UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

OSCAR SALAZAR, *et al.*,	)	
Plaintiffs,	)	
	)	**C.A. No. 93-452 (GK)**
v.	)	
DISTRICT OF COLUMBIA, *et al.*,	)	
Defendants.	)	

THE DISTRICT OF COLUMBIA'S OPPOSITION TO PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

INTRODUCTION

By their motion for a preliminary injunction, plaintiffs seek to embroil this Court in overseeing the District of Columbia's implementation of the Affordable Care Act (the ACA), the dramatic change to health care insurance coverage in the United States, including for Medicaid beneficiaries. To shoehorn their action concerning the ACA into this 1993 lawsuit, plaintiffs resurrect Sections II and III of the 1999 Settlement Order, both of which were terminated by this Court years ago. Plaintiffs agreed to terminate Section II of the Settlement Order over five years ago, and the Court terminated Section III more than two years ago because it was entirely at odds with the ACA. Plaintiffs' strained efforts now to create jurisdiction in this Court where none exists should be rejected. But even if this Court were to determine these issues were properly before it, plaintiffs have failed to demonstrate that they are entitled to the extraordinary relief they seek. As set forth in the accompanying Declaration of Medicaid Director Claudia Schlosberg, contrary to plaintiffs' anecdotal and speculative claims, since implementation of the ACA, the District of Columbia has *increased* the percentage and numbers of its Medicaid enrollees, with the committed goal of ensuring Medicaid benefits to all District residents eligible

to receive them. The District has, at every step of its implementation of the ACA, obtained the review and express approval of the federal oversight authority, the United States Centers for Medicare and Medicaid Services (CMS). In short, plaintiffs' Motion is beyond the Court's jurisdiction and, even if it were appropriate to raise it in this litigation, the Motion is without merit. And, even if the Court had jurisdiction to consider plaintiffs' Motion and the Motion had merit, the plaintiffs have failed to include an indispensable party, the United States, to obtain the relief they seek. For any or all of these reasons, plaintiffs' Motion for a Preliminary Injunction should be denied.

PROCEDURAL BACKGROUND

In 1993, plaintiffs filed this case asserting violations of federal law arising from several aspects of the District's administration of its Medicaid program. The certified class in this case was not a unified, comprehensive one, "but has always been a collection of several sub-classes, with each sub-class consisting of Medicaid applicants and recipients with a particular set of claims." (ECF No. 2046, at 2; *see also id.* at 3 ("the class should be certified as five separate sub-classes rather than as one comprehensive class") (quotation omitted).) The controlling class definition is found in the Court's November 3, 1994 order, which granted the parties' joint motion to clarify the operative definition. There, the Court described the class as follows:

> All persons who have applied, have attempted to apply, or will apply in the future during the pendency of this litigation, for medical assistance pursuant to Title 19 of the Social Security Act ("Medicaid"), and all persons who have received, are receiving, or will receive in the future during the pendency of this litigation, Medicaid in the District of Columbia with respect to the following claims:
>
> Any claims for declaratory, injunctive, or other relief premised on the alleged lack of immediate Medicaid coverage for newborns using the Medicaid number of their mothers, who are eligible for Medicaid at the time of the babies' birth [Sub-Class I]

> Any claims for declaratory, injunctive, or other relief premised on an alleged inability to apply for Medicaid at disproportionate share hospitals and federally-qualified health centers [Sub-class II]
>
> Any claims for declaratory, injunctive, or other relief premised on an alleged delay in excess of 45 days in the processing of Medicaid applications [Sub-class III]
>
> Any claims for declaratory, injunctive, or other relief premised on an alleged lack of advance notice of the discontinuance, suspension or obligation to recertify Medicaid benefits, after being found eligible [Sub-class IV]
>
> Any claims for declaratory, injunctive, or other relief premised on an alleged lack of effective notice of the availability of early and periodic screening, diagnostic and treatment ("EPSDT") services for children under 21 years of age, and/or an alleged lack of EPSDT services for eligible children under 21 years of age [Sub-class V].

(ECF No. 100, at 1-2 (brackets in original).) Claims regarding the first two Sub-classes were resolved prior to trial. (ECF No. 2046, at 4 n.2.)

In 1996, following a bench trial, the Court found the District liable for five categories of violations involving Sub-classes III through V: (1) the District did not process and decide on applications for Medicaid eligibility in a timely manner; (2) the District did not provide advance adequate notice before suspending or terminating benefits; (3) the District failed to provide EPSDT services when requested; and (4) the District did not adequately notify eligible families regarding the availability of EPSDT services. *Salazar v. District of Columbia*, 954 F. Supp. 278, 324-34 (D.D.C. 1996). And, as a remedy for class members who incurred out-of-pocket expenses as a result of the violation of their rights, the Court ordered the District to reimburse class members for eligible out-of-pocket expenses. *Id.*

Thereafter, in 1999, the parties entered into the Settlement Order, memorializing the District's obligations to remedy the violations. Section II of the Settlement Order detailed steps

the District was to take to redress problems related to the timely processing of initial applications for Medicaid eligibility on behalf of members of Sub-class III. (ECF No. 663, at ¶¶ 6-16.) In general, Section II required the District to decide Medicaid applications and notify beneficiaries within 45 days of receiving an application. (*Id.* at ¶ 6(a).) In addition, Section II imposed various reporting requirements and compliance standards. (*See generally id.* at ¶¶ 6-16.) If the District demonstrated compliance over three consecutive years, the Settlement Order provided that Section II would terminate. (*Id.* at 74.) On February 24, 2009, the District notified the Court that it had satisfied the exit criteria for Section II and represented that plaintiffs were in agreement with that position. (ECF No. 1443.) The District therefore requested, with plaintiffs' consent, that the Court vacate Section II. (*Id.*) The Court granted the motion to vacate the same day. (Minute Order dated Feb. 24, 2009.)

Section III of the Settlement Order concerned the annual recertification of Medicaid benefits on behalf of Sub-class IV. (ECF No. 663, at ¶¶ 17-28.) At the time, Medicaid laws then in effect required that the District mail recertification forms to beneficiaries each year for them to complete and return or risk losing their benefits. Section III prescribed a schedule by which the District sent out application forms, using language specified by the Settlement Order, and various notices to advise beneficiaries as to the status of their recertification. (*Id.* at ¶ 17.)

After passage of the ACA, however, the law changed significantly. Instead of the active recertification system required by Section III, the ACA required the District to move to a passive renewal model in which beneficiaries' eligibility is determined to the extent possible through reliable information available to the District, such as data available through the IRS or the Social Security Administration. *See* 42 C.F.R. § 435.916. The District is working under the supervision and oversight of CMS to implement the passive renewal system.

In light of the change in law, the District moved pursuant to Fed. R. Civ. P. 60(b)(5) to be relieved of complying with Section III, pointing out that it could not move forward with implementation of the ACA's passive renewal system while being bound by conflicting provisions in Section III. (ECF No. 1870.) The Court agreed, finding that "[t]here is simply no comparison between the statutory framework that existed at the time this Court made its factual findings in 1996 and what implementation of the ACA envisions," noting that the ACA's renewal provisions "are in direct conflict with the renewal process in Section III." (ECF No. 1886, at 6.) For that reason, the Court "conclude[d], pursuant to Fed. R. Civ. P. 60(b)(5), that passage of the ACA has created a 'significant change in circumstances' that justifies termination of the provisions of Section III of the Consent Order." (*Id.* at 5.)

As the Court recognized when it terminated Section III, the task before the District in implementing the passive renewal process "presents many technological and logistical challenges . . . [and] will be a massive undertaking requiring the resources, creativity, and attention to detail of many people within the District of Columbia Government." (*Id.* at 5.) And the Court understood that "implementation will undoubtedly be both rocky and fairly long in coming." (*Id.* at 6.) Plaintiffs did not appeal the Court's decision to terminate Section III.

FACTUAL BACKGROUND

I. Creation of the DC Access System

It is no understatement to say that the ACA has transformed Medicaid, particularly in how states determine the eligibility of individuals who initially apply for benefits or during annual renewal of eligibility. This is especially so in the District of Columbia, which currently has almost a quarter of a million Medicaid beneficiaries constituting approximately one in three District residents. A key component of the new eligibility standards is the ACA's Modified

Adjusted Gross Income (MAGI) methodology, which uses household tax information to assess income, household composition, and family size. This methodology applies only to particular categories of beneficiaries: parents and caretakers, children, pregnant women, and a new category of childless adults.[1] MAGI beneficiaries constitute the majority of the District's Medicaid population. Different eligibility standards are used to assess the eligibility of individuals with disabilities and the elderly, as well as other special populations, who collectively are referred in the eligibility context as the non-MAGI population. Where applicable, the MAGI methodology is used in determining eligibility at the time an individual submits an initial application, at the time he or she renews eligibility annually, and whenever the beneficiary experiences a change in circumstances affecting eligibility.

To implement the eligibility reforms called for by the ACA, the District began building a new, automated eligibility determination system, the DC Access System (DCAS). (Declaration of Claudia Schlosberg, Ex. A (Schlosberg Decl.), at ¶¶ 14-15.) When fully realized, DCAS will provide streamlined, automated eligibility determinations for all public health and human services benefits offered by the District, at which point the District will retire its legacy eligibility system, the Automated Client Eligibility Determination System (ACEDS). (*Id.* at ¶ 15.) However, due to the scope and complexity of this massive project, the transition from ACEDS to DCAS has been carried out in stages to allow for better management, to minimize disruptions on day-to-day operations, and to minimize risks to beneficiaries. (*Id.*)

Since October 1, 2013, individuals have been able to submit applications for Medicaid benefits online, over the phone, by fax, by mail, or in person at the Department of Human

[1] Childless adults are a new, optional coverage category provided for by the ACA. The District was one of only six jurisdictions that opted to expand coverage to childless adults immediately upon enactment of the ACA. Approximately 30 jurisdictions now offer coverage for this category.

