see also Goldberg*, 397 U.S. at 262. However, this is different from the entitlement to *specific Medicaid services* pursuant to a State's utilization review procedures. *See e.g. Johnson v. Guhl*, 91 F. Supp. 2d 754 (D.N.J. 2000) (plaintiffs found not entitled to procedural safeguards with respect to property interest for which they were not qualified).

There is generally no property right in the continuation of such benefits beyond their expiration date or period. *See Holman v. Block*, 823 F.2d 56, 59 (4th Cir. 1987), *citing Banks v. Block*, 700 F.2d 292 (6th Cir. 1983) (no protectable property interest in the continuous entitlement to food stamps beyond the expiration of the certification period); *Shvartsman v. Apfel*, 138 F.3d 1196, 1200 (7th Cir. 1998) (plaintiffs correctly conceded that there is no property right in continuing Food Stamp benefits, which were cut off on a set date unless plaintiffs became citizens prior to that date); *Kaplan v. Chertoff*, 481 F. Supp. 2d 370 (E.D. Pa. 2007) (no right to SSI benefits beyond period provided by Congress, regardless of governmental delays).

When an entitlement is time-limited, as is the PCS provided to plaintiffs herein, there is no property right beyond the particular time period approved. Even if some plaintiffs had their PCS terminated prior to the end of a particular approved time period, the governing federal regulation specifies that recipients are not

entitled to a hearing "if the sole issue is a Federal or State law requiring an automatic change adversely affecting some or all recipients." 42 C.F.R. 431.220(b). In this case, there was a change in the State Medicaid Plan concerning PCS eligibility criteria which adversely affected a group of recipients. They had no property right in receiving a fair hearing.

ii. Plaintiffs have no claim to an ongoing violation because they have not been *deprived* of anything without due process.

Even if plaintiffs had a property right in this action, there has yet to be any deprivation without due process. *See, e.g., Zinermon*, 494 U.S. at 126; *Boyland*, 487 F. Supp. 2d at 180. No plaintiff has lost anything (whether "property" or not) as a result of the allegedly "defective" notice. A plaintiff has no claim unless he shows resulting *prejudice* from the arguably deficient due process procedures. In this case, no plaintiff alleges that he was prejudiced by any failure to comprehend the notices. This bedrock principle was recognized by this Court nearly twenty years ago in *Riccio v. County of Fairfax*, 907 F.2d 1459, 1468-69 (1990):

> [T]he mere fact that a state enacts an entitlement to a procedure does not mean that the procedure so created inevitably reduces the likelihood of an erroneous deprivation to a point warranting constitutional recognition. … Because the allegedly violated procedures here at issue would not have affected the likelihood of a proper resolution of Riccio's case to any appreciable extent, violation of those procedures is of no constitutional moment.

The Order found that "the fact that plaintiffs timely appealed their termination is not, however, determinative of whether or not defendant's notice comports with due process." While it may not be determinative, it is certainly a significant factor, one which was erroneously discounted by the District Court. *See Wagner v. Duffy*, 700 F. Supp. 935, 943 (N.D. Ill. 1988) ("Meaningful notice must edify the receiver sufficiently so that he or she will have an opportunity to respond to the government action."). The Order also found that plaintiffs were likely to prevail on their due process claims because the "termination of in-home PCS could be quantified as a 'brutal need'" and the notices failed to provide "detailed reasons" for the proposed termination of benefits, *citing Schroeder v. Hegstrom*, 590 F. Supp. 121, 128 (D. Or. 1984). First, the quantum of process due does not depend upon a finding of "brutal need" and the District Court's conclusion otherwise relied upon an erroneous legal standard. Second, there was no basis in the record for the District Court to determine that intermittent assistance with activities of daily living constitutes a "brutal need," whatever that may be. Third, the Order fails to specify how the alleged lack of detailed reasons deprived any plaintiff of anything.

