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

NANSEMOND INDIAN NATION, et al.,	
Plaintiffs,	**Civil Action No. 2:25-cv-00195**
v.	
COMMONWEALTH OF VIRGINIA, et al.,	**MEMORANDUM IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**
Defendants.	

MEMORANDUM IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

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INTRODUCTION

In 2023—forty (40) years after securing state recognition and five (5) years after securing federal recognition—the Nansemond Indian Nation ("Nation") established Fishing Point Healthcare, LLC ("Fishing Point") (collectively, "Plaintiffs"). Fishing Point is not a pop-up clinic; it is the linchpin of the Nation's effort to provide first-rate healthcare to both its citizens and its underserved neighbors in southeastern Virginia. From the start, the Nation's approach was firmly rooted in federal law and the structured framework set forth in the Commonwealth of Virginia's Centers for Medicare & Medicaid ("CMS")-approved State Medicaid Plan Amendment 21-007 ("Tribal Reimbursement SPA"). *See* Complaint ("Compl.") (ECF No. 1) ¶¶ 100–03, Exhibit 3. The Tribal Reimbursement SPA unequivocally mandates that Tribal Health Programs operating under an Indian Self-Determination and Education Assistance Act ("ISDEAA") Title I Contract shall be reimbursed at the Indian Health Service's ("IHS") All-Inclusive Rate ("Federal AIR") for all covered services. *See* Compl. ¶¶ 100–03, Exhibit 3. That is, Fishing Point may serve American Indian/Alaska Native ("AI/AN") and non-AI/AN Medicaid patients and shall be reimbursed for such services at the same fixed rate. This has been standard practice throughout Indian Country for decades, and its consistency and predictability are essential to a working system of health care services.

The Commonwealth of Virginia and certain agencies and officials—including the Virginia Department of Health and Human Resources ("SHHR"), the Virginia Department of Medical Assistance Services ("DMAS"), Governor Glen Youngkin, SHHR Secretary Janet Kelly, DMAS Director Cheryl Roberts, and DMAS Chief Deputy Director Jeffery Lunardi (collectively, "Defendants")—are defying the clear mandates of federal law and the Commonwealth's own Tribal Reimbursement SPA. The Commonwealth has "pended"

indefinitely over one hundred and thirty thousand (130,000) of Fishing Point's legitimate encounters and is pressuring Plaintiffs to turn its personal care assistance ("PCA") patients—AI/AN and non-AI/AN alike—over to Virginia's Managed Care Organizations ("MCOs"), which are owned by some of the nation's largest health insurance companies. The Commonwealth's message has been clear: give up your lawful services to the big insurers or we will bankrupt you by withholding the reimbursements that are essential to your financial viability.

Plaintiffs respectfully seek a Preliminary Injunction because, without it, the Commonwealth will, indeed, succeed in driving Fishing Point out of business in Virginia. Further, the Commonwealth will so damage the credibility and trust that Fishing Point has built with its patients and the surrounding community. There will be no resurrection of those services later. Ultimately, the vulnerable patients will be directly harmed and left underserved during a period of confusion and transfer to providers offering inferior care.

Three things are important to consider when evaluating the likelihood of Plaintiff's prevailing on the merits of this matter. First, a federal audit of the exact question of the appropriateness of Fishing Point's billing and the Commonwealth's refusal to reimburse, concluded that Fishing Point's practices are fully compliant, and, in fact, the Commonwealth had been underpaying Fishing Point for the claims it did process. Defendants hid the results of this audit from Fishing Point for months. Second, the Court now has before it numerous internal documents revealing that Defendants *know* that Fishing Point's patient services and billing practices are legitimate and that they lack any lawful basis to deny these reimbursement claims.[1]

[1] *See, e.g.*, Compl. ¶¶ 113–15, 126, 128, 140, 142, 147, 153–54, 192, 197, 199, 203, 210; Exs. 9–13, 18–19, 22, 26, 39, 41, 43 (where Defendants admit the Federal AIR is the required

Third, Defendant's public statements upon filing of Plaintiffs' complaint reveal a complete lack of legal defenses to justify their actions; realizing that Fishing Point is more effective than they expected at serving a greater number of patients than they expected, Defendants no longer like *their own clear policy* as set forth in the Tribal Reimbursement SPA. Without a broken law or policy to point to, the Governor's own spokespeople have resorted to labelling Fishing Point's fully cleared practices as "potentially fraudulent." These potentially libelous attacks from the Commonwealth's highest public office further illuminate the irreversible harm that Defendants are inflicting on a sovereign Tribal Nation and its efforts to be of service to its community.

The Nation and Fishing Point have repeatedly asked why the Commonwealth is treating them in such an unfair and unlawful manner. Based on available information, they believe the Commonwealth is motivated by two concerns. First, Defendants miscalculated their Medicaid budget by failing to anticipate the volume of non-AI/AN patients who would seek care from Fishing Point. Now facing a shortfall, they are seeking political cover by shifting blame to Plaintiffs. Second, Managed Care Organizations wield significant political influence in Virginia, backed by major insurers with deep lobbying resources. Fishing Point's success threatens these entrenched interests.

Defendants' actions are particularly egregious given Plaintiffs' offer to help Defendants remedy their own budgeting incompetence by crafting an agreement under which Fishing Point would cover the Commonwealth's Medicaid share for *all* non-AI/AN Medicaid services—an offer the Commonwealth summarily rejected without explanation. When the Nation requested good-faith, "government-to-government" consultation with Defendant Youngkin—as expressly

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reimbursement rate, that services are provided to both AI/AN and non-AI/AN Medicaid enrollees, and that the five-encounter-per-day cap applies).

required by federal law—his office declined to engage. *See* Compl. ¶¶ 178–79. That refusal casts a long shadow over every claim left to languish in "pended" status. Fishing Point cannot afford further delay. Its financial position is at a breaking point at a time when continued access to care remains critical for southeastern Virginia's rural and medically underserved communities. Plaintiffs do not ask for special treatment; they demand only what the law already requires: that Defendants take their foot off the neck of a lawfully operating Tribal Health Program; comply with the CMS-approved State Medicaid Plan; and allow Medicaid funds to reach the underserved patients who need medical care. This is the minimum requirement of Defendants under both federal and state law.

Plaintiffs previously sought emergency relief via an *ex parte* motion for Temporary Restraining Order. ECF No. 4. The Court denied the motion on procedural grounds, without reaching the merits of Plaintiffs' claims. ECF No. 17. Plaintiffs initially sought *ex parte* relief due to a well-founded fear of further retaliation, particularly after discovering that, on March 31, 2025, Defendants—without notice—pended nearly all of Fishing Point's outstanding Medicaid reimbursements