Services (DHS) Economic Security Administration (ESA) Service Centers. (*Id.* at ¶ 25.) The District largely has been successful in adopting MAGI methodologies to assess eligibility at the time of initial application. Once the application is received, the information is compared against federal and local data sources and processed through an automated rules engine. (*Id.* at ¶ 26.) The individual is then notified of the results of the application. (*Id.*) If the information is sufficient to make an eligibility determination, the individual is notified and approved for Medicaid immediately. (*Id.*) Since October 2013, over 33,000 new electronic applications for Medicaid were processed in DCAS on the same day they were submitted. (*Id.* at ¶ 99.) This means that 33,000 new applicants applied for Medicaid and received a determination on the same day based solely upon electronic data that demonstrated they met Medicaid eligibility criteria.

II. Implementation of Passive Renewals

After an initial application is approved, Medicaid eligibility must be re-determined on an annual basis. The ACA mandates a passive renewal process for MAGI beneficiaries. *See* 42 C.F.R. § 435.916(a). When a MAGI beneficiary is due to be renewed, the District uses available local and federal data to attempt to verify the beneficiary's continued eligibility. (Schlosberg Decl. at ¶ 32.) If the available information is sufficient to confirm that the individual is eligible, the beneficiary is notified of that decision and need not take any further action. (*Id.*) If the information available is insufficient to make an eligibility determination, the beneficiary is sent a form 60 days prior to the renewal date that is pre-populated, and instructed to return the pre-populated form. (*Id.* at ¶ 33.) If the beneficiary does not return the pre-populated form, the beneficiary is provided 30 days' notice that benefits will terminate if the pre-populated form is not returned before the renewal date. (*Id.*; MAGI 30-day Notice, Ex. D.) Recipients of this notice

are advised of their appellate rights. (Schlosberg Decl. at ¶ 33; Ex. D.) However, even when an individual fails to provide the needed information on time, the District extends a 90-day grace period, meaning that benefits will terminate at the end of the certification period as required by law, but if a beneficiary returns the completed form late, benefits can be restored retroactive to the date of termination if the beneficiary's information establishes that he or she remains eligible. (Schlosberg Decl. at ¶ 33.)

The passive renewal process for MAGI beneficiaries has been managed in two phases. The first phase was to implement passive renewal functionality for MAGI beneficiaries whose eligibility had been determined using pre-ACA methodologies. These beneficiaries are referred to as the M1 renewal group. (*Id.* at ¶¶ 34-35.) In other words, any MAGI beneficiary who applied and was determined eligible for Medicaid prior to October 1, 2013 belonged to the M1 renewal group. The second phase involved beneficiaries who previously were determined eligible through MAGI methodologies, referred to as the D1 renewal group. (*Id.* at ¶ 45.) Beneficiaries in the D1 renewal group include MAGI beneficiaries who applied on or after October 1, 2013 as well as any M1 beneficiary who successfully completed the renewal process. (*Id.*) Stated differently, as M1 beneficiaries are renewed utilizing MAGI methodologies, they become part of the D1 renewal group.

Because of the time needed to develop, test and implement the technology to move forward with passive renewals, CMS granted the District a waiver that permitted it to defer renewals for all 135,000 M1 MAGI beneficiaries due to renew between January 1, 2014 and December 31, 2014. (*Id.* at ¶¶ 34, 36; CMS 6/18/13 Early Adoption of MAGI and Renewal Extension, Ex. E.) The majority of Medicaid beneficiaries therefore did not have to renew their eligibility for all of 2014. (Schlosberg Decl. at ¶ 36.)

The automated passive renewal process for M1 beneficiaries began in December 2014 for beneficiaries whose renewals had been deferred to January 2015, and continued throughout 2015. (*Id.* at ¶ 37.) Passive renewal functionality for the D1 population was initially expected to be implemented in November 2014, but technological challenges required the deployment to be delayed. (*Id.* at ¶ 46.) The District sought to extend the current waiver from CMS to delay further eligibility redeterminations for the D1 population while continuing to develop the required technology. (*Id.* at ¶¶ 47-48.) CMS, however, would not permit the District to delay further renewals for D1 beneficiaries with renewal dates on or after October 2015 due to the need to ensure correct eligibility determinations. (*Id.*) CMS instead approved a waiver that delayed D1 renewals for beneficiaries scheduled to renew between October 1, 2014 and September 30, 2015, giving these beneficiaries an additional 12 months of continuous coverage. (*Id.*; CMS 11/20/15 D1 Contingency Plan, Ex. F.)

For D1 beneficiaries with renewal dates after September 30, 2015, CMS authorized the District to use a temporary, modified renewal process for D1 renewals for beneficiaries due to renew on or after October 2015. (Schlosberg Decl. at ¶¶ 47-49; CMS 11/20/15 D1 Contingency Plan, Ex. F.) Under the temporary process approved by CMS, D1 beneficiaries received an abbreviated D1 Renewal Form, which was reviewed and edited by CMS prior to approval as well as by the local advocacy community. (Schlosberg Decl. at ¶¶ 49-50.) The D1 Renewal Form was sent 60 days prior to the beneficiary's scheduled renewal date, and beneficiaries who did not return it within 30 days were given a second notice that their benefits would be terminated if the completed form was not returned timely and advised of their appellate rights. (*Id.* at 49; MAGI 30-day Notice, Ex. D.) CMS instructed the District that it must terminate the eligibility of D1 beneficiaries who did not return the completed D1 Renewal Form timely (although these

beneficiaries would also receive a 90-day grace period through which they may be eligible for retroactive coverage) or who no longer were eligible. (Schlosberg Decl. at ¶ 50.)

The temporary process was utilized for individuals with renewal dates between September 2015 and January 2016—a period of five months. (*Id.* at ¶ 52.) Because the District was able to accelerate the technology upgrades needed to conduct full passive renewals for the D1 population, the automated passive renewal process began in December 2015 for MAGI beneficiaries with renewal dates in February 2016. (*Id.* at ¶ 54.) During this first cycle, the District processed over 9,000 cases. (*Id.*) Sixty-three percent were passively renewed, meaning an eligibility determination was made based on available data sources—these beneficiaries were required to take no action. (*Id.*) The remainder have been sent the abbreviated D1 renewal form and the District is processing those forms as they are returned. (*Id.* at ¶ 55.)

The District anticipates that it will automate many functions necessary to renew benefits for the non-MAGI population at a later stage of its implementation of DCAS. (*Id.* at ¶ 57.) In the meantime, non-MAGI beneficiaries go through the same renewal process that the District has used for the last 15 years. (*Id.*) They are sent a renewal form 90 days before their eligibility expires and advised that they must complete and return the form. (*Id.* at ¶ 58.) If they fail to do so within 30 days of the renewal date, they are advised that their benefits will terminate if the completed form is not received timely and explained their appellate rights. (Non-MAGI 30-day Notice, Ex. I.)

Throughout 2015, the District instituted a variety of new, enhanced outreach strategies to remind beneficiaries who are unable to passively renew of the need to complete and submit documentation to establish their continued eligibility for Medicaid. For instance, the District developed a new procedure in which, every month, each of the District's for Managed Care

Organizations (MCOs) is provided the names of the beneficiaries on their respective rosters that are due to renew 50 days prior to the renewal date. (Schlosberg Decl. at ¶ 39.) The MCOs in turn conduct outreach phone calls, encouraging beneficiaries due to renew to complete needed renewal forms and offering assistance if needed. (*Id.*) In cases where an individual is terminated due to their failure to return needed forms, the MCOs are sent a second list enabling them to continue their outreach during the 90-day grace period in an attempt to assist eligible beneficiaries to receive retroactive coverage. (*Id.*) In addition, after beneficiaries receive a renewal form, the District mails a postcard to remind them of the need to return the renewal form, followed up with an automated robocall to the telephone number on file for the beneficiary. (*Id.* at ¶ 38.) Moreover, in cases where the D1 Renewal Forms are returned as undeliverable, ESA staff call the beneficiary to obtain a current address. (*Id.* at ¶ 40.) DHS has also added eight staff members to its call centers to answer questions beneficiaries may have with respect to renewals. (*Id.* at ¶ 22.)

These strategies, coupled with the implementation of passive renewals, have proven tremendously successful in renewing coverage for beneficiaries. Historically, roughly only 60% of beneficiaries responded to renewal notices under the pre-ACA framework. In 2015, the response rate surged to 86.3%. (*Id.* at ¶ 44.) With passive renewals for the D1 population moving forward, the District anticipates a similarly high response rate for 2016. (*Id.*)

III. Challenges Presented by the Transition from ACEDS to DCAS

The transition from ACEDS to DCAS is of critical importance not only to the District but to the federal government as well. CMS thus has monitored all aspects of this transition closely and meets frequently with the Department of Health Care Finance (DHCF) and DHS through conference calls and in-person meetings. (*Id.* at ¶ 14.) CMS has reviewed and approved every

systemic action the District has taken with respect to the implementation of DCAS, including the timetable for the various phases of the project as well as the content and timing of renewal forms sent to beneficiaries. (*Id.* at ¶¶ 16, 18, 22, 25, 30, 32, 36, 47-50, 57, 63, 65-67, 69, 75.)