The essential question in *Schroeder* was whether inclusion of more detailed information in the notice impacted a recipient's decision "whether to request a hearing." *Id.* at 127. Here, no plaintiff alleged that any purported failure to

include more detailed reasons for the termination of PCS had any effect whatsoever on their decision whether or not to request a hearing. In fact, each of the named plaintiffs timely requested a hearing, and the vast majority resolved their appeals satisfactorily prior to the hearing on plaintiffs' motion. Moreover, the applicable federal regulation does not require "detailed" reasons, merely "reasons." 42 C.F.R. 431.210(b). No plaintiff demonstrated that she was deprived of anything by any purported failure of the notice, and the District Court erred in finding that plaintiffs showed a likelihood of success on the merits of their due process claims.

IV. THE ORDER DOES NOT COMPLY WITH THE RULE 65 REQUIREMENTS FOR AN INJUNCTION.

The Order in this case violates Fed. R. Civ. P. 65 both by its lack of specificity and its failure to address the issue of security. Either violation constitutes sufficient grounds for the Order to be vacated.

A. THE ORDER WAS SO UNCLEAR THAT THE DISTRICT COURT HAS ALREADY ATTEMPTED TO CLARIFY ITS MEANING, RESULTING IN FURTHER CONFUSION.

As the Supreme Court has stated, "the specificity provisions of Rule 65(d) are no mere technical requirements. The Rule was designed to prevent uncertainty and confusion on the part of those faced with injunctive orders, and to avoid the possible founding of a contempt citation on a decree too vague to be understood." *Schmidt v. Lessard*, 414 U.S. 473, 476 (1974), *citing Int'l Longshoremens Ass'n. v.*

Philadelphia Marine Trade Ass'n., 389 U.S. 64, 74-76 (1967). Here, the final statement in the Order expressly prohibited defendant "from implementing IHCA Policy 3E," (J.A. 1461) which was the relief specifically requested by the plaintiffs (J.A. 17, 423-24). Nothing in the Order or the pleadings filed by plaintiffs suggested otherwise. Accordingly, defendant took steps to undo Policy 3E and began to implement the previous policy, incidentally removing certain services that were included in Policy 3E.

The District Court then issued another Order on 2 March 2012, on plaintiffs' motion, clarifying that the Court intended something different from the plain meaning of the Order, stating that "any construction of this Court's [8 December] order by Defendant contrary to the relief requested by Plaintiffs is unreasonable" and preventing defendant from decreasing PCS services "in any way." (J.A. 1581) The District Court further reiterated the confusing statement from the Order that defendant was only required to reinstate PCS to those recipients "who were found to be entitled to such benefits prior to June 1, 2011," suggesting that defendant implement different eligibility standards depending upon whether a recipient was assessed before or after 1 June 2011. *Id.* Moreover, the Order enjoins implementation of Policy 3E but does not enjoin implementation of the SPA itself, which potentially jeopardizes federal financial participation. The confusion

inherent in the District Court's 2 March 2012 Order demonstrates that the 8 December Order violated Rule 65 by its lack of specificity.

B. THE ORDER IS SILENT ON THE QUESTION OF SECURITY.

The Order also violates Rule 65 by failing to address the issue of security. *Eyewonder, Inc. v. Abraham*, 293 F. Appx. 818, 821 (2d Cir. 2008) ("[W]hile it might be 'within the discretion of the district court to decide that, under the circumstances, no security [is] required, the district court [is] required to make this determination before it enter[s] the preliminary injunction.'") *See also System Operations, Inc. v. Scientific Games Dev. Corp.*, 555 F.2d 1131, 1145 (3d. Cir. 1977) (a "district court commits reversible error when it fails to require the posting of a security bond"); *Yolton v. El Paso Tenn. Pipeline Co.*, 318 F. Supp. 2d 455, 475 (E.D. Mich. 2003) (it is error for a judge "to have failed to exercise the discretion required of him by Rule 65(c) by expressly considering the question of requiring a bond."); *see also Habitat Educ. Ctr. v. U.S. Forest Serv.*, 607 F.3d 453, 459-60 (7th Cir. 2010).

