IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NORTH CAROLINA
WESTERN DIVISION

K.C., *et al*., Plaintiffs, vs. LANIER CANSLER, *et al.*, Defendants.	Civil Action No. 5:11-cv-354-FL **DEFENDANTS PAMELA L. SHIPMAN AND PBH's RESPONSE IN OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

Defendants Pamela L. Shipman ("Shipman") and PBH (together, "PBH"), by and through their undersigned attorneys, respectfully submit this Response in Opposition to Plaintiffs' Motion for Preliminary Injunction [D.E. 31] (the "Motion").

NATURE OF THE CASE

This case involves the Innovations program, a community-based federal Medicaid waiver approved by the federal Secretary of the U.S. Department of Health and Human Services and its division, the Centers for Medicare and Medicaid Services ("CMS"), and is operated by PBH as a managed care program pursuant to a contract with the North Carolina Department of Health and Human Services (the "Department"). The subject of Plaintiffs' Complaint is the design and implementation of the Support Needs Matrix, a utilization management tool approved by CMS and the Department and used by PBH in the Innovations program. Plaintiffs allege that the implementation of the Support Needs Matrix by the Defendants has resulted in PBH making reductions in Plaintiffs' Medicaid services without first (1) providing prior written notice to the Plaintiffs explaining the reductions; (2) providing an opportunity for a fair hearing where the Plaintiffs can challenge the alleged reductions in services; and (3) providing continued benefits at the previously authorized level pending the outcome of a fair hearing. Plaintiffs claim that

PBH is legally required to take these steps before making the alleged reductions, and that PBH's failure to do so is in violation of the Medicaid Act, the applicable federal regulations, and the Due Process Clause of the Fourteenth Amendment. The Defendants have denied most of Plaintiffs' factual allegations, and all of their claims for relief.

Plaintiffs now seek an Order from this Court preliminarily enjoining the Defendants "from reducing or terminating Medicaid services to the named plaintiffs and all others similarly situated under the N.C. Innovations Waiver based on budget limits under the Support Needs Matrix until Defendants first provide advance notice and the opportunity for a fair hearing prior to the reduction or termination of services." Motion, p. 2. Plaintiffs further seek an Order requiring the Defendants "to reinstate the level of services authorized prior to July 1, 2011 to Plaintiffs and all others similarly situated until the Court issues a final ruling." *Id.* For the reasons set forth below and in the Memorandum submitted by Defendant Cansler, Plaintiffs have not met their burden under *Winter v. Natural Resources Def. Council, Inc.*, 555 U.S. 7 (2008) and Fed. R. Civ. P. 65(a), and Plaintiffs' Motion should be denied.

STATEMENT OF FACTS

PBH incorporates herein by reference the Statement of Facts set forth in its Response in Opposition to Plaintiffs' Motion for Class Certification [D.E. 103]. In addition to those facts, PBH further states as follows:

PBH began informing all Innovations waiver enrollees about the Support Needs Matrix system in August 2010, when it mailed the first of several "Waiver Alerts" regarding the Supports Needs Matrix. Misenheimer Second Decl. [D.E. 105] ¶ 17, Exhs. A-D. In March 2011, PBH notified all Innovations waiver enrollees of the change over to the Support Needs Matrix, and provided each enrollee with information about the Support Needs Matrix generally,

and the specific Support Needs Matrix category for each enrollee individually. Cote Decl. [D.E. 107] ¶ 3; Misenheimer Second Decl. [D.E. 105] ¶ 19, Exh E. PBH also advertised and held a series of town hall meetings throughout its catchment area where Innovations waiver enrollees, providers, and interested parties had an opportunity to learn about the Support Needs Matrix and its implementation, and to ask questions of PBH staff. *Id.* ¶ 21. Further, each enrollee's PBH Care Coordinator was available to meet (and most did meet) with each enrollee individually to discuss the Support Needs Matrix, to answer questions about the Support Needs Matrix, and to aid the enrollee in planning for his or her services under their Support Needs Matrix Base Budget. Cote Decl. [D.E. 106] ¶ 4.

For those enrollees whose Support Needs Matrix Base Budgets were less than the total amount of Base Budget Services requested in the enrollee's then-existing Individual Support Plan ("ISP"), PBH Care Coordinators encouraged the enrollee to meet with their treatment team (consisting of the enrollee, their guardian and family members, their provider(s), their Care Coordinator, and any other individual with an interest in the enrollee's treatment) to re-examine their existing ISP and the full array of Innovations waiver services available to develop a plan of care within their Support Needs Matrix Base Budget. *Id.* ¶¶ 5-7.

If enrollees believed that their Support Needs Matrix Base Budget was inadequate to provide the services necessary to support their needs, PBH Care Coordinators informed them of their options, which included seeking an Intensive Review. *Id.* ¶¶ 10-11. Intensive Review is for enrollees who believe that they have support needs which make them outliers as opposed to others in their Support Needs Matrix category. *Id.* If an enrollee wished to pursue an Intensive Review, the PBH Care Coordinators assisted the enrollee to gather the necessary documentation, complete the request, and to submit the request to PBH's Intensive Review Committee. *Id.*

PBH Care Coordinators encouraged enrollees to explore planning options within their Support Needs Matrix Base Budget before requesting Intensive Review because one portion of the Intensive Review form asks for an explanation of the options attempted before requesting Intensive Review. *Id.* ¶ 12. If an enrollee still felt that his or her Support Needs Matrix Base Budget (with or without Intensive Review) was inadequate to provide the services they believed to be necessary to support their needs, the enrollee could submit an ISP or an update to the ISP requesting services in excess of their Support Needs Matrix Base Budget. *Id.* ¶ 13.

Facts about the named Plaintiffs are included in Sections III and VI of the argument.

ARGUMENT

I. STANDARD OF REVIEW

"A preliminary injunction is an extraordinary remedy which should not be granted unless there is a clear showing of both likely success and irreparable injury." *Muhammad v. Plaster*, 5:10-CT-3199-FL, 2011 U.S. Dist. LEXIS 59654 (E.D.N.C., June 3, 2011) (*citing The Real Truth About Obama, Inc. v. FEC*, 575 F.3d 342, 345 (4th Cir. 2009), *vacated on other grounds*, 130 S. Ct. 2371 (2010), *reinstated in relevant part on remand*, 607 F.3d 355 (4th Cir. 2010)).

> A movant must establish the following to obtain a preliminary injunction: (1) that he is likely to succeed on the merits; (2) that he is likely to suffer irreparable harm in the absence of preliminary relief; (3) that the balance of equities tips in his favor; and (4) that an injunction is in the public interest.

Muhammad at *1-2 (*citing Winter v. Natural Resources Defense Council, Inc.*, 555 U.S. 7 (2008). "Because a preliminary injunction grants relief before trial, it is 'an extraordinary remedy never awarded as of right.'" *Galaton v. Johnson*, 5:11-CV-397-D, 2011 U.S. Dist. LEXIS 92125 at *5 (E.D.N.C., Aug. 17, 2011) (quoting *Winter*, 555 U.S. at 24).

Although Plaintiffs assert that the Motion is necessary "to preserve the status quo," [D.E. 32, p. 3], the relief Plaintiffs seek would significantly change, rather than preserve, the status quo. As such, Plaintiffs' Motion is appropriately reviewed under the far stricter standards required for a mandatory preliminary injunction. "[M]andatory preliminary injunctions do not preserve the status quo and normally should be granted only in those circumstances when the exigencies of the situation demand such relief." *E. Tenn. Natural Gas Co. v. Sage*, 361 F.3d 808, 828 (4th Cir. 2003). In general, mandatory injunctions "are not granted unless extreme or very serious damage will result . . . " *Anderson v. U.S.*, 612 F.2d 1112, 1115 (9th Cir. 1979); *see also Little v. Jones*, 607 F.3d 1245, 1251 (10th Cir. 2010) (to obtain a mandatory preliminary injunction "which requires the nonmoving party to take an affirmative action . . . the movant must make a heightened showing of the four factors.").