As with virtually every other jurisdiction attempting to implement new eligibility systems as a result of the ACA, the District has encountered some technological challenges with respect to the transition from ACEDS to DCAS. (*Id.* at ¶¶ 19-20.) The District has been proactive during this process; it continually self-identifies problems and works to correct them with CMS's guidance. To confront technological challenges, the District has repurposed and trained staff to support its mitigation plans. (*Id.* at ¶ 22.) At the same time, the District has engaged stakeholders and the advocacy community to assist with the identification of beneficiaries who may have been affected and has established dedicated email addresses for individuals, stakeholders, and advocates to promptly resolve problems on behalf of individuals. (*Id.* at ¶ 24.) In addition, the District has substantially increased caseworkers to process applications and renewals, and has added staff in ESA Service Centers to answer questions related to renewals. (*Id.* at ¶ 22.)

This strategy has been effective in managing technological problems to minimize the effects on individual beneficiaries. For example, in October 2015, the District discovered that 1,188 beneficiaries may not have received their eligibility form because of a technical issue that changed a single digit in the address. (*Id.* at ¶ 64.) Once identified, and in accordance with guidance provided by CMS, the District immediately reinstated coverage for any affected beneficiary who had lost it and sent an informational notice to affected beneficiaries in November 2015, advising that their benefits had been reinstated and extended. (*Id.*) The technical problem was fixed immediately and, in January 2016, updated renewal forms were reissued to these beneficiaries. (*Id.*)

In addition, the District identified an issue in DCAS in May 2014 affecting the accuracy of immigration eligibility decisions; the system was not properly determining eligibility for aslyees and was approving coverage for applicants even where the applicants lacked an eligible immigration status. (*Id.* at ¶ 31.) The District implemented a manual "work around" to ensure correct determinations while resolving the underlying technical issue. (*Id.*) The technical problems that lead to the error regarding asylee status and most of the issues that were causing ineligible applicants to be found eligible were fixed by November 2014. (*Id.*) A residual issue that was authorizing Medicaid for a small number of legal immigrants who were barred from Medicaid during their first five years of residence was fixed in August 2015. (*Id.*)

Two issues persist but are being managed pursuant to CMS guidance to mitigate adverse impact on beneficiaries and the integrity of the Medicaid program. First, the District has found that certain renewal and application cases in DCAS were "stuck/malformed," meaning that technical issues prevented the system from making a fully formed case in DCAS when information was entered into the system. (*Id.* at ¶ 65.) Those technical errors prevent a caseworker from reviewing a case to reach a determination. The District initially believed that there were 999 cases affecting renewals, but determined that some of these instances were false positives with no issue to correct. (*Id.*) As of January 14, 2016, less than 10 "stuck/malformed" renewals remain under analysis. (*Id.*) And of the initial tally of 2,122 "stuck/malformed" initial applications appearing as pending over 45 days discovered in October 2015, the District has reduced this total to 1,408 and continues to work these numbers down. (*Id.*) DHCF and DHS have worked closely to minimize any effect on beneficiaries and have developed instructions for addressing these cases. (*Id.*) CMS has approved the District's plan to remedy this issue. (*Id.*) The District already has resolved many of the underlying causes of these technical issues, but

some of the systemic repairs cannot be implemented until the District conducts a scheduled system upgrade that currently is anticipated in June 2016. (*Id.*) However, now that the District understands the causes of the "stuck/malformed" cases, it will be monitoring the system and reviewing cases as they appear to ensure timely resolution of eligibility cases. (*Id.*)

The District is also successfully working through a second issue that is causing a backlog of applications. In April 2015, the District discovered that a report used to monitor application processing times no longer was accurate and immediately began investigating the causes. (*Id.* at ¶ 66.) The District consulted with CMS for guidance and worked with CMS to develop a remediation plan. (*Id.*)

Due to the status of the applications and concerns that an unknown number represented individuals who would not be not be eligible, CMS directed that the District's caseworkers conduct manual review of each application appearing in the backlog, which initially appeared to affect approximately 12,000 individuals. (*Id.* at ¶ 67.) The District developed processing instructions that CMS approved and caseworkers began clearing the various backlogged applications in August 2015, working nights and weekends to resolve the backlog as quickly as possible. (*Id.*; Resolution Strategy, Ex. G.) Cases were prioritized pursuant to CMS's guidance. Where a beneficiary was determined eligible but had not received a determination, the individual was notified and approved retroactively to the date of the initial application along with instructions on how to request reimbursement for any eligible out-of-pocket expenses. (*Id.* at ¶ 70.) In cases where a beneficiary was determined ineligible, a denial notification was sent that explained the decision and the beneficiary's right to appeal. (*Id.*; Medicaid Denial Notice, Ex. H.)

The District has significantly reduced this application backlog. As of January 11, 2016, 1,247 individuals appear on this list. (*Id.* at ¶ 71.) Of the approximately 12,000 individuals appearing on the original backlog report, more than half have received Medicaid benefits as a result of the caseworkers' efforts, even though most failed to provide verification documents or provided them late. (*Id.* at ¶ 69.) Approximately 15 percent of the original 12,000 already were receiving Medicaid and accordingly required no action other than to remove them from the list. (*Id.*) And in approximately 27 percent of cases, the application was denied in accordance with the instructions approved by CMS, and an explanation of the denial and appeal rights was sent. (*Id.*)

At the same time caseworkers have manually reviewed backlogged cases, the District has worked to solve the underlying technical problems that caused the backlog. As with the "stuck/malformed" cases, some of these fixes have been implemented but several cannot be administered until a system upgrade, expected in June 2016. (*Id.* at ¶ 75.) However, with knowledge of the causes of these problems, and with the use of daily monitoring reports, the District expects to avoid additional applications from becoming backlogged in the first place. (*Id.* at ¶¶ 74-75.)

STANDARD OF REVIEW

"A preliminary injunction is 'an extraordinary remedy that may only be awarded upon a clear showing that the plaintiff is entitled to such relief.'" *Sherley v. Sebelius*, 644 F.3d 388, 393 (D.C. Cir. 2011) (quoting *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 22 (2008)). Preliminary injunctive relief is appropriate only when the movant demonstrates (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. *Winter*, 555 U.S. at 20.

It is particularly important for the movant to demonstrate a likelihood of success on the merits, as it is a free-standing requirement for a preliminary injunction. *Sherley*, 644 F.3d at 393 (quoting *Davis v. Pension Benefit Guaranty Corp.*, 571 F.3d 1288, 1296 (2009) (concurring opinion)). Absent a "substantial indication" of a likelihood of success on the merits, "there would be no justification for the court's intrusion into the ordinary processes of administration and judicial review." *Naegele v. Albers*, 843 F. Supp. 2d 123, 126-27 (D.D.C. 2012) (quoting *Am. Bankers Ass'n v. Nat'l Credit Union Admin.*, 38 F. Supp. 2d 114, 140 (D.D.C. 1999)). If a party fails to make a sufficient showing of irreparable injury, a court may deny a motion for preliminary relief without considering the other factors. *CityFed Fin. Corp. v. Office of Thrift Supervision*, 58 F.3d 738, 747 (D.C. Cir. 1995). If the movant demonstrates a likelihood of success *and* irreparable injury, the court "must balance the competing claims of injury and must consider the effect on each party of the granting or withholding of the requested relief." *Amoco Prod. Co. v. Gambell*, 480 U.S. 531, 542 (1987). Indeed, "courts of equity should pay particular regard for the public consequences in employing the extraordinary remedy of injunction." *Weinberger v. Romero–Barcelo*, 456 U.S. 305, 312 (1982).

ARGUMENT

I. Plaintiffs' Motion Should Be Denied Because The Court Has Terminated The Provisions At Issue

The Court has terminated the two Sections of the Settlement Order that cover the subject matter raised in plaintiffs' motion. There is nothing left for plaintiffs to monitor or enforce with respect to the District's determination of Medicaid eligibility. Because those provisions of the Settlement Order no longer are in effect, the District cannot be held to them. *See EEOC v. Local*

40, Internat'l Ass'n of Bridge, Structural and Ornamental Iron Workers, 76 F.3d 76, 80 (2d Cir. 1996) ("In the presence of the decree's termination clause, the district court does not have indeterminate power to ensure compliance with its terms.").

Plaintiffs freely concede that the relief they seek is independent from the requirements in the Settlement Order. (Mot. at 3, 34-35.) That concession is bolstered by the fact that plaintiffs have dispensed with the requirements of Paragraph 80 of the Settlement Order, which required:

> Before any party moves the Court to enforce or construe this Order . . . it shall give the other party 10 days' notice of its intention. During that 10-day period, the parties shall negotiate in good faith in an effort to resolve the dispute without seeking a decision from the Court.

(ECF No. 663, at ¶ 80.) Plaintiffs' unilateral decision to bypass this process further demonstrates that resolution of their motion presents entirely new claims divorced from the District's requirements under the Settlement Order. Indeed, plaintiffs have pointed to no provisions of the Settlement Order as a basis for their requested relief.