V. THE DISTRICT COURT ERRED IN CERTIFYING THE CLASS.

As noted earlier, an appeal brought under 28 U.S.C. §1292(a) "brings before the appellate court the entire order, not merely the propriety of injunctive relief." *Allstate*, 382 F.2d at 88. Therefore, this Court has jurisdiction to review the propriety of the class certification.

A. THE PLAINTIFFS LACK STANDING TO BRING THIS LAWSUIT.

The Order erroneously concludes that each plaintiff has standing to challenge the implementation of Policy 3E even though their individual claims against the Department have been mooted or are not ripe. Article III of the Constitution limits the jurisdiction of the federal courts to the consideration of "cases" and "controversies." U.S. Const. art. III, §2. The "irreducible constitutional minimum of standing," rooted in Article III's case-or-controversy requirement, consists of three elements: (1) an "injury in fact," by which is meant "an invasion of a legally protected interest"; (2) "a causal connection between the injury and the conduct complained of"; and (3) a likelihood that "the injury will be redressed by a favorable decision." *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992). "'The rule in federal cases is that an actual controversy must be extant at all stages of review.'" *Id.*, quoting *Steffel v. Thompson*, 415 U.S. 452, 459 n.10 (1974). The Supreme Court has stated that "Article III requirements must be met 'at the time the complaint is filed, and at the time the class action is certified by the District Court pursuant to Rule 23.'" *Id.*, quoting *Sosna v. Iowa*, 419 U.S. 393, 402 (1975). It is "essential that named class representatives demonstrate standing through a 'requisite case or controversy between themselves personally and [defendants],' not merely allege that 'injury has been suffered by other, unidentified members of the class to which they belong and which they purport to

represent.'" *Id.*, quoting *Blum v. Yaretsky*, 457 U.S. 991, 1001 n.13 (1982) (citations omitted). "[I]f none of the named plaintiffs purporting to represent a class establishes the requisite of a case or controversy with the defendants, none may seek relief on behalf of himself or any other member of the class." *O'Shea v. Littleton*, 414 U.S. 488, 494 (1974).

Eleven of the named plaintiffs dismissed their administrative appeals prior to the injunction hearing.[2] This Court has held "that when a putative class plaintiff voluntarily dismisses the individual claims underlying a request for class certification, as happened in this case, there is no longer a 'self-interested party advocating' for class treatment in the manner necessary to satisfy Article III standing requirements." *Rhodes v. E.I. du Pont de Nemours & Co.*, 636 F.3d 88, 100 (2011), quoting *U.S. Parole Comm'n v. Geraghty*, 445 U.S. 388, 403 (1980). The *Rhodes* court recognized that a "case must be brought by a party with a 'personal stake' in the litigation," and that this "personal interest must continue throughout the litigation, including on appeal." *Id.* at 99, quoting *U.S. v. Hardy*, 545 F.3d 280, 283 (4th Cir. 2008) and *Geraghty*, 445 U.S. at 396. If circumstances change while a case is pending, thereby leaving a plaintiff without the personal

[2] Plaintiffs Pashby, Baxley, Drew, Ford, Gabijan, Hutter, James Moore, Lucretia Moore, Shropshire and Splawn dismissed because they qualified for IHCA, and Plaintiff Jones dismissed his appeal on the advice of his legal representative. (J.A. 947-963)

stake necessary to maintain Article III standing, "the district court or appellate court must dismiss the case for lack of subject-matter jurisdiction." *Id.*, *citing Distaff, Inc. v. Springfield Contracting Corp.*, 984 F.2d 108, 110-11 (4th Cir. 1993).