Under the standard cited by the Plaintiffs that the status quo is defined as "the last uncontroverted status preceding the pending litigation," *Fed. Leasing, Inc. v. Underwriters at Lloyd's*, 487 F. Supp. 1248, 1259 (D. Md. 1980), *aff'd* 650 F.2d 495 (4th Cir. 1981), the injunction that Plaintiffs purport to seek would change the status quo, and is thus a mandatory injunction. The relief Plaintiffs seek includes an Order requiring PBH "to reinstate the level of services authorized prior to July 1, 2011 to Plaintiffs and all others similarly situated until the Court issues a final ruling." Motion [D.E. 31], p. 2. However, each of the Plaintiffs presently receives services that have they have requested and that have been specifically authorized by PBH for limited periods of time.

As discussed in Section III.A, *infra*, the expiration of a limited authorization is not considered a "reduction, suspension, or termination" entitling the enrollee to continued benefits during some appeals process. Rather, under the managed care Medicaid regulations that apply to

PBH's operation of the Innovations waiver program, at or before the expiration of an authorization period, the enrollee must submit a request for re-authorization of services to receive the same services, which the managed care Medicaid regulations treat as a "new" request. If the enrollee requests re-authorization of the same level of services, and if PBH does not approve the full dollar amount or scope of the requested services, PBH is not required to provide the enrollee with continued benefits at the now-expired level during the appeal process. Thus, Plaintiffs do not seek to restore the status quo. Instead, they seek continued benefits at the now-expired levels indefinitely during the pendency of this case, in contravention of the managed care Medicaid regulations.

Additionally, as discussed in Section III.A, *infra*, the injunction that Plaintiffs seek is inconsistent with the managed care Medicaid regulations that govern PBH's operation of the Innovations waiver program at issue in this case. These regulations require PBH to provide notice of appeal rights only when it takes an "action," as that term is defined in the regulations. Most of what the Plaintiffs complain of are not "actions" pursuant to the applicable regulations, and thus do not trigger appeal rights for the Plaintiffs. Plaintiffs seek an injunction from the Court which would rewrite these regulations and require PBH to issue appeal rights (and to provide continued benefits while Plaintiffs exercised those newly created appeal rights) with respect to PBH decisions that are not "actions." Plaintiffs seek a fundamental change in PBH's operation which is not supported by the applicable Medicaid regulations; this would not maintain the status quo, but rather would be a mandatory injunction.

II. BASED ON ALL THE MATERIALS SUBMITTED BY THE PLAINTIFFS TO DATE, THIS COURT HAS ALREADY FOUND THAT PLAINTIFFS HAVE FAILED TO MEET THEIR BURDEN UNDER THE *WINTER* STANDARD TO OBTAIN INJUNCTIVE RELIEF.

This Court has twice considered Plaintiffs' request for the same injunctive relief they seek in the instant Motion, and has twice found that the Plaintiffs have failed to carry their burden under the *Winter* standard. On July 12, 2011, the Court issued an Order denying the request for temporary injunctive relief in Plaintiffs' Complaint. [D.E. 19]. Noting that the Plaintiffs had not yet submitted affidavits or other materials in support of their Complaint, the Court found that at that early stage, the Plaintiffs had not yet satisfied their burden. *Id.*

On August 24, 2011, the Plaintiffs filed the instant Motion, a Memorandum in Support of the same, and a large volume of materials in support of their Motion. [D.E. 31, 32]. On December 20, 2011, Plaintiffs K.C., D.C., and intervening Plaintiff M.S. moved the Court for a temporary restraining order. [D.E. 70] These moving plaintiffs incorporated all of the materials and Memorandum submitted in support of the Motion for Preliminary Injunction into their motion for a temporary restraining order, and also filed additional supporting materials. [D.E. 71, p. 2, n. 4]. With this entire record before the Court, on December 28, 2011 the Court again found that the Plaintiffs had failed to carry their burden under *Winter*. [D.E. 82]. "Plaintiffs have not satisfied the requirements of *Winter* or Rule 65(b)(1) at this juncture. The court cannot conclude that plaintiffs have demonstrated a likelihood of success on the merits, that the balance of equities tips in their favor, or that a temporary injunction is in the public interest." *Id.* at 3. The Court also expressed doubt as to Plaintiffs ability to show irreparable harm. *Id.*

Plaintiffs have not submitted any additional materials in support of the instant Motion beyond what was before the Court at the time it issued its December 28, 2011 Order. The Court

was correct to deny Plaintiffs' motion for temporary injunctive relief, and the Court should further deny Plaintiffs' motion for preliminary injunctive relief on the same record.

III. PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION SHOULD BE DENIED BECAUSE PLAINTIFFS ARE NOT LIKELY TO SUCCEED ON THE MERITS OF THEIR CLAIMS.

Plaintiffs' Motion should be denied, as an initial matter, because Plaintiffs are unlikely to succeed on the merits of their claims. As "a preliminary injunction affords relief before trial," the burden is on the plaintiff to "make a clear showing that [plaintiff] will likely succeed on the merits at trial." *Real Truth*, 575 F.3d at 346 (*citing Winter*, 129 S.Ct. at 374, 376).

Plaintiffs' Complaint and materials submitted in support of their Motion contain a blizzard of dates and names and alleged statements by various PBH employees, most of which is superfluous to Plaintiffs' actual claims.[1] At the core of this blizzard, Plaintiffs allege that the PBH Defendants have "reduced" and/or "terminated" Medicaid services for the Plaintiffs without providing Plaintiffs the due process afforded them by the Medicaid Act and the regulations promulgated thereto, and by the Fourteenth Amendment to the United States Constitution as set forth in *Goldberg v. Kelly*, 397 U.S. 254 (1970) and its progeny.

Plaintiffs' motion does not address or rely on their First Claim for Relief,[2] and Plaintiffs

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[1] Further, Plaintiffs' Declarations contain numerous inaccuracies and errors, some of which are addressed in the Declarations of Sonja Goodwin [D.E. 108], Melissa Campbell [D.E. 109], Denise Denosky [D.E. 110], and Tanyon Martin [D.E. 111].

[2] Plaintiffs Motion for Preliminary Injunction is only brought as to Claims Two and Three in their Complaint. As noted in the Memorandum submitted by Defendant Cansler [D.E. 102], Plaintiffs did not include Claim One in their Motion, and Plaintiffs' Memorandum in Support of their Motion does not substantively address Plaintiffs' First Claim for Relief. Consequently, Plaintiffs' Motion for Preliminary Injunction is appropriately limited to Plaintiffs' Second and Third Claims for Relief.

Further, Plaintiffs' First Claim, which asserts a substantive due process claim, is unavailing. It is based on the allegation that PBH acted arbitrarily and subjectively in allocating Medicaid funds among Innovations Waiver enrollees. *See* Compl. ¶ 125. "Substantive due process rights guard against the government's exercise of power without any reasonable justification in the service of a legitimate governmental objective. Only the most egregious official conduct can be said to be arbitrary in the

are unlikely to succeed on the merits of their Second and Third Claims for Relief. Plaintiffs' argument focuses primarily on PBH's alleged failure to adequately fulfill the mechanics of due process, while largely glossing over the more important prerequisite of whether due process rights are even triggered here. Rather than glossing over this first issue as Plaintiffs urge, the proper analysis would be as follows:

> There are, essentially, three issues before us . . . First, does the change in . . . services . . . constitute an agency action under [the applicable regulations]? If so, what process was due those recipients as a consequence of that action? Finally, were the recipients entitled to aid-continuing pending disposition on the merits of their challenge to the agency action?