But plaintiffs may not impose new requirements on the District that are not memorialized in the Settlement Order, which is just that—a settlement between the parties to resolve this lawsuit. "Because a decree is the sole source of the parties' rights, a district court may not impose obligations on a party that are not unambiguously mandated by the decree itself." *King v. Allied Vision, Ltd.*, 65 F.3d 1051, 1058 (2d Cir. 1995) (citing *Local No. 93, Int'l Ass'n of Firefighters v. City of Cleveland*, 478 U.S. 501, 522 (1986), and *United States v. Armour & Co.*, 402 U.S. 673, 681–82 (1971)); *accord Reynolds v. Roberts*, 207 F.3d 1288, 1300 (11th Cir. 2000); *Tourangeu v. Uniroyal, Inc.*, 101 F.3d 300, 307 (2d Cir. 1996). The parties agreed that the District would abandon its appeal of this Court's liability decision and Amended Remedial Order dated May 6, 1997 in exchange for the certainty provided by the Settlement Order. In other

words, the Settlement Order resolved all the claims raised in plaintiffs' Second Amended Complaint and plaintiffs' rights are limited to those expressed in the Settlement Order; any new relief must be sought in the context of a new lawsuit. Plaintiffs' concession that they seek relief outside of what is contained in the Settlement Order should end this Court's analysis and dispose of this motion. *See Barcia v. Sitkin*, 367 F.3d 87, 105-10 (2d Cir. 2004) (finding district court abused its discretion in imposing additional obligations on defendants not contained in consent decree).

Plaintiffs do not discuss these well-established principles in their motion, and in fact cite no authority at all for the Court to impose the relief they seek. Instead, plaintiffs advance an entirely unsupported position: that because the District did not explicitly seek de-certification of the Sub-classes relevant to Sections II and III of the Settlement Order, plaintiffs are vested with plenary authority to enforce provisions of the ACA—a statute not even in effect until decades after they filed suit and the parties entered into the Settlement Order—notwithstanding the Court's termination of the District's obligations in these areas. The total lack of authority for plaintiffs' assertion should come as no surprise. The existence or non-existence of a class is irrelevant to the scope of a case once the parties agree to and the Court enters a consent decree. *See Local No. 93, Int'l Ass'n of Firefighters*, 478 U.S. at 522 ("it is the agreement of the parties, rather than the force of the law upon which the complaint was originally based, that creates the obligations embodied in a consent decree"). From that point forward, the terms of the consent decree, in this case the Settlement Order, provide the sole source of a plaintiff's rights in the action. *See, e.g., King v. Allied Vision, Ltd.*, 65 F.3d at 1058.

In any event, the foundation of plaintiffs' argument—that Sub-classes III and IV "remain certified" under the Court's November 3, 1994 Order—is erroneous. Indeed, because the Court

has terminated its oversight of the District's compliance with Sections II and III of the Settlement Order, what remains of the class in this case consists of children who are eligible for EPSDT services, which is memorialized in Sub-class V. The Court has been consistent that the subclasses are discrete one from the other, and that the Court never intended to certify a unified class. (ECF No. 92 ("The Court finds, however, that for analytical clarity the class should be certified as separate sub-classes rather than as one comprehensive class …"); ECF No. 2046, at 2 ("Over the long life of this case, the Plaintiff class has always been described as a collection of several sub-classes, with each sub-class consisting of Medicaid applicants and recipients with a particular set of claims.").) Individuals with claims regarding the timeliness of decisions on initial Medicaid applications (Sub-class III) or the adequacy of notice in the context of recertification or renewal of benefits (Sub-class IV) do not share anything meaningful in common with the remaining provisions in the Settlement Order concerning EPSDT services. (Sub-class V). Thus, contrary to plaintiffs' arguments, once the Court terminated Sections II and III, the Sub-classes giving rise to those portions of the Settlement Order terminated with them.

Plaintiffs' reliance on a footnote from the Court's decision terminating Section III, simply stating that "members of the plaintiff class can also contact Plaintiffs' counsel, as they have been doing over the years, to obtain legal assistance," does not create or continue jurisdiction in this Court or vest plaintiffs' counsel with the powers they seek to exercise. (ECF No. 1886, at 9 n.1.) This footnote does not authorize plaintiffs' counsel to monitor the District's implementation of the Affordable Care Act. Nor does the footnote grant plaintiffs' counsel any enforcement mechanism. The Court simply acknowledges that plaintiffs' counsel remain free to serve any clients they choose in other fora or litigation.

Permitting jurisdiction in these circumstances would defeat the rationale behind terminating segregable portions of a consent decree. *See Bobby M. v. Chiles*, 907 F. Supp. 368, 371 n.8 (N.D. Fla. 1995) (after partial termination of consent decree, the appropriate remedy to redress new violations is to file a new lawsuit); *Hadix v. Johnson*, No. 80 Civ. 73581, 2014 WL 4678252, at *2 (E.D. Mich. Sept. 18, 2014) (denying motion by inmate to enforce terminated provisions of partially-terminated consent decree, directing filing of new lawsuit). If this Court's orders terminating Sections II and III of the Settlement Order are to have meaning, plaintiffs cannot continue monitoring the manner in which the District determines Medicaid eligibility. Otherwise, it would have been pointless for the Court to have terminated those Sections in the first place, as both before and after termination plaintiffs unilaterally could haul the District into this Court at their whim to air their grievances, monitor compliance, and seek relief from the Court. Particularly as to Section II, where the parties agreed that the District satisfied the exit criteria, permitting ongoing jurisdiction to enforce those dismissed terms deprives the District of the benefit of the bargain it negotiated: ending judicial oversight and plaintiffs' enforcement powers in exchange for meeting agreed-upon metrics. *See EEOC v. Local 40*, 76 F.3d at 81 ("If we were to enforce this consent decree against Local 40 twelve years after its expiration, we would be depriving the union of the benefit of its bargain."); *United States v. Overton*, 834 F.2d 1171, 1174 (5th Cir. 1987) (municipality would lose the benefit of its bargain were the Court to enforce provisions of consent decree after municipality satisfied exit criteria).

In addition to the fact that the Court already has terminated oversight of the subject matters at issue, plaintiffs' motion is based not on the systemic failures that gave rise to the Settlement Order some sixteen years ago, but on alleged violations of an entirely different law. (*See, e.g.*, Mot. at 6-7 (alleging violations of ACA mandates regarding passive and manual

renewals), 8 (alleging violations of the ACA provision mandating that renewal forms be accepted online), 10-11 (alleging violations of the ACA 45-day eligibility determination requirement).) Plaintiffs should not be allowed to shoehorn new claims that the District is not complying with the ACA into what remains of this lawsuit, which is now focused on the provision of EPSDT services to children. *Bobby M.*, 907 F. Supp. at 371 n.8; *Hadix v. Johnson*, 2014 WL 4678252, at *2.

The Settlement Order never mandated compliance with the ACA for the simple reason that the ACA did not exist at the time the parties entered into it. And this Court has found that "[t]here is simply no comparison between the statutory framework that existed at the time this Court made its factual findings in 1996 and what implementation of the ACA envisions." (ECF No. 1886, at 6.) This Court should reach the same conclusion as virtually every other court to have considered this issue: plaintiffs' attorneys should file a new lawsuit should they wish to litigate these issues. *Bobby M.*, 907 F. Supp. at 371 n.8; *Hadix v. Johnson*, 2014 WL 4678252, at *2; *Shepard v. Madigan*, 958 F. Supp. 2d 996, 1000-01 (S.D. Ill. 2013) (allegation concerning new law "is a new claim, about an entirely new law, which must be raised in a new lawsuit").

Of course, the fact that issues concerning Medicaid eligibility no longer are part of this case does not mean that individuals, including plaintiffs' counsel, are without means to obtain information regarding the District's implementation of the ACA or raise concerns regarding compliance. To the contrary, the District holds regular public meetings of its Medical Care Advisory Committee where beneficiaries and advocates have received updates regarding the operations of Medicaid, including how the District is working to carry out the changes in eligibility determinations mandated by the ACA. *See generally* Department of Health Care Finance, *DC Medical Care Advisory Committee*, http://dhcf.dc.gov/page/dc-medical-care-

advisory-committee (last visited December 18, 2015). Indeed, these issues have been discussed extensively at MCAC meetings. *See* MCAC Agenda for September 23, 2015, http://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/2015-9-23%20MCAC%20Agenda.pdf (last visited December 18, 2015); MCAC Agenda for October 28, 2015, http://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/MCAC%20Meeting%20Minutes_Oct%2028%2C%202015.pdf (last visited December 18, 2015); MCAC Agenda for December 10, 2015, http://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/2015-12-10%20MCAC%20Agenda.pdf (last visited December 18, 2015). DHS also hosts a regular monthly meeting for advocates at which issues concerning Medicaid eligibility can be discussed and addressed. In addition to designated public fora to receive information and discuss concerns, the District has a robust Freedom of Information Act, through which individuals, including plaintiffs' counsel, may request and receive agency records on virtually any topic, including how the District is implementing the eligibility provisions of the ACA. *See* D.C. Code § 2-531 *et seq.* And when individuals assert the District has acted in error, they remain free to seek administrative relief before the D.C. Office of Administrative Hearings.

Plaintiffs have failed to provide adequate authority for the Court to order the relief they seek. Following the Court's termination of Sections II and III of the Settlement Order, the parties should focus their attention on the District's provision of EPSDT services as well as the notice of the availability of those services, which are embodied in Sections V and VI of the Settlement Order. Plaintiffs' counsel's current complaints should not be addressed in the context of this lawsuit.