In reaching its ultimate conclusion that a putative class plaintiff who voluntarily settles his or her claim does not have a "sufficiently concrete interest in the certification question to satisfy the case-or-controversy requirement of Article III," this Court found that "[t]wo conditions must be met, however, to retain Article III jurisdiction." *Id.* "The 'imperatives of a dispute capable of judicial resolution [must be] sharply present,' and there must be 'self-interested parties vigorously advocating opposing positions.'" *Id.*, quoting *Geraghty*, 445 U.S. at 403. The plaintiffs who dismissed their appeals no longer have a dispute against defendant capable of judicial resolution. The District Court erroneously found that these plaintiffs were still at risk "because they continue to face termination of their in-home PCS" by virtue of the annual clinical reassessment. (J.A.1452) The State Plan has always required annual re-evaluation for PCS; this "risk" would occur regardless of whether Policy 3E was implemented or not. In any event, because all PCS terminates effective 30 April 2012, none of the plaintiffs continue to face this speculative "risk."

Applying the principles set forth by this Court in *Rhodes*, the District Court erred when it held that the plaintiffs who dismissed their administrative claims satisfied Article III standing requirements and are capable of serving as class representatives.

Further, two remaining plaintiffs lack standing because their claims are not ripe for review.[3] "For a case or controversy to be ripe for judicial review, it must involve 'an administrative decision [that] has been formalized and its effects felt in a concrete way by the challenging parties.'" *Arch Mineral Corp. v. Babbitt*, 104 F.3d 660, 665 (4th Cir. 1997), *citing Charter Fed. Sav. Bank v. Office of Thrift Supervision*, 976 F.2d 203, 208 (4th Cir. 1992). Here, the remaining plaintiffs filed a timely appeal request but, at the time of the District Court's hearing on the motion for injunctive relief, no final administrative decision was issued on the central question of whether they qualified for IHCA under the new eligibility requirements. *Id.* Thus, it remains entirely speculative whether, at some unspecified point in the future, either of these plaintiffs will ultimately be denied benefits as a result of the SPA and Policy 3E. *See, e.g.*, *Egan v. Davis*, 118 F.3d 1148, 1150 (7th Cir. 1997) ("Persons who actually lose as a result of the administrative appeal would be appropriate plaintiffs, but as we have stressed no

[3] Plaintiffs Pettigrew and Phillips are still in the administrative appeal process. (J.A. 1059-61)

such person is before the court."). The District Court erred in finding that these two plaintiffs met standing requirements.

B. THE CLASS IS NOT IDENTIFIABLE.

As the Supreme Court reiterated in *Wal-Mart Stores, Inc. v. Dukes*, 131 S. Ct. 2541 (2011), "[t]he class action is 'an exception to the usual rule that litigation is conducted by and on behalf of the individual named parties only.'" *Id.* at 2550, quoting *Califano v. Yamasaki*, 442 U.S. 682 (1979). "In order to justify a departure from that rule, 'a class representative must be part of the class and possess the same interest and suffer the same injury as the class members.'" *Id.*, quoting *East Tex. Motor Freight System, Inc. v. Rodriguez*, 431 U.S. 395, 403 (1977). The purpose of Rule 23(a) is to ensure "that the named plaintiffs are appropriate representatives of the class whose claims they wish to litigate." *Id.*

As courts have noted, "the final three requirements of Rule 23(a) 'tend to merge, with commonality and typicality serving as guideposts for determining whether … maintenance of a class action is economical and whether the named plaintiff's claim and the class claims are so interrelated that the interests of the class members will be fairly and adequately protected in their absence.'" *Lienhart v. Dryvit Sys.*, 255 F.3d 138, 147 (4th Cir. 2001) (citations omitted). In this case, because each plaintiff's disability status, medical condition, personal care needs, alleged risk of institutionalization, and desire or ability to live at home must be

decided on an individual, fact-specific basis, they did not meet the requirements of Rule 23(a).