Granato v. Bane, 74 F.3d 406, 411 (2d Cir. 1996). Here, because the changes about which Plaintiffs complain do not constitute agency "actions" under the applicable regulations, the analysis ends there.[3] Further, because the first and third issues in this analysis should be answered in the negative, Plaintiffs are not entitled to receive continued benefits during the appeal process. Lastly, even if the Plaintiffs had been able to show a likelihood of success at some point, the claims of all five of the named Plaintiffs are now moot.

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constitutional sense and therefore unconstitutional." *County of Sacramento v. Lewis*, 523 U.S. 833, 846, 118 S.Ct. 1708, 140 L.Ed.2d 1043 (1998) (citations omitted). Plaintiffs' complaint fails to allege facts that could give rise to a claim that the PBH Defendants behavior was outrageous or egregious so as to "shock the conscience." *See, e.g.*, *Pestera Center for Mental Health v. Lawton*, 111 F.Supp.2d 768, 778 (S.D. W.Va. 2000). ("The substantive component of the Due Process Clause is violated by executive action only when it 'can properly be characterized as arbitrary, or conscience shocking, in a constitutional sense.' Conduct deliberately intended to injure in some way, unjustifiable by any government interest, is the sort of official action most likely to rise to the conscience-shocking level.")

[3] Plaintiffs' characterization of a Medicaid agency's legal requirements might be correct *if* the Innovations waiver at issue here was a traditional fee-for-service Medicaid program. However, the legal and regulatory requirements for PBH's operation of Innovations as a managed care Medicaid program are substantively different, and do not support Plaintiffs' Second and Third Claims for Relief. As such, Plaintiffs' assertions about PBH's legal requirements are clearly erroneous, and these errors drive Plaintiffs' incorrect characterization of the Support Needs Matrix as a "reduction in services."

A. Plaintiffs' Claims for Relief are Based on a Clearly Erroneous Assertion of PBH's Legal Requirements.

The Medicaid Act requires that the State Medicaid plan must

> provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness.

42 U.S.C. § 1396a(a)(3). The CMS regulations promulgated pursuant to this statute generally require that an enrollee be provided with an opportunity for a fair hearing whenever the Medicaid agency takes an "action" as that term is defined in the applicable regulations. *See* 42 C.F.R. §§ 431.201(b); 438.400(b). Thus, by design of CMS, enrollees are not able to challenge any and every decision of the Medicaid agency, but rather are only permitted to challenge decisions defined as "actions." However, the CMS regulations governing the operation of traditional fee-for-service Medicaid programs, and those governing the operation of managed care Medicaid programs, define "action" differently. The difference in the definition of "action" – which Plaintiffs' entire lawsuit attempts to blur – is at the heart of why the Plaintiffs are unlikely to succeed on the merits of their claims.

1. Managed Care Medicaid Regulations, the Waiver, and PBH's Contract with the State of North Carolina Require PBH to Implement a "Grievance System" Pursuant to 42 C.F.R. § 438 Subpart F.

PBH operates as a Pre-Paid Inpatient Health Plan ("PIHP"), as that term is defined at 42 C.F.R. § 438.2. *See* Contract between PBH and the Department § 2 ("Contractor Designated as a Single Prepaid Inpatient Health Plan (PIHP)") [D.E. 31-5, p. 6]; 1915(c) Waiver [D.E. 31-3, p. 5]. A PIHP is a type of MCO which is prepaid by the State, based on capitation rates, to provide care, and accepts the financial risk of providing that care.[4]

[4] This arrangement intentionally creates an incentive for PBH to provide the most efficient and cost-effective care, which includes not authorizing care requested by or on behalf of a consumer where

The specific regulations adopted pursuant to the statutory language in 42 U.S.C. § 1396a(a)(3) for the operation of managed care Medicaid by MCOs, including PIHPs like PBH, are found at 42 C.F.R. Part 438 ("Managed Care"). These regulations require MCOs to establish a "Grievance System" that enables enrolled Medicaid consumers to contest certain decisions of an MCO in a fair hearing process as those decisions relate to consumers' services. *See* 42 C.F.R. § 438 Subpart F. The "Grievance System" set forth in 42 C.F.R. § 438 Subpart F is comprised of "appeals" and "grievances," as those terms are defined in the regulations. Plaintiffs' Second and Third Claims for Relief relate to "appeals," which are defined as "a request for review of an action, as 'action' is defined in this section." 42 C.F.R. § 438.400(b). The federal regulations governing PBH's operation as a PIHP require PBH to provide notice of and an opportunity for a fair hearing (*i.e.*, an "appeal") for "actions," which are defined in pertinent part as follows:

> *Action* means –
>
> In the case of an MCO or PIHP –
>
> (1) The denial or limited authorization of a requested service, including the type or level of service;
>
> (2) The reduction, suspension, or termination of a previously authorized service;

42 C.F.R. § 438.400(b). [5]

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there is not a demonstrated clinical need for the care. Any cost savings realized by PBH as a result of providing efficient and cost-effective care are required to be used to provide additional medical care for Medicaid beneficiaries enrolled in the plan. Shipman Decl. [D.E. 41] ¶ 8.

[5] 42 C.F.R. § 438.400(b) defines "grievance" in pertinent part as "an expression of dissatisfaction about any matter other than an action, as 'action' is defined in this section." Critically, the submission of a "grievance" does not initiate the fair hearing process. Plaintiffs do not allege that they have been deprived of the opportunity to submit "grievances" to PBH expressing their dissatisfaction about any matter other than an action, and do not allege that PBH has failed to respond to any grievance as required by the federal regulations.

In its Utilization Management process, PBH makes time-limited prior authorizations for specific requested services. Under managed care Medicaid, the natural expiration of a time-limited authorization is not treated as a "termination" of services triggering notice and due process. For the enrollee to receive the service after the end of the authorization period for that service, she must submit a new request for that service, which PBH must then authorize.

This distinction is set out in subsections (1) and (2) in the managed care Medicaid definition of "action." If an enrollee is requesting a service for the first time, a denial or limited authorization of that service is an "action" pursuant to subsection (1). If PBH reduces, suspends, or terminates a previously authorized service during the authorization period, that is an "action" pursuant to subsection (2). However, if an enrollee's prior authorization expires on its own accord, and the enrollee requests re-authorization of the service at the same level, and PBH authorizes the service at a lower level than the enrollee requested, this is an "action" under subsection (1) (*i.e.*, a "denial or limited authorization") and *not* under subsection (2) (a "reduction, suspension, or termination of a previously authorized service").[6]

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[6] This distinction is further clarified in the Comments and Responses in the Final Rule adopting 42 C.F.R. § 438 Part F. In response to the Proposed Rule, CMS received conflicting comments, with some commenters urging that the expiration of an existing authorization does not constitute a "termination" requiring notice and appeal rights, while other commenters urged the opposite view. In the Final Rule, CMS weighed in on the side of the former:

> We agree with the first set of commenters that the expiration of an approved number of visits does not constitute a termination for purposes of notice and continuation of benefits. Likewise, when a prescription (including refills) runs out and the enrollee requests another prescription, this is a new request not a termination of benefits. In these circumstances, the MCO or PIHP would not need to send a notice of continued benefits pending the outcome of an appeal of State fair hearing. If the enrollee requests a re-authorization that the MCO or PIHP denies, the MCO or PIHP must treat this request as a new request for service authorization and provide notice of the denial or limitation. **We disagree with the second commenters that a denial of authorization for additional days is a "termination," since the enrollee had no expectation of coverage on those days, and this was**

Further, in this third scenario, PBH is required to (and does) issue appeal rights to the enrollee pursuant to 42 C.F.R. § 438.404, but is not required to provide the enrollee with continued benefits at his previously authorized (but now expired) level pending the outcome of the appeal. *See* 42 C.F.R. 438.420(b) (PIHP "must continue the enrollee's benefits if . . . the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment" . . . and "the original period covered by the original authorization has not expired."); *see also Karen L. v. Health Net of the Northeast*, 267 F. Supp. 2d 184, 191 (D. Conn. 2003) (referring to subsection (2), "the Federal Medicaid regulations require MCOs to provide aid pending appeal only in certain circumstances."). Plaintiffs erroneously argue that in this third scenario, PBH is legally required to provide continued benefits pending the outcome of the appeal. Pltffs' Memo. [D.E. 32] p. 20, n. 10.

In support of this argument, Plaintiffs cite 42 C.F.R. §§ 435.916(a) and 440.230(d), neither of which address the issue of continuation of managed care Medicaid services past the expiration of their prior authorization. Plaintiffs confuse regulations pertaining to an enrollee's continued *eligibility* to receive any services with the expiration of a time-limited authorization to provide a specifically requested service. Further, Plaintiffs' argument ignores the applicable

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> **thus simply a denial of a new request, not a termination of services the enrollee had a right to expect to continue.**
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> We believe that the proposed rule already clearly reflected the above interpretation. In the definition of "Action," the reference to a "reduction, suspension, or termination" in the proposed rule was qualified by the phrase, "of a previously authorized service." **Thus, the cessation of services because the authorization expired would not be an "action," because services after the date when the authorization expired would not be "previously authorized.**"

67 Fed. Reg. 40989, 41058 (June 14, 2002) (second Comment and Response under "3. Notice of Action (Proposed 438.404).") (emphases added).

managed care Medicaid regulation – 42 C.F.R. § 438.420(b) – and the Comments and Response in the Final Rule adopting that regulation.[7]

Although Plaintiffs relegate this argument to a footnote in their Memorandum, their claim to continued benefits when the Plaintiffs submit updated ISPs requesting changes in their services, or even after the expiration of a previous authorization, is truly the gravamen of the Prayer for Relief in their Complaint, and is at the heart of the injunctive relief they seek in the instant Motion. As discussed in Section IV.B., *infra*, Plaintiffs presently have the ability to trigger and enjoy due process appeal rights they purport to seek, but such due process rights do not include continued benefits during an appeal. Plaintiffs are not satisfied with the due process rights afforded them by the legal and regulatory framework for managed care Medicaid, and instead ask this Court to create new due process rights which run contrary to the existing framework.[8]

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[7] *See* 67 Fed. Reg. 40989 at 41064 (second, third, and fifth Comments and Responses under "9. Continuation of Benefits When an MCO or PIHP Appeal of a Termination, Suspension, or Reduction, and State Fair Hearings on Such an Action, are Pending (Proposed 438.420).") ("[W]e agree that the expiration of an approved number of visits does not constitute a termination for purposes of notice and continuation of benefits. If an enrollee requests re-authorization for services and the MCO or PIHP denies the request or re-authorizes the services at a lower level than requested, the MCO or PIHP must treat this request as a new service authorization request and provide notice of the denial." . . . "[W]e believe that if services are discontinued on the date the authorization expires, this is not a 'termination' of services that the enrollee has any right to expect to receive, and thus is not a termination within the meaning of section 1902(a)(3) [42 C.F.R. § 1396a(a)(3)] and the implementing regulations. . . . We believe that this process is fully consistent with the Medicaid statute and constitutional requirements, to the extent applicable.").

See also Id. at 41058 (second Comment and Response under "3. Notice of Action (Proposed 438.404") ("In a case in which services which *were* 'previously authorized' are continued or reinstated at the request of the enrollee pending appeal, and during this continuation period, the period of authorization expires, services may be terminated as provided in the original authorization.") (emphasis in original).

[8] Plaintiffs' failure to cite the traditional fee-for-service regulation requiring continued benefits during appeals (42 C.F.R. § 431.230) is a tacit acknowledgment by the Plaintiffs that the fee-for-service regulations do not control with respect to PBH's operation of the Innovations wavier program as a PIHP. Further, the only case that Plaintiffs contend holds that *Goldberg* requires continued benefits after the expiration of a prior authorization is inapplicable here. Continuation of benefits arose in *Jonathan C. v.*

2. Plaintiffs' Claims are Based on Substantively Different Regulations Governing Traditional Fee-for-Service Medicaid Programs Under 42 C.F.R. § 431 Subpart E.

In contrast, the standard that underlies Plaintiffs' Second and Third Claims for Relief, and upon which Plaintiffs seek injunctive relief from this Court, is the materially different and inapplicable definition of "action" found in the regulations for fee-for-service Medicaid, which are found at 42 C.F.R. § 431 Subpart E. [9] As with Managed Care Medicaid, traditional fee-for-service Medicaid requires due process rights only when the State takes an "action." However, in traditional fee-for-service Medicaid, "action" is defined as "a termination, suspension, or reduction of Medicaid eligibility or covered services." 42 C.F.R. § 431.201. Unlike the more limited definition of "action" which applies to the managed care Innovations program, the fee-for-service definition of "action" is not tied to requests for authorization, and is broad and unlimited as to time. If a fee-for-service enrollee is receiving a service, any reduction or termination of that service, even at the end of an authorization period, is an "action" requiring the due process rights the Plaintiffs seek here (*i.e.*, (1) prior written notice explaining the proposed reduction, (2) an opportunity for a fair hearing to contest the proposed reduction; and (3) continued benefits at the previously authorized level pending the outcome of the fair hearing.).

Hawkins, 2006 WL 3498494 (E.D. Tex., Dec. 5, 2006) pursuant to the fee-for-service regulations which are not applicable here. Further, the factual situation in *Jonathan C.*, where the agency failed to comply with the numerous orders reversing its decisions on appeal, is extreme and inapposite to the facts before the Court here.

[9] While some the general provisions for fair hearings for consumers for all Medicaid entities set forth in 42 C.F.R. § 431 Subpart E might apply to PBH, these general provisions are superseded by the specific provisions for the Grievance System for PIHPs, like PBH, set forth in 42 C.F.R. § 438 Subpart F to the extent the more specific provisions governing managed care Medicaid are inconsistent with the general provisions for all Medicaid entities. The general procedures for fair hearings, set out in 42 C.F.R. § 431 Subpart E apply when a "PIHP takes action under subpart F of part 438 of this chapter." 42 C.F.R. § 431.200(b). Thus, CMS has by regulation mandated that for a PIHP like PBH, the definition of "action" in Part 438, and not the definition of "action" in Part 431, describes the "actions" that trigger an opportunity for a fair hearing.

The Plaintiffs' reliance on this broad and limitless definition of "action" with its right to continued benefits in all fair hearings underlies Plaintiffs Second and Third Claims for Relief. *See* Compl. [D.E. 6] ¶ 127, 131; Memorandum in Support of Motion for Preliminary Injunction [D.E. 32] p. 2. This reliance is clearly erroneous.[10] Further, it is this misapplication of Medicaid regulations that causes the Plaintiffs to incorrectly characterize the implementation of the Support Needs Matrix (where PBH did not take an "action" by reducing or terminating a previously authorized service) as a "reduction in services." Plaintiffs are unlikely to succeed on the merits of their claims as a result.