II. Even If The Court Determines That It Has Jurisdiction To Hear Challenges Relating To The District's Implementation Of The Affordable Care Act, Plaintiffs Have Failed To Demonstrate That They Are Entitled To A Preliminary Injunction

The District has employed effective measures to address the inevitable challenges occasioned by implementing the ACA's ambitious vision for making eligibility determinations, all the while working responsibly and diligently to prevent or minimize lapses in coverage for individuals who are eligible for Medicaid. Nearly every jurisdiction has faced equal or greater problems launching new eligibility systems. But the District already has a proven track record of resolving them expeditiously. The District can and will resolve the technical issues that linger regardless of whether the Court grants plaintiffs' motion, and it has worked under the direction of CMS every step of the way.

Plaintiffs have failed to demonstrate that they are entitled to a preliminary injunction. As an initial matter, plaintiffs' motion should be denied on procedural grounds. "The Supreme Court has made clear that '[t]he purpose of a preliminary injunction is merely to preserve the relative positions of the parties until a trial on the merits can be held.'" *Rufer v. FEC*, 64 F. Supp. 2d 195, 206 (D.D.C. 2014) (quoting *Univ. of Tex. v. Camenisch*, 451 U.S. 390, 395 (1981)). The trial in this case occurred twenty years ago in 1996. It is not at all clear what further proceedings plaintiffs envision, but their time to seek a new trial in this case has long since expired. *See* Fed. R. Civ. P. 59(b) (motion for new trial must be filed no later than 28 days after entry of judgment).

In any event, injunctive relief is not required. Plaintiffs are not likely to succeed on the merits, nor have they established irreparable injury absent the requested relief. The balance of equities favors the District, and a preliminary injunction would not serve the public interest.

A. Plaintiffs Are Not Likely To Succeed On The Merits

As stated in Point I above, plaintiffs' motion should be denied because it is based upon provisions of the Settlement Order that this Court terminated in 2009 (Section II) and 2013 (Section III). Because those provisions are no longer in effect, the District cannot be held to them. *EEOC*, 76 F.3d at 80-81. Therefore, plaintiffs cannot meet their burden of demonstrating a likelihood of success on the merits, and the motion should be denied. *Sherley*, 644 F.3d at 393.

Even if the Court rejects the District's jurisdictional argument, the various issues raised by plaintiffs concerning the District's implementation of requirements under the ACA simply do not warrant the extraordinary relief sought by plaintiffs.

1. The District's Renewal System Contains No Systemic Issues Causing Unlawful Terminations of Beneficiaries' Coverage

Plaintiffs cannot establish a likelihood of success on the merits of their claims with respect to renewals. As an initial matter, plaintiffs' assertion that the District "do[es] not have the technical capability to passively renew any Medicaid recipients" is incorrect. (Mot. at 8.) Plaintiffs' counsel was advised before they filed their motion that the requisite functionality to accomplish passive renewals was added to DCAS in December 2015. (*See, e.g.*, Pls.' Ex. 2, at 6.) And, in fact, the District has begun processing passive renewals for the D1 renewal group. (Schlosberg Decl. at ¶ 54.) Indeed, 63% of the D1 cases due to renew in February 2016 were able to be passively renewed without any action needed on the beneficiary's part. (*Id.*) Thus, plaintiffs' allegation that "from January 2016 onwards, all Medicaid recipients will be required to submit a renewal form or else lose coverage, even if the information sought on the form is

already available to the agency through its own files or federal or local databases" is wrong.[2] (Mot. at 8.)

Indeed, the data available to the District demonstrates that the overall response rate for renewals is higher than ever before. In 2015, the average monthly response rate was 86.3 percent of beneficiaries compared to historical rates of approximately 60 percent. (*Id.* at ¶ 100.) This data directly refutes plaintiffs' contentions that there are widespread systemic issues that are preventing individuals from retaining coverage at the time of renewal.

Plaintiffs make numerous allegations that are either factually inaccurate, unsupported, or concern issues that have been resolved. For example, plaintiffs claim that Medicaid beneficiaries' benefits have lapsed due to failures of the legacy eligibility system, ACEDS, to transfer data to DCAS. (Mot. at 18.) Yet the record does not support their assertions. Plaintiffs principally rely on a report from MCOs that they believed their enrollment levels may be dropping along with internal District emails from nearly a year ago discussing the potential development. But the District investigated the MCOs' concerns rigorously and determined they were unfounded. (Schlosberg Decl. at ¶ 89.) Due to the manner in which ACEDS and DCAS communicate, MCOs were initially misinterpreting renewals as terminations in their data systems. (*Id.*) The District's analysis of MCO enrollment, which has *increased* by approximately 9% since the District began using DCAS, as well as more recent reports from MCOs, confirms that this "issue" was illusory. (*Id.* at ¶ 98.)

[2] Plaintiffs are also wrong in stating that the District "did not seek permission from CMS to continue individuals' eligibility while they worked to get their computer systems in order." (ECF No. 2070 at 9.) The District indeed did seek and obtain such permission, but CMS would not allow the District to defer eligibility determinations past September 2015, requiring the District to move to a streamlined manual renewal process for D1 renewals on a temporary basis until passive functionality was added to DCAS. In any event, passive renewal functionality is now available for D1 renewals and has been implemented for D1 beneficiaries due to renew in February 2016 or later.

Plaintiffs additionally claim that the District at one point experienced an issue with making accurate immigration eligibility determinations, but concede that they do not know whether the issue is ongoing. (Mot. at 21.) It is not. The issue that caused a small number of immigrants (asylees) to be denied Medicaid was corrected over a year ago in November 2014. (Schlosberg Decl. at ¶ 31.)

Plaintiffs also try to find fault with the temporary D1 Renewal Form that the District used to renew benefits for some D1 beneficiaries because the form was not available online as required by 42 C.F.R. 435.907(a)(1). (Mot. at 8.) However, CMS has the authority to waive its own regulations or indeed any Medicaid provision relating to eligibility. 42 U.S.C. § 1396a(e)(14)(A). CMS did so by approving the waiver and explicitly approving the District's use of the D1 Renewal Form. (*Id.* at ¶ 50; CMS 11/20/15 D1 Contingency Plan, Ex. F.)

Plaintiffs also are incorrect in claiming that individuals are losing coverage due to issues processing life event changes. (Mot. at 21.) No individual has lost coverage due to such issues. (Schlosberg Decl. at ¶ 94.) In January 2015, DCAS experienced a technical issue with adding newborns into the system, so newborns successfully were added manually to ensure coverage. (*Id.*) And in August 2015, a backlog of life event changes was discovered, but no individual has lost coverage because of the issue. (*Id.*) Unlike some application or renewal backlog issues, Medicaid benefits continue even where the District has not acted upon life event changes. (*Id.*) For example, if a beneficiary reports moving out of the District or that his or her income has increased, the beneficiary continues to receive coverage as if he or she never reported the change.

Plaintiffs again are in error in claiming the District does not consider beneficiaries for alternative coverage categories at renewal when they no longer qualify for their current coverage

category. (Mot. at 28-29.) When a MAGI beneficiary attempts to renew benefits but has experienced a change in status rendering the beneficiary ineligible for coverage according to MAGI methodology, the District considers whether the beneficiary is eligible for other categories of non-MAGI coverage according to data available to the District and the information submitted by the beneficiary. (Schlosberg Decl. at ¶ 95.) If that data and information establishes that the beneficiary is eligible for a non-MAGI coverage category, the beneficiary is approved for the new non-MAGI coverage category. (*Id.*) Due to the nature of the eligibility requirements for non-MAGI coverage categories, which require disclosure of assets and may require proof of a disability, in many cases data available to the District will be insufficient to establish eligibility for non-MAGI categories. (*Id.*) In such cases, the District requests that the beneficiary submit any missing information needed to establish non-MAGI eligibility. (*Id.*) If the information is received prior to the beneficiary's renewal date, and the information establishes eligibility in a non-MAGI coverage group, the beneficiary will not experience a lapse in coverage. (*Id.*) If, however, the beneficiary is unable to establish eligibility in the relevant non-MAGI category by the renewal date, the benefits end, but the beneficiary may be eligible for reinstatement and retroactive coverage during the 90-day grace period. (*Id.*)

In situations where a non-MAGI beneficiary no longer qualifies for her current coverage category due to a change in circumstance, the District will consider eligibility for MAGI coverage. (*Id.* at ¶ 96.) However, because MAGI methods rely upon information that historically has not been required, the District often must request additional information. (*Id.*) If the beneficiary provides the information prior to the termination date, and the information submitted establishes eligibility, the individual's coverage will be continued in the new coverage category. (*Id.*)

The lone example that plaintiffs identify in their motion involves the latter situation involving a non-MAGI beneficiary who was no longer eligible in the coverage category in which she was enrolled. (Mot. at 29.) While the District's practice is to consider all individuals for alterative coverage categories, the District had insufficient information to establish that this individual was eligible for a different coverage category. (Schlosberg Decl. at ¶ 97.) On April 8, 2015, this individual received a 30 day notice to terminate her Medicaid benefits because she was over income. (*Id.*) The notice explained her appeal rights and also contained information regarding who to contact for help. (*Id.*; Non-MAGI 30-Day Notice, Ex. I.) In addition, this individual received general correspondence from the District specifically advising her to file an application through DCAS (DC Health Link) so that she can be considered for eligibility under other Medicaid coverage groups and informing her that she could apply in person, on line and over the telephone. (Schlosberg Decl. at ¶ 97.) According to the District's records in ACEDS, this individual received a total of three such communications. (*Id.*) Eventually, she did file the correct application and her Medicaid coverage in the childless adults category began on December 1, 2015. (*Id.*)

This procedure is in contrast to the approach taken by Michigan in *Crippen v. Kheder*, cited by plaintiffs, in which the state "automatically terminat[ed] the benefits of [M]edicaid recipients solely because their S[upplemental] S[ecurity] I[ncome] benefits ha[d] been terminated." 741 F.2d 102 (6th Cir. 1984). The District does not automatically terminate beneficiaries who may qualify for other categories of Medicaid coverage. Rather, the District attempts to establish their eligibility by reference to the information available to it or provided by the beneficiary. *See Soskin v. Reinertson*, 353 F.3d 1242, 1258-61 (10th Cir. 2004) (upholding

Colorado's procedure of terminating individuals after searching records available to it in an attempt to establish alternative grounds for coverage).