In *Wal-Mart*, the Supreme Court found that "what matters to class certification . . . is not the raising of common 'questions'—even in droves—but, rather the capacity of a classwide proceeding to generate common answers apt to drive the resolution of the litigation. *Dissimilarities within the proposed class* are what have the potential to impede the generation of common answers." 131 S. Ct. at 2551 (internal citations omitted). Similarly, a question is not common "if its resolution 'turns on a consideration of the individual circumstances of each class member.'" *Thorn v. Jefferson-Pilot Life Ins. Co.*, 445 F.3d 311, 319 (4th Cir. 2006). The District Court erred as a matter of law in failing to properly apply this analysis. The proposed class did not meet the final three interrelated Rule 23(a) factors.

C. THE PLAINTIFFS CANNOT REPRESENT THE CLASS AS TO THE DUE PROCESS CLAIMS.

The District Court erred in finding that the named plaintiffs could represent the class as to the due process claims for the reasons discussed in Section III.C.4., *infra*. No plaintiff was deprived of anything or prejudiced in any way by the alleged deficiency with defendant's notice. The named plaintiffs cannot serve as

class representatives for individuals who did not file an administrative appeal; their claims are not typical of the claims of those individuals.

VI. THE PLAINTIFFS' CLAIMS SHOULD BE DISMISSED FOR LACK OF SUBJECT MATTER JURISDICTION.

The *Independent Living* decision suggests that plaintiffs' Medicaid claims should be dismissed and they should be required to proceed against CMS under the Administrative Procedure Act ("APA"), 5 U. S. C. §701 *et seq.*:

> For one thing, the APA would likely permit respondents to obtain an authoritative judicial determination of the merits of their legal claim. … For another thing, respondents' basic challenge now presents the kind of legal question that ordinarily calls for APA review.

565 U.S. ___, ___ (2012) (slip op., at 7-8). As applied in this case, the District Court lacked subject matter jurisdiction over plaintiffs' Medicaid claims because their dispute properly lies with CMS, not with defendant. Further, if plaintiffs cannot establish constitutional standing, their claims must be dismissed for lack of subject matter jurisdiction. Finally, because CMS has now approved termination of all personal care services in North Carolina effective 30 April 2012 in preparation for implementation of the 1915(i) waiver, there no longer exists any "cognizable danger" of recurrent alleged violations, and plaintiffs' claims should be dismissed as moot. *See United States v. Jones*, 136 F.3d 342, 348 (4th Cir. 1998), *citing United States v. W.T. Grant Co.*, 345 U.S. 629, 633 (1953).

CONCLUSION

Wherefore, for the aforementioned reasons, defendant respectfully requests that this Honorable Court reverse the Order of the District Court and DENY plaintiffs' motions for preliminary injunction, class certification and leave to file additional declarations, and further, that the Court DISMISS plaintiffs' claims with prejudice.

REQUEST FOR ORAL ARGUMENT

Defendant believes that oral argument will assist the Court in clarifying the issues raised in this appeal. The case involves complex and evolving issues of standing, constitutional due process, and federal Medicaid law, some of which are issues of first impression in this Circuit.

CERTIFICATE OF COMPLIANCE WITH TYPEFACE AND LENGTH LIMITS

Undersigned counsel certifies that this brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because this brief contains 13,423 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

Respectfully submitted, this the 6th day of March, 2012.

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CERTIFICATE OF SERVICE

I hereby certify that on this day, 6 March 2012, I electronically filed the foregoing **DEFENDANT-APPELLANT'S OPENING BRIEF** with the Clerk of the Court using the CM/ECF system which will send notification of such filing to the following: John R. Rittelmeyer, Jennifer L. Bills, Elizabeth Edwards, Jane Perkins, Sarah Somers and Douglas S. Sea, attorneys for plaintiffs, and I hereby certify that I have mailed the document to the following non CM/ECF participants: none. Three copies of the same were served by depositing one copy in the United States mail, first class postage prepaid, to each of the following:

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