3. Plaintiffs' Constitutional Due Process Rights, if any, are Coterminous with their Statutory and Regulatory Due Process Rights.

Courts have held that the Due Process clause of the Fourteenth Amendment, as interpreted in *Goldberg* and its progeny, applies to Medicaid because enrollees have a "property interest" in the benefits. However, "property interests are not created by the Constitution, 'they are created and their dimensions are defined by existing rules or understandings that stem from an independent source such as state law.'" *Cleveland Bd. of Educ. v. Loudermill*, 470 U.S. 532, 538 (1985) (quoting *Bd. of Regents v. Roth*, 408 U.S. 564, 577 (1972)). "In determining whether a given benefits regime creates a property interest protected by the Due Process Clause, we look to the statutes and regulations governing the distribution of benefits." *Kapps v. Wing*, 404 F.3d

[10] Indeed, ***all*** of the Medicaid-related cases cited by the Plaintiffs in support of their Motion for Preliminary Injunction arise in the fee-for-service context applying the broad and, in this case, erroneous § 431.201 definition of "action." *See, e.g.*, *Granato v. Bane*, 74 F.3d 406, 411 (2d Cir. 1996) (first issue before the court was "does the change in home care services . . . constitute an agency action under 42 C.F.R. § 431.201?"); *Catanzano v. Dowling*, 60 F.3d 113, 117 (2d Cir. 1995) (followed definition of "action" in 42 C.F.R. 431 Subpart E); *Jonathan C. v. Hawkins*, 2006 WL 3498494 at *6 (E.D. Tex., Dec. 5, 2006) (court looked to the definition of "action" in 42 C.F.R. § 431.201 to identify due process requirements); *Cramer v. Chiles*, 33 F. Supp. 2d 1342, 1351-52 (S.D. Fla. 1999) (same); *Ladd v. Thomas*, 962 F. Supp. 284, 291 (D. Conn. 1997) (same); *Perry v. Chen*, 985 F. Supp. 1197, 1203 (D. Ariz. 1996) (same); *Haymons v. Williams*, 795 F. Supp. 1511, 1520-21 (M.D. Fla. 1992) (same). Plaintiffs do not cite any case (and PBH is not aware of any case) applying the broad § 431.201 definition of "action" to the operation of a PIHP.

105, 113 (2d Cir. 2005). Because the "property interest" of Medicaid benefits was created (and can be changed or eliminated) by Congress, Courts defer to the Congress and to CMS to define the scope of the "property" which an enrollee may protect under the Due Process Clause.

Here, the Innovations waiver program is not an entitlement, but rather is an optional waiver program. The Medicaid Act does not make mandatory the Home and Community-Based Services pursuant to 42 U.S.C. § 1396n(c), such as the Innovations waiver, and thus Medicaid beneficiaries "can prove no set of facts" in support of claims that would have a Court order a Medicaid agency to provide benefits under such a waiver. *A.M.H. v. Hayes*, 2004 U.S. Dist. LEXIS 27387 at *30 (S.D. Ohio, Sept. 30, 2004). The Innovations waiver (the 1915(c) waiver) is not a Medicaid entitlement, but rather is an alternative to the Medicaid entitlement. Shipman Decl. [D.E. 41] ¶ 6; *See also* 1915(c) Waiver [D.E. 31-3] p. 5 ("Purpose: The Innovations Waiver is designed to provide an array of community based services and supports that promote choice, control and community membership. These services provide *a community based alternative to institutional care* for persons who require an ICF-MR level of care.") (emphasis added). Because the Innovations program is an optional program, and not an entitlement, Innovations enrollees do not have constitutional due process rights with respect to the program. Rather, their due process rights are limited to those provided by statute, regulation, and contract.

Even if the Court finds that Innovations enrollees have constitutional due process rights in the managed care Medicaid context applicable to this case, such rights are coterminous with the enrollees' statutory/regulatory due process rights. The protectable "property interest" is only in an enrollee's existing, time-limited authorization for a specific service during the duration of the authorization, and in an enrollee's request for authorization of a specific service. As the regulations and the Comments and Responses adopting them cited in footnotes 6 and 7, *supra*,

make clear, Congress and CMS have narrowly defined the "property" in which an enrollee has a right to protect under the Due Process Clause. CMS's interpretation of 42 U.S.C. § 1396a(a)(3) "is entitled to considerable deference; a court may not substitute its own reading unless the agency's interpretation is unreasonable." *Skandalis v. Rowe*, 14 F.3d 173 (2d Cir. 1994) (citing *Chemical Man'f Ass'n v. Natural Resources Defense Council, Inc.*, 470 U.S. 116, 125 (1985); *Chevon U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 844 (1984)).[11]

For the Plaintiffs to succeed on the merits of their claims, this Court will have to find that the managed care Medicaid regulations at 438 Subpart F fail to meet the requirements of the 14th Amendment as set forth in *Goldberg* and its progeny. The PBH Defendants' research has revealed no court in the country which has so held. This Court should decline to be the first.

B. <u>Application of Legal Standard to Plaintiffs' Claims.</u>

In the Memorandum in Support of their Motion, Plaintiffs argued they are "highly likely to prevail on their legal claims," [D.E. 32, p. 2] and framed those claims around the following:

> (1) the use of the SIS to determine Plaintiffs' level of need without an opportunity for a fair hearing;
>
> (2) assignment to a SNM category and Base Budget without an opportunity for a fair hearing;
>
> (3) the denial of Intensive Review without an opportunity for a fair hearing; and
>
> (4) Plaintiffs were informed that "they must sign new plans of care substantially reducing their covered services, and if they refused to do so, *all of their services would stop*."

Id. Plaintiffs are unlikely to succeed on the merits as to the first three of these issues because those are not "actions", and therefore the Plaintiffs have no right to a fair hearing to contest

[11] When an agency construes its own regulations, as CMS did in its Responses to Comments in the Final Rule cited in foot notes 6 and 7, *supra*, "such deference is particularly appropriate, and even more appropriate where, as here, we consider a small corner of a labyrinthine statute." *Id.* (internal citation omitted).

them. With respect to the fourth, Plaintiffs' allegations are factually inaccurate. However, even if true, these are not "actions" triggering due process rights.

1. The Administration of the SIS, the Assignment of each Plaintiff to a SNM Category and Base Budget, and Intensive Review are not "Actions" for which Plaintiffs have direct appeal rights, but rather are part of the managed care planning process.

Plaintiffs complain that PBH has "used an assessment tool to decide each Plaintiff's and others' medical and behavioral health needs but provided no opportunity to appeal the validity of their assessment scores." [D.E. 32, p. 2]. Plaintiffs refer here to the Supports Intensity Scale ("SIS"), which is nationally-recognized evaluation tool used as a standardized measure of a person's level of support needs. Misenheimer Decl. [D.E. 42] ¶ 7, Exh. A.

The support needs of all Innovations enrollees as reflected on their SIS scores, as well as demographic and other information, are used to develop the Support Needs Matrix. *Id.* ¶¶ 7-8. An enrollee's SIS score is one of the components used to assign each enrollee to a Support Needs Matrix category with a cohort of other enrollees with comparable levels of support needs. *Id.* Taking into account the limited financial resources available to the Innovations program, each Support Needs Matrix category is assigned a Base Budget, which reflects the total amount of money available to fund the typical types of services used by enrollees in each category. *Id.* ¶ 10. Plaintiffs also complain that PBH has not provided Plaintiffs with "proper written notice or any right of fair hearing to contest the [Support Needs Matrix] category to which they were assigned." Compl. ¶ 109. This is false.