In a further effort to obtain relief based on matters that have long since been resolved, plaintiffs point to a list of beneficiaries provided by Legal Services Providers of individuals who were experiencing issues with respect to their applications or renewals. (Mot. at 22 (citing Pls.' Ex. 18.) Each of these individual cases was reviewed by ESA, and in only a few instances was the issue ongoing by the time ESA obtained the information necessary to review the case. (Schlosberg Decl. at ¶¶ 90-91.) The one or two cases that were not were the result of were routine processing errors that are not indicative of systemic issues within DCAS. (*Id.* at ¶ 91.) The District reported the results of its review to Legal Services Providers in person in June 2015, more than six months ago. (*Id.*)

2. Notice Provided to Beneficiaries Prior to Termination of Benefits is Adequate

The District's method of notifying beneficiaries that their benefits will terminate is adequate and has been approved by CMS. If a beneficiary does not return a renewal form, whether it is a pre-populated form for MAGI beneficiaries who the District is unable to passively renew, the D1 Renewal Form that was sent between September and December 2015, or the form sent to non-MAGI beneficiaries, the District sends a notice to the beneficiary advising that the District intends to terminate Medicaid benefits in 30 days unless the individual returns the necessary information. (MAGI 30-Day Notice, Ex. D; Non-MAGI 30-Day Notice, Ex. I.) The notices advise recipients that if they disagree with the decision, they may file a request for a fair hearing. (*Id.*)

Without citation, plaintiffs claim that District violates the ACA if the District does not send an additional notice at the time of termination advising a beneficiary that his or her

coverage has, in fact, been terminated. (Mot. at 32.) That is not the law. The District is required to provide "timely and adequate notice of *proposed* action to terminate, discontinue, or suspend their eligibility" and must do so at least 10 days before the proposed termination. 42 C.F.R. §§ 431.211, 435.919(a) (emphasis added). The District meets this obligation by notifying the beneficiary 30 days in advance—three times as much notice as required by the regulations. There is no requirement that the District separately issue another notice at the time of termination. Indeed, even when Section III of the Settlement Order was operative, only advance notice was required. (Settlement Order, ¶ 18 ("Each member of the plaintiff class has a right not to have any Medicaid benefits terminated without *advance* notice and an opportunity for a hearing.") (emphasis added).)

Plaintiffs additionally point to another notice issue that already has been resolved fully by the District. (Mot. at 31-32.) In October 2015, the District discovered a systems issue that affected the addresses for approximately 1,188 notices that were sent out as part of the M1 renewal group and likely were not received. (*Id.* at ¶ 64.) In response, the District expeditiously re-issued the notices to the correct addresses, reinstated coverage as necessary to beneficiaries, and resolved the underlying cause of the error. (*Id.*) Plaintiffs point to no evidence at all that this issue is ongoing, yet nevertheless rely on these allegations as part of their everything-but-the-kitchen sink approach to bolster their claim for prospective injunctive relief.

3. The District Has Reduced Application Backlog and "Stuck/ Malformed" Cases Significantly Pursuant to CMS Instructions and Guidance

Plaintiffs have exaggerated the extent of the backlog of initial applications pending in DCAS. Put simply, there never were 12,000 individuals who were entitled to Medicaid waiting for coverage more than 45 days after submission of their applications. The 12,000 figure reported

by the District represented an initial run of data as it appeared in DCAS of individuals with applications showing as having not been processed within 45 days, which could be attributable to any number of causes. (*Id.* at ¶ 66.) Indeed, of the approximately 12,000 cases appearing on the report, approximately 15 percent already had active Medicaid coverage. (*Id.* at ¶ 69.) Another quarter of these cases were applications that had been determined to be ineligible but the system simply had not closed them out. (*Id.*) The remaining instances—roughly half of the 12,000 individuals appearing on the initial backlog report—largely consisted of applications where the applicant failed to submit required documentation timely or at all. (*Id.*) The District nevertheless provided Medicaid coverage, with CMS's approval, to almost all of these individuals, notwithstanding that their applications could have been denied. (*Id.*) As of January 11, 2016, the District has reduced the list of individuals on backlogged applications to 1,247. (*Id.* at ¶ 71.)

The District also has reduced "stuck/malformed" applications and renewals drastically over a shorter time frame. These problems were identified in October 2015 and present a host of technical challenges to permit caseworkers to review affected cases. (*Id.* at ¶ 73.) The District already has reduced "stuck/malformed" cases from an initial count of 999 renewals and 2,122 applications to fewer than ten renewals and 1,408 applications. (*Id.* at ¶¶ 65, 73.) Unfortunately, there are not simple solutions to these complex problems; technical analysis is underway to enable caseworkers to conduct manual review of each case and alert the beneficiary through either DCAS or ACEDS depending on the individual circumstances. (*Id.*)

But it is important to remember how these issues came to the District's attention in the first place. This was not a situation in which advocates, plaintiffs' counsel, or CMS raised concerns that individuals were not receiving timely decisions on Medicaid applications. Instead, the District discovered these problems through its own proactive monitoring of the system, and

immediately developed mitigation plans to determine the root cause of the issues, mitigate any adverse impact on individuals entitled to Medicaid benefits while balancing the need to protect the integrity of the program. And in addition, the District sought out CMS's guidance and encouraged the advocacy community to bring any individuals affected to the District's attention to remedy any effect on them. (*Id.* at ¶ 24, 63, 65-67, 75.) These steps are precisely those that a responsible Medicaid agency should perform in conducting serious self-analysis of its systems.

The District has worked, and continues to work, tirelessly to resolve these problems with oversight and regular monitoring from CMS. After developing protocols with CMS to identify the various categories of backlogged applications, the District has employed teams of individuals working overtime and on weekends to resolve technical issues and provide assistance where needed to beneficiaries. (*Id.* at ¶ 68.) It has hired 47 new staff to process renewals and applications to ensure individuals receive prompt decisions. (*Id.* at ¶ 51.) And it has initiated daily reports to track pending applications before they cross the 45-day threshold in the first place. (*Id.* at ¶ 74.)[3]

The District has strategies to resolve the remaining cases, strategies that have been reviewed and approved by the very agency charged with overseeing the implementation of the ACA. This Court should not second guess CMS or the District's proven track record in resolving technical challenges in deploying DCAS.

4. ESA Service Centers Preserve Beneficiaries' Paperwork and Are Accessible

Plaintiffs further contend that there is a systemic issue in the retention of paperwork. (Mot. at 14, 22.) The District takes a number of steps to ensure that documents submitted by

[3] Plaintiffs contend there is a separate backlog of paper applications. (Mot. at 13-14, 36.) There is not. (Schlosberg Decl. at ¶ 76.)

beneficiaries are retained and processed promptly. ESA employs a Case Records Management Unit that is dedicated to maintaining documents submitted by beneficiaries and uses a Document Imaging Management System (DIMS), which can be accessed by workers who process renewals. (*Id.* at ¶ 59.) Renewal documents regularly are scanned into DIMS to ensure preservation. (*Id.*) In June 2015, ESA began adding scanners to its Service Centers so that documents could be scanned into DIMS immediately upon receipt. (*Id.* at ¶ 61.) Three of the five Service Centers use these scanners and the remaining two Centers are scheduled to begin using them this month (January 2016). (*Id.*) Although at one point a technical issue impaired communication between DIMS and DCAS, that issue has been resolved. (*Id.* at ¶ 62.) In any event, even where relevant information was not transmitted to DCAS, case workers were able to obtain needed information by entering DIMS. (*Id.*)

In addition, plaintiffs suggest that long wait times at ESA Service Centers could prevent individuals from renewing their benefits, but cite no examples of beneficiaries who were unable to renew because of this alleged deficiency. (Mot. at 26.) In fact, wait times at Service Centers declined by an average of 11 minutes between Fiscal Year 2013 and Fiscal Year 2015. (*Id.* at ¶ 84.) Nevertheless, the District is aware that individuals can experience long wait times and has taken action to reduce the amount of time spent waiting. In November 2015, the District hired a business process consulting team to review Service Centers and recommend changes to business processes to minimize wait times. (*Id.* at ¶ 77.) The District also acted to obviate the need for individuals to appear at Service Centers by implementing self-help renewal centers and a new interactive voice response system to call centers that would allow individuals to obtain information regarding the status of their benefits without waiting in line at a Service Center. (*Id.*

at ¶ 80.) And of course with implementation of the passive renewal process, fewer beneficiaries will require ESA's assistance as eligibility determinations are automated to a large degree.

Plaintiffs predict that "cessation of the passive renewals" will exacerbate wait times in Service Centers because more individuals will need to appear to have benefits renewed. That prediction has not come to pass and, in any event, the District has resumed passive renewals for MAGI beneficiaries who are due to renew in February 2016 or later, thus resolving plaintiffs' concern regarding any additional strain on Service Centers. (*Id.* at ¶ 54.)

B. Plaintiffs Will Not Suffer Irreparable Harm If The Preliminary Injunction Is Denied

The D.C. Circuit "has set a high standard for irreparable injury." *Chaplaincy of Full Gospel Churches v. England*, 454 F.3d 290, 297 (D.C. Cir. 2006). Plaintiffs must show that "'[t]he injury complained of is of such *imminence* that there is a clear and present need for equitable relief to prevent irreparable harm.'" *Id.* (quoting *Wisc. Gas Co. v. FERC*, 758 F.2d 669, 674 (D.C. Cir. 1985) (*per curiam*) (emphasis in original; citations, brackets, and internal quotation marks omitted)). The asserted injury "must be certain and great; it must be actual and not theoretical." *Id.* In addition, plaintiffs must show that the injury is "beyond remediation." *Id.* Although the factors relevant to a preliminary injunction "interrelate on a sliding scale ... the movant must, at a minimum, demonstrate that irreparable injury is likely in the absence of an injunction." *Bill Barrett Corp. v. U.S. Dep't of Interior*, 601 F. Supp. 2d 331, 334–35 (D.D.C. 2009) (internal quotation marks and citations omitted) (emphasis in original).

Plaintiffs do not meet this high standard. To begin with, plaintiffs rely on numerous instances of alleged harms to individuals who are not even Medicaid beneficiaries or applicants. For example, plaintiffs rely on the experiences of individuals enrolled or attempting to enroll in the DC Health Care Alliance (Pls.' Ex. 8 at 3, 5; Pls.' Ex. 18 at 20; Pls. Ex. 19 at 6, 7, 16, 20, 21)

or individuals attempting to obtain Supplemental Nutrition Assistance Benefits (SNAP) (Pls.' Ex. 5; Pls.' Ex. 6; Pls.' Ex. 7; Pls.' Ex. 8 at 5; Pls. Ex. 9A; Pls.' Ex. 9B; Pls.' Ex. 19 at 8, 9, 16, 19, 22, 23). Indeed, five of the exhibits attached to plaintiffs' motion relate solely to the effectiveness of the SNAP program. (Pls.' Ex. 5; Pls.' Ex. 6; Pls.' Ex. 7; Pls.' Ex. 9; Pls.' Ex. 10.) While plaintiffs have taken an extraordinarily broad view of the remaining scope of this case, there is no colorable claim that these programs formed the basis of plaintiffs' Complaint in 1993, were included at any time in the class definition, or at any point subject to the terms of the Settlement Order in 1999. Put simply, there is no nexus between any alleged harm to these beneficiaries and harm to Medicaid beneficiaries.

In addition, the injunctive relief requested by plaintiffs would not remedy an imminent harm to Medicaid beneficiaries. The District already is taking every conceivable step to prevent or mitigate any harm to beneficiaries, and will continue to do so even if no injunction is issued. An injunction will not materially improve conditions; to the contrary, it is likely to impede the District's ability to swiftly discern and resolve problems as they arise. Indeed, simply preparing the opposition to this motion has consumed a tremendous portion of the waking hours of the very individuals who are charged with implementing the ACA's enhanced eligibility framework. As this Court recognized after passage of the ACA, "implementation will undoubtedly be both rocky and fairly long in coming." (ECF No. 1886, at 6.) While technical issues unfortunately are inevitable in a transition of this magnitude—and to be sure, virtually every jurisdiction has experienced its share of challenges in implementing the ACA—the District actively seeks out technical problems within its systems, determines whether any individual has been affected, and develops strategies to assist individuals as needed while resolving the root cause of the problem. And it has been effective in doing so.

That is not to say that there have not been instances in which a beneficiary experiences problems with respect to his or her coverage or application. Plaintiffs allege several examples of individuals who waited for an application to be approved or for benefits to be renewed. The District notes however that plaintiffs' exhibits overwhelmingly refer to individuals anonymously or by pseudonym, so the District cannot dispute or confirm many of these accounts. Yet, plaintiffs' own evidence establishes that the District already has remedied these problems or restored coverage in most of these cases. (Pls.' Ex. 24 at ¶¶ 8, 9, 11, 12, 15, 20, 21; Pls.' Ex. 25 at ¶¶ 6(a), 6(d), 9(a), 9(b), 10(a), 11(a), 11(c), 13(a); Pls.' Ex. 26 at 6(b)-(e); Pls.' Ex. 32 at ¶¶ 7, 11; Pls.' Ex. 48 at ¶9.) In addition, the District has been able to confirm that many other proffered examples from plaintiffs are resolved. (Schlosberg Decl. at ¶¶ 91, 97.) The relative few cases where effects are alleged to persist comprise a small fraction of the approximately 250,000 individuals on Medicaid.

Indeed, the District has navigated this massive transition period without affecting the coverage of the overwhelming majority of Medicaid beneficiaries. In fact, Medicaid enrollment has increased by a significant margin even in the face of the challenges the District confronted in implementing the ACA's eligibility standards. Since the District launched DCAS in October 2013, overall Medicaid enrollment has grown by approximately 10 percent, and enrollment in the District's MCOs has increased by approximately 9 percent. (*Id.* at ¶ 98.) And the roll off of coverage that the District has seen month to month is in line with historical trends. (*Id.* at ¶¶ 85-86.)

Further, now that the District has implemented passive renewals for the D1 MAGI population, higher percentages of Medicaid beneficiaries than ever before are likely to retain coverage when their eligibility is re-determined. Prior to passage of the ACA, roughly 60% of

beneficiaries responded to renewal notices each year. (*Id.* at ¶ 100.) In 2015, the District achieved a response rate of almost 87%, in large part due to conducting passive renewals for the M1 population and the District's enhanced outreach efforts. (*Id.*) With passive renewals beginning for D1 renewals and the enhanced outreach continuing, the District is optimistic that a similar or higher response rate will be reached in 2016. (*Id.*)

If systemic issues exist that endanger the coverage of large numbers of Medicaid-eligible individuals as plaintiffs allege, it is not borne out by data or facts. With more individuals enrolled in Medicaid and substantially more beneficiaries retaining benefits on a yearly basis, injunctive relief is not warranted. The District has worked and continues to work diligently to resolve the the underlying causes of any technical issue that comes to its attention, and has strategic plans in place to manage and mitigate the impact of the two lingering issues: the "stuck/malformed" cases and a dwindling number of backlogged initial applications. Injunctive relief will not speed this process; it will only slow it down while the dedicated staff responsible for working through these issues are distracted with further litigation.

Plaintiffs have not shown that beneficiaries will experience imminent, irreparable harm unless the Court enjoins the District. Both the number of individuals that could be affected and the extent of harm that may be caused while the District fixes the few remaining issues are entirely speculative.

C. The Balance Of Equities Favors The District

Plaintiffs' motion seeks two categories of relief: (1) provisional approval of all Medicaid applications pending over 45 days until a final decision can be made and (2) indefinite continuation of all Medicaid benefits recipients due to be renewed. (ECF No. 2070-1.) Plaintiffs' approach is an extreme one: give everyone who asks for it Medicaid coverage and continue that

coverage into perpetuity. Such injunctive relief would cause *the District* substantial harm that is likely irreparable. "When the issuance of a preliminary injunction, while preventing harm to one party, causes injury to the other, this factor does not weigh in favor of granting preliminary injunctive relief." *ConverDyn v. Moinz*, 68 F. Supp. 3d 34, 53 (D.D.C. 2014) (citing *Serono Labs, Inc. v. Shalala*, 158 F. 3d 1313, 1326 (D.C. Cir. 1998) and *Alina Health Servs. v. Sebelius*, 756 F. Supp. 2d 61, 69 (D.D.C. 2010)).

1. Provisional Approval for Initial Applications Pending Over 45 Days

With respect to provisional approval for initial applicants, plaintiffs contend that 42 C.F.R. § 435.1101, *et seq.* authorizes the District to extend temporary coverage in these circumstances. (Mot. at 42.) But the regulations plaintiffs cite permit provisional eligibility only for children under age 19, 42 C.F.R. § 435.1102(a), or for certain medical treatment for pregnant women, 42 C.F.R. § 435.1103(a). Those regulations do not apply broadly to provide states flexibility to provide broad temporary Medicaid coverage as plaintiffs contend.

Moreover, even if the federal government pays a federal share to cover benefits during the provisional eligibility pursuant to court order, the District and its taxpayers will have expended local dollars for individuals who are neither eligible for nor entitled to Medicaid benefits. And the District will have no remedy to recoup these unwarranted expenditures from providers who have served these ineligible individuals, which may include individuals who are not residents of the District, who leave the District, who have not submitted requested information or documentation, who do not have a qualified immigration status or are undocumented, or who are over the mandated income requirements. Granting coverage to all individuals with applications pending over 45 days would lead to governmental waste and enable fraud.

2. Automatic Continuation of Eligibility for Individuals Due to Be Renewed

Plaintiffs' request to extend coverage indefinitely for individuals who are due to have their benefits renewed is unwarranted and contravenes the instructions the District has been given by CMS, which has monitored the District's implementation of the ACA's new eligibility standards closely and has approved the District's plans to remedy remaining issues. Indeed, CMS only approved a waiver to continue eligibility for D1 renewals until September 30, 2015 and would not approve a waiver for beneficiaries with renewal dates in or after October 2015. And, in any event, the District has now built, tested and successfully deployed allowing the District to proceed with passive renewals for this population.

Not only would continuing coverage for all beneficiaries due to renew violate CMS's specific instructions, it would cause waste on a massive scale. Issuing plaintiffs' requested injunction would deprive the District and its taxpayers of the ability to terminate coverage to those who are not eligible, leaving the District without means to recoup those funds. It is no response for plaintiffs to suggest that federal funds may cover some of this unauthorized spending. (Mot. at 42-43.) As noted below, plaintiffs have not joined the United States as a party to the action, notwithstanding plaintiffs' acknowledgement that federal funds are at stake. In any event, the District's taxpayers are of course federal taxpayers too. That the cost of providing coverage for ineligible individuals would be spread more widely does not alleviate the financial harm involved in providing coverage for individuals who are not otherwise eligible. It simply means that more taxpayers would be harmed by the requested injunction. *See Majhor v. Kempthorne*, 518 F. Supp. 2d 221, 255 (D.D.C. 2007) (court must consider "the extent to which a preliminary injunction would 'substantially injure other parties'") (quoting *CityFed*, 58 F.3d at 746).

Contrasted with the speculative harm that could be caused to an unknown number of unidentified beneficiaries in the face of the District's robust efforts to implement the ACA's eligibility framework responsibly, it is certain that granting plaintiffs' motion will cause financial harm to District residents that will not be recoverable. The balance of harms therefore weighs against issuing an injunction.

D. A Preliminary Injunction Is Not In The Public Interest

The public interest is not furthered by the requested injunction. While for "several hundred years" courts sitting in equity have had the discretion to weigh the public interest in granting or denying injunctive relief, such courts "should pay particular regard for the public consequences in employing the extraordinary remedy of injunction." *United States v. Oakland Cannabis Buyers' Co-op.*, 532 U.S. 483, 496 (1981) (citing *Hecht Co. v. Bowles*, 321 U.S. 321, 329–30 (1944) and *Weinberger v. Romero-Barcelo*, 456 U.S. 305, 312 (1982)). Notwithstanding that plaintiffs have not demonstrated an imminent risk of irreparable harm, "[w]here an injunction may adversely affect a public interest, the Court, in its exercise of discretion, may withhold such relief even though such denial may prove burdensome and cause hardship to the petitioner." *Marine Transport Lines, Inc. v. Lehman*, 623 F. Supp. 330, 334–35 (D.D.C. 1985) ("The award of such relief is not a matter of right, even though the petitioner claims and may incur irreparable injury.").

CMS is the federal agency charged with directing public policy regarding Medicaid, and can fairly be said to represent the public's interest in this regard. CMS has endorsed the District's approach rather than plaintiffs'. To be sure, with CMS's broad authority to oversee implementation of the ACA and waive income and eligibility requirements, it could have directed the District to provide provisional eligibility and to hold renewal determinations in

abeyance as plaintiffs ask this Court to do. *See* 42 U.S.C. § 1396a(e)(14)(A) ("The Secretary may waive such provisions of this subchapter and subchapter XXI as are necessary to ensure that States establish income and eligibility determination systems that protect beneficiaries."). CMS has not done so. To the contrary, CMS has expressed its disapproval of continuing eligibility for individuals due to renew their eligibility. (Schlosberg Decl. at ¶¶ 47-48.) CMS has instead worked with the District, provided guidance, and approved the District's plans for moving forward with the implementation of the new eligibility standards and redressing potential harm to beneficiaries. (*Id.* at ¶¶ 47-50, 55, 63, 66-67, 75.) It has directed that the District conduct a manual review of the remaining backlogged applications, and directed that the District deny coverage to individuals in the D1 renewal category that do not return the D1 Renewal Form, do not provide all needed information, or who are found ineligible. (*Id.* at ¶ 67.) The ACA without question is among the most important laws CMS is charged with overseeing. This Court should not second guess CMS during the implementation of a critical and ambitious health care law that will expand coverage to needy individuals.

Moreover, the public interest is not served in permitting ineligible individuals to remain on the District's Medicaid rolls into perpetuity. CMS and the District have responsibility to protect the public fisc against fraud, waste, and abuse of the Medicaid system. Providing coverage to individuals who are not eligible for or entitled to it constitutes governmental waste. *See, e.g., Washington v. District of Columbia*, 530 F. Supp. 2d 163, 173 (D.D.C. 2008) ("[I]t is indisputably in the public's interest for government costs to be minimized.") (citing *Baker Elec. Co-op., Inc. v. Chaske*, 28 F.3d 1466, 1474 (8th Cir. 1994)); *accord District of Columbia v. Masucci*, 13 F. Supp. 3d 33, 41-42 (D.D.C. 2014). In addition to spending taxpayer funds for ineligible individuals, an injunction here would enable fraud and abuse. Indeed, CMS regards

individuals using false credentials among the most common Medicaid fraud schemes. *See* Common Medicaid Rip-Offs and Tips to Prevent Fraud, https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforConsumers/Ripoffs_and_Tips.html (last visited January 14, 2016).

The public would be served best by denying plaintiffs' request for a preliminary injunction.

III. The Preliminary Injunction Should Be Denied Because the United States is a Necessary Party

In addition to determining jurisdictional issues and whether plaintiffs have met their burden for a preliminary injunction, plaintiffs have not satisfied the standards set forth in the applicable Federal Rules of Civil Procedure—specifically, Rule 65 relating to injunctions and Rule 19 regarding indispensable parties—which are prerequisites for the Court to grant relief. *See, e.g.*, *Ram v. Lal*, 906 F. Supp. 2d 59, 68 (E.D.N.Y. 2012). Rule 65 provides that an injunction issued by a federal court may only bind: (1) the parties; (2) the parties' officers, agents, servants, employees, and attorneys; and (3) other persons who are in active concert or participation with any of the aforementioned. *Id.*; Fed. R. Civ. P. 65(d)(2). As the Second Circuit has noted, "in exercising its equitable powers, a court 'cannot lawfully enjoin the world at large.'" *Ram*, 906 F. Supp. 2d at 68 (quoting *People of State of N.Y. v. Operation Rescue Nat'l*, 80 F.3d 64, 70 (2d Cir.1996)). Beyond the scope of injunctive relief, Rule 19 provides that relief may not be granted if necessary parties are not before the Court. In particular, Rule 19(a)(1) states that a party is necessary to a litigation if: (1) in that party's absence, the court cannot accord complete relief among existing parties; or (2) the proceeding would either (i) "impair or impede the [party]'s ability to protect [its] interest" in the action or (ii) "leave an existing party subject to a substantial risk of incurring double, multiple, or otherwise inconsistent obligations

because of the [missing party's] interest" in the action. Fed. R. Civ. P. 19(a)(1); *Capitol Med. Ctr., LLC v. Amerigroup Maryland, Inc.*, 677 F. Supp. 2d 188, 191-93 (D.D.C. 2010).

In their motion, plaintiffs argue that to the extent the injunctive relief sought would result in individuals receiving Medicaid benefits who may not otherwise be eligible for such benefits—a scenario that would cause the District to incur substantial costs—"federal financial participation may be available." (Mot. at 42-43 (citing 42 C.F.R. 431.250(b)(2); 42 C.F.R. 435.1002(c)).) Plaintiffs further contend that because the relief sought "aims to effectuate the requirements of the federal Medicaid program," the federal government may provide financial assistance, and any financial burden imposed on the District would be outweighed by the harm allegedly suffered by plaintiffs. (*Id.* at 43.) Even assuming plaintiffs' argument has merit (which the District denies), the United States would be a necessary party because the requested injunction seeks to bind the federal government. In the absence of the United States, the Court cannot grant complete relief among the existing parties, and a grant of the requested preliminary injunction would impair the federal government's ability to protect its interests. Fed. R. Civ. P. 19(a)(1). For example, the new childless adult eligibility category under the ACA currently is funded completely by the federal government. Childless adults comprised roughly a quarter of the District's Medicaid population in September 2015.

The notion that it would be appropriate for the Court to grant the requested injunctive relief without considering the federal government's position, and without any opportunity for the United States to protect its interests, should be rejected. Because the United States is a necessary party to plaintiffs' requested injunction, the relief should be denied. *See, e.g.*, *Ram*, 906 F. Supp. 2d at 77-79 (finding that missing necessary parties to the lawsuit precluded the entry of an injunction); *Boat Basin Investors, Inc. v. First Am. Stock Transfer, Inc.*, No. 03 Civ. 493, 2003

WL 282144, at *1 (S.D.N.Y. Feb. 7, 2003) ("In the absence of … a necessary party under Rule 19(a) of the Federal Rules of Civil Procedure, the merits may not be reached and a preliminary injunction may not be granted."); *Shenandoah v. U.S. Dep't of Interior*, No. 96 Civ. 258, 1997 WL 214947, at *3 (N.D.N.Y.1997) ("Plaintiffs' failure to join [a necessary party] also disposes of their preliminary injunction motion, because plaintiffs cannot show a likelihood of success on the merits of their lawsuit.").

CONCLUSION

For the foregoing reasons, plaintiffs' Motion for Preliminary Injunction should be denied.

Respectfully submitted,

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

OSCAR SALAZAR, *et al.*,	)	
Plaintiffs,	)	
	)	**C.A. No. 93-452 (GK)**
v.	)	
DISTRICT OF COLUMBIA, *et al.*,	)	
Defendants.	)	

ORDER

Upon consideration of plaintiffs' Motion for a Preliminary Injunction Concerning District of Columbia Medicaid Applications and Renewals (ECF No. 2070) and the District of Columbia's Opposition, it is

ORDERED that plaintiffs' Motion is **DENIED**.

_____
Hon. Gladys Kessler
Senior United States District Judge