If an enrollee's treatment team believes that she needs more services than her Base Budget will provide, the enrollee can request Intensive Review to determine if the enrollee should be classified as an outlier from her Support Needs Matrix category and whose behavioral, safety, health and welfare needs differ significantly from others in the same category.

Misenheimer Decl. [D.E. 42] ¶ 14; Cote Decl. [D.E. 107] ¶ 11; D.E. 105-5, pp. 13-15. Plaintiffs complain that they were not given sufficient notice about Intensive Review, and that if PBH's Intensive Review Committee does not recommend that the Plaintiff's needs made her an outlier within her Support Needs Matrix category, that the Plaintiffs are not given an opportunity for a fair hearing to challenge this recommendation. [12]

Critically, none of these issues - the administration of a SIS evaluation, the assignment of an enrollee to a Support Needs Matrix category with a specific Base Budget, or an Intensive Review – is an "action" as defined in 42 C.F.R. § 438.400(b). "Actions" in the managed care Medicaid context are tied to specific requests for authorization of services by an enrollee. None of these issues is tied to a specific request for authorization of services. Rather, each falls within the purview of the necessary and important planning and budgeting functions of a PIHP, which are not "actions" triggering appeal rights.

Moreover, Plaintiffs have the ability to challenge their SIS score, their Support Needs Matrix category or Base Budget, or a denial of an Intensive Review recommendation. Within 90

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[12] In their Complaint, Plaintiffs allege that the Defendants "have engaged in a procedure and practice of insisting or strongly encouraging that waiver participants not file requests for Intensive Review . . . " Compl. ¶ 114. The only evidence put forward by the Plaintiffs that PBH encouraged any of Innovations participant not to file a request for Intensive Review is limited to the Declarations of Ron S. [D.E. 31-23] and Linda Johns [D.E. 31-69]. Ron S. stated that his son's Care Coordinator, Sonja Goodwin, "told me that L.S. would need to wait until at least six months after his new budget became effective before we can make a request for an Intensive Review." D.E. 31-23, ¶ 17. Ms. Goodwin declares that she never told Ron S. or any other member of L.S.'s family that he had to wait any period of time before being allowed to make a request for Intensive Review. Goodwin Decl. [D.E. 108] ¶ 6. Linda Johns stated that her son's Care Coordinator, Denise Denosky, "discouraged me from requesting an Intensive Review." Ms. Denosky declares that she did not discourage Ms. Johns from requesting Intensive Review. Denosky Decl. [D.E. 110] ¶ 14. In fact, Plaintiff Allison Taylor Johns did submit a request for Intensive Review in June 2011. Covert Decl. [D.E. 106] ¶ 12.

The other Plaintiffs and putative class members either requested an Intensive Review (*see* Decl. of Penny C. [D.E. 31-34] ¶¶ 35-36; Decl. of Africa Health [D.E. 31-61] ¶ 20; Decl. Melissa W. [D.E. 31-74] ¶¶ 18-19), or stated that Intensive Review was never discussed with them (*see* Decl. of Rachelle S. [D.E. 52-3] ¶ 24). In sum, there is no credible evidence before the Court to support Plaintiffs' allegation in paragraph 114 of the Complaint.

days of receiving their SIS scores, any enrollee may challenge the accuracy of their SIS evaluation. Each enrollee may request an Intensive Review if they believe that their level of support needs makes them an outlier within their Support Needs Matrix category cohort. Cote Decl. [D.E. 107] ¶ 11. Even if the Intensive Review Committee does not recommend that an enrollee is an outlier, each enrollee may still submit a request for authorization of services to PBH Utilization Management in excess of her Base Budget and provide documentation to show that she is an outlier in support of that request. *Id.* ¶¶ 13-14; D.E. 105-5 at 15. As discussed in Section VI.B., *infra*, with or without an Intensive Review, each enrollee may force PBH to take an "action" by submitting a request for authorization of services in excess of their Support Needs Matrix Base Budget which, if PBH denies it in whole or in part, triggers appeal rights. If an enrollee exercises her appeal rights at that stage, she may challenge her SIS evaluation, her Support Needs Matrix category and Base Budget, and her Intensive Review. Not before.

2. Plaintiffs' Claim that PBH Required Plaintiffs to Sign New Plans of Care Reducing their Services and Threatened Plaintiffs with Termination of All Services is Factually Inaccurate, and is also Not an "Action" Triggering Appeal Rights.

In March and April 2011, each of the Plaintiffs received a letter from PBH informing them of the Support Needs Matrix categories to which they had been assigned, along with their Base Budget. Cote Decl. [D.E. 107] ¶ 3; *e.g.*, D.E. 31-28. For enrollees whose Base Budget was significantly less than the actual cost of their care from January to December 2010, PBH provided a series of budget step-downs to gradually transition the enrollee to his new Support Needs Matrix Base Budget in 6-month increments. Misenheimer Second Decl. [D.E. 105] ¶ 23, Exhs. B, D. PBH also sent all enrollees a copy of the 2011 Support Needs Matrix Guide providing important information about the program, and held a series of open community meetings where enrollees and families could learn more and ask questions of PBH about the

Support Needs Matrix. *Id.* ¶ 21, Exh E. Further, each enrollee's PBH Care Coordinator met with the enrollee and his treatment team to discuss the Support Needs Matrix, to provide information, and to answer questions. Cote Decl. [D.E. 107] ¶ 4.

PBH informed the enrollees that it would begin using the Support Needs Matrix as the Utilization Management criteria for requests for authorization of services to be provided on or after July 1, 2011. Each enrollee's Support Needs Matrix Base Budget reflected the total amount of money that enrollee could spend on Base Budget services during the year. Misenheimer Decl. [D.E. 42] ¶ 11. If enrollees had previously authorized services which extended beyond July 1, 2011, PBH did not reduce or terminate those services, but instead allowed those enrollees to continue to receive their previously authorized services at their previously authorized levels. Covert Decl. [D.E. 106] ¶ 8. Plaintiff Allison Taylor Johns is such an enrollee. When Ms. Johns was assigned to her Support Needs Matrix category and assigned a Base Budget, she had existing authorizations for services through the end of her ISP plan year on October 31, 2011. *Id.* ¶ 10. PBH did not terminate or reduce Ms. Johns' services during those previous authorizations, and Ms. Johns continued to receive the all of her previously authorized services through October 31, 2011. *Id.* ¶ 11.

However, for enrollees like Ms. Johns who chose to continue to receive their previously authorized services, they consumed their remaining Support Needs Matrix Base Budget at a faster rate than they would have if they had updated their ISPs effective July 1 to request services within their Support Needs Matrix Base Budget. Consequently, when Ms. Johns requested authorization for services beginning November 1, 2011 in her new ISP, Ms. Johns had less money remaining in her Base Budget available to provide services. *Id.* ¶ 13. PBH authorized a limited pro-rated share of Ms. Johns' requested services and denied the amount in excess of her

remaining Base Budget, and then issued Ms. John s notice of appeal rights , which she exercised. *Id.* ¶¶ 14-15.

To avoid the faster spend-through that Ms. Johns experienced, PBH encouraged all enrollees whose Support Needs Matrix Base Budgets were less than their previously authorized services to closely exam ine the array of Base Budget Services and Non-Base Budget Services available to them and identify a group of services that could meet their support needs within their Support Needs Matrix Base Budget. Cote Decl. [D.E. 107] ¶¶ 6-8, 12, 14. When each enrollee's treatment team had identified such a group of services, the enrollee submitted an update to his or her ISP requesting authorization of the new array of services beginning July 1, 2011. W ith the approval of an update to an enrollee's ISP, thei r newly authorized services supplanted their existing overlapping services.

Plaintiffs now argue that this pro cess of updating the ir existing ISPs constitu ted a "reduction in services" which required advanc e written notice explaining the reduction, a fair hearing process in which the Plaintiffs could challenge the reduction, and continued benefits during the fair hearing process. Plaintiffs' ar gument is fundam entally flawed. PBH did not terminate or reduce an existing authorization wit hout the approval of an en rollee. Covert Decl. [D.E. 106] ¶ 8. Rather, PBH reviewed and appr oved the Plaintiffs' new, updated requests for services. It was the Plaintiffs who reques ted an authorization for a dif ferent array of services beginning on or after July 1, 2011, including pha se-in steps that changed budgets in m ore manageable increments. If, as occurred with Plaintiffs K.C., L.S., D.C., and M.S ., PBH authorized all of the services that the Pla intiffs requested, there was no "action" to appeal. [13] Covert Decl. [D.E. 106] ¶¶ 20, 27, 37-38, 43.

[13] A logical playing out of Plaintiffs' argument further reveals its flaws. Plaintiffs argue that these ISP updates were reductio n in services which required PB H to provide advanc e notice to the Plaintiffs

Plaintiffs further complain that "PBH care managers have informed participants that the plan of care may not request more in services than the Support Needs Matrix budget allows." Compl. ¶ 112. This, too, is factually incorrect. Rather, every Innovations participant, including each of the Plaintiffs, received the 2011 Support Needs Matrix Guide in March 2011, which specifically states that "[t]he planning team may submit the Individual Support Plan to Utilization Management *with a request for Base Budget Services that exceeds the individual's Support Needs Matrix Category*." *See* D.E. 31-8, p. 15 of 18 (emphasis added). In its Answer to Plaintiffs' Complaint, PBH reiterated that each of the Plaintiffs could submit a request for services in excess of their Base Budget which, if denied in whole or in part, would trigger appeal rights. [D.E. 38, ¶¶ 72, 80, 91, 106] Indeed, Plaintiffs Allison Taylor Johns and D.C., and putative class member Kimberly Beare, all submitted ISPs or updates to their ISPs requesting approval for Base Budget Services in excess of their Support Needs Matrix category. Covert Decl. [D.E. 106] ¶¶ 13-14, 26, 53-54. All of these requests were approved in part and denied in part by Utilization Management, and PBH issued these individuals notice of appeal rights. *Ids.*

C. <u>The Named Plaintiffs' Claims are Moot.</u>

Even should the Court finds that the July 1, 2011 implementation of the Support Needs Matrix was a reduction in Plaintiffs' previously authorized services and thus was an "action" triggering appeal rights, the claims of all of the named Plaintiffs are now moot.

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explaining the reduction. But it was the Plaintiffs who requested the change in services by submitting the ISP update in the first place. What kind of notice should PBH provide to the Plaintiffs explaining the reduction that the Plaintiffs had initiated by submitting the request? Next, Plaintiffs argue that PBH was required to provide an opportunity for a fair hearing where the Plaintiffs could challenge the very changes in services that they had requested when they submitted the ISP updates. Lastly, Plaintiffs argue that PBH was required to continue to provide Plaintiffs' previously authorized services during this fair hearing process, rather than the change in services that the Plaintiffs themselves had requested at the start of the review process. Each of Plaintiffs' contentions fail under the weight of common sense.

If Plaintiffs K.C. and L.S. had not updated their ISPs effective July 1, their previously authorized services would all have expired by now, and their claims would now be moot. K.C.'s previously authorized services would have expired on their own accord on September 30, 2011, while L.S.'s previous authorizations would have expired on November 30, 2011. Covert Decl. ¶¶ 21, 39. Both of these Plaintiffs have since submitted new ISPs requesting authorization of services within their Support Needs Matrix Base Budgets, and PBH authorized all of the services K.C. and L.S. requested in those ISPs.[14] *Id.* ¶¶ 22, 40. Thus, their claims are now moot.

Plaintiff Allison Taylor Johns' previously authorized services *did* expire of their own accord on October 31, 2011, and she submitted a new ISP requesting re-authorization of services at her previously authorized levels, which was in excess of her Support Needs Matrix Base Budget. PBH Utilization Management authorized a pro-rated portion of Ms. Johns' requested services, denied the remainder, and issued Ms. Johns notice of her appeal rights, which she has exercised. *Id.* ¶¶ 13-15. Ms. Johns' claim here is now moot.

Additionally, the claims of the remaining Plaintiffs – D.C. and M.S. – also are moot. In November 2011, both D.C. and M.S. received new SIS evaluations. When scored, these new SIS evaluations reflected a greater level of need than their prior SIS evaluations. D.C. and M.S.'s new SIS evaluations resulted in changes in their respective SNM categories, and a corresponding increase in their respective Support Needs Matrix Base Budgets. *Id.* ¶¶ 30, 46, Exhs. B, C. Both D.C. and M.S. now have Support Needs Matrix Base Budgets available to them in excess of their last previously authorized services. *Id.* ¶¶ 34, 48. Ironically, if D.C. and M.S. are successful on

[14] As discussed in Section III.A., *supra,* under managed care Medicaid, these requests are treated as new requests for services. Although neither K.C. nor L.S. did so, if they had submitted an ISP requesting authorization for services in excess of their Base Budgets, and if PBH authorized these new requests at a lower level than their expired authorizations to fit within their Support Needs Matrix Base Budgets, these Plaintiffs would have been issued appeal rights, but would not have been entitled to continuation of benefits at their previously authorized (but since expired) level during any appeal.

their claims and receive all the relief to which they claim to be entitled, each will now see a *decrease* in their available Base Budgets as a result. D.C. and M.S's claims are now moot.

IV. PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION SHOULD BE DENIED BECAUSE PLAINTIFFS WILL NOT BE IRREPARABLY HARMED.

To obtain a preliminary injunction, a plaintiff is required to "make a *clear showing* that it is *likely* to be irreparably harmed absent preliminary relief." *Real Truth* at 347 (citing *Winter*, 129 S.Ct. at 374-76) (emphasis added). Plaintiffs have failed to make a clear showing that they are likely to be irreparably harmed in the absence of injunctive relief.

A. Two Innovations Consumers Who are the Basis of the Preliminary Injunction Motion Have No Injury Because They Have Exercised their Appeal Rights and Have Obtained Exactly the Services Requested.

Plaintiffs claim that they have been deprived the due process right to challenge various decisions made by PBH. Plaintiffs are clear that they do not seek a ruling that they are entitled to the underlying services at issue, but only that the Defendants must provide the Plaintiffs with due process rights. D.E. 32, p. 29. Plaintiffs assert that they will be irreparably harmed unless the Court issues an injunction because they will not have the due process rights they seek.

Contrary to their protestations, none of the Plaintiffs has been irreparably harmed. The Plaintiffs in this case and their counsel know exactly how to obtain the appeal rights that they are purporting to seek in this case. In fact, two of the Innovations enrollees who are discussed in Plaintiffs' motion have exercised their appeal rights and, as a result. Covert Decl. ¶¶ 13-15, 53-54.

In March 2011, PBH described to all Innovations enrollees how to obtain appeal rights in the "2011 Support Needs Matrix Guide." PBH explained:

> The planning team may submit the Individual Support Plan to Utilization Management with a request for Base Budget Services that exceeds the individual's Support Needs Matrix Category.

> Utilization Management will either approve or deny the Person Centered Plan. If Utilization Management denies the request, the individual or legally responsible person will receive their appeal rights.

D.E. 105-5. Likewise, in filings in this case, PBH had reiterated that an enrollee can request services that exceed his or her category budget, in which case PBH will approve the request for those services within the budget limits, it will deny the services that exceed the budget limits, and the enrollee will be given notice of his or her appeal rights. *See* PBH Answer [D.E. 38, ¶¶ 72, 80, 91, 106]. On September 16, 2011, PBH further explained:

> Enrollees and their planning teams may submit TARs [treatment authorization requests] for Base Budget Services that exceeds [*sic*] the Base Budget for the enrollee's Support Needs Matrix category. They may also submit TARs in which the combination of Base Budget Services and Non-Base Budget Services exceed the waiver Cost Limit of $135,000 per person per year. In such scenarios, PBH will authorize the services and amounts which are compliant with the Support Needs Matrix, or waiver Cost Limit, and deny those services that are not. Enrollees will be given notice of their right to appeal the denial of those services because they are non-compliant and not available under the Innovations waiver.

Misenheimer Decl. [D.E. 42, ¶ 19].

Indeed, Allison Taylor Johns, a named Plaintiff, and Kimberly Beare, a purported class member, have followed this process. Both Johns and Beare submitted ISPs requesting authorization of services in excess of their Support Needs Matrix Base Budgets. PBH Utilization Management authorized a limited portion of their requested service pro-rated to their Base Budget, denied the remainder, and issued notice of appeal rights to both Johns and Beare. Both Johns and Beare elected to pursue their appeal rights.

B. <u>Plaintiffs Could Avoid the Alleged Injury, But Have Chosen Not to Do So.</u>

The remaining Plaintiffs are fully capable of obtaining the relief they seek – and, thus, avoiding the injury they complain of – without the need for the extraordinary remedy of a

preliminary injunction. Because Plaintiffs have the ability to obtain the due process hearings that they seek at any time, they do not require this Court's extraordinary assistance in obtaining that relief. Because they can avoid their alleged irreparable injuries, but have not chosen to do so, they are not entitled to a preliminary injunction.

"Any party claiming an injury is under a duty to mitigate its damages. A movant for extraordinary relief cannot mask an ongoing failure on its part to mitigate its damages as an ongoing instance of irreparable harm." *Lanvin Inc. v. Colonia, Inc.*, 739 F. Supp. 182, 192-93, (S.D.N.Y. 1990). "Nor can it claim irreparable harm when its delay is itself the cause of whatever harm it alleges." *Id.* at 193.

"Even if [plaintiff] could demonstrate that it would be irreparably harmed, it must also show that it could not prevent such harm." *Air Transp. Int'l LLC v. Aerolease Fin. Group, Inc.*, 993 F. Supp. 118, 123 (D. Conn. 1998). *See also American Brands, Inc. v. Playgirl, Inc.*, 498 F.2d 947, 950 (2d Cir. 1974) (in discussion of irreparable harm, the Court noted that "[i]t would appear to be basic that [plaintiff] is obligated to mitigate its damages").

The remaining Plaintiffs have had, and continue to have, the ability to follow the same procedure as Johns and Beare. Each could submit an over-budget request for services, should they desire to do so, and obtain the due process rights they purport to seek.

Any alleged injury asserted by Plaintiffs that supposedly flows from not having had a due process hearing can be easily avoided by Plaintiffs. All Plaintiffs have the ability to obtain a due process hearing regarding their level of services under their Support Needs Matrix category. Because the Plaintiffs are fully capable of avoiding the harm that they claim they are suffering, they have failed to make a clear showing of irreparable harm, and their motion for preliminary injunction should be denied.

V. THE BALANCE OF THE EQUITIES TIPS IN FAVOR OF THE DEFENDANTS.

The balance of the equities tips in favor of the Defendants and their use of the Support Needs Matrix funding system. One of the fundamental objectives of the Support Needs Matrix system is to make the funding of services more equitable for ***all*** Innovations enrollees including the Plaintiffs. *See* Misenheimer Decl. [D.E. 42] ¶¶ 4-5. All Innovations enrollees have been evaluated according to the same standardized criteria. Further, there are several mechanisms in place to address outliers, as well as temporary or permanent changes in an individual's needs. *Id.* ¶¶ 13-14.

The injunction sought by Plaintiffs would turn back the clock to June 30, 2011. Because of the finite sum of money available to PBH for the Innovations waiver, such an injunction would require funds to be taken away from individuals with greater needs in order to provide increased budgets for individuals, like Plaintiffs, with fewer needs as measured on the same standardized criteria. This is certainly not an equitable result.

The balance of the equities is one of the four requirements that a plaintiff must prove to be entitled to a preliminary injunction. Because Plaintiffs have not satisfied this requirement, their motion should be denied.

VI. AN INJUNCTION IS NOT IN THE PUBLIC INTEREST.

In addition, a plaintiff is required to show that an injunction is in the public interest. *See Real Truth* at 346. "[I]n *Winter*, the Supreme Court emphasized the public interest requirement, stating, 'In exercising their sound discretion, courts of equity should pay particular regard for the public consequences in employing the extraordinary remedy of injunction.'" *Id.* at 347 (citing *Winter*, 129 S.Ct. at 376-77). The injunction that Plaintiffs seek is not in the public interest.

The federal waivers that PBH operates began as a pilot project in PBH's original five-county area. Because these waivers have proven to be a successful way to manage behavioral health services and costs, the North Carolina General Assembly enacted legislation to expand the PBH model statewide. See N.C. Sess. Laws 2011-264 (House Bill 916). Indeed, the General Assembly specifically instructed the Department to follow the PBH model and to use utilization management criteria to allocate resources based on an assessment of need so that an appropriate amount of services are authorized. This is exactly what the Support Needs Matrix system accomplishes. *See also* Shipman Aff. [D.E. 41] ¶ 9.

In addition, the Innovations waiver and its use of the Support Needs Matrix funding system has been approved by both the Department and CMS. Misenheimer Aff. [D.E. 42] ¶ 6. PBH adopted the Support Needs Matrix system in order "to distribute limited Medicaid funds in an efficient, fair, equitable, and sustainable manner." *Id.* at ¶ 4.

Thus, the Support Needs Matrix system is designed to promote the public interest of providing access to an appropriate level of services for all Innovations enrollees, according to their needs. Because of the finite pool of funds available to fund services under the Innovations program, an injunction that requires individuals with fewer needs, relative to other Innovations enrollees, to receive funding at an increased level, would necessarily mean that other Innovations enrollees with greater needs would have to receive less funding. Such a result is certainly not in the public interest.

CONCLUSION

For the reasons set forth above, Plaintiffs have failed to meet their burden under *Winter* and Fed. R. Civ. P. 65(a), and the Court should deny Plaintiffs' Motion for Preliminary Injunction.

Respectfully submitted, this the 1st day of February, 2012.

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CERTIFICATE OF SERVICE

I, the undersigned attorney of the law offices of Nelson Mullins Riley & Scarborough LLP, attorneys for Defendants Shipman and PBH do hereby certify that on February 1, 2012, I electronically filed the foregoing DEFENDANTS PAMELA L. SHIPMAN AND PBH'S RESPONSE IN OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION with the Clerk of the Court using the CM/ECF system which will send notification of such filing to the following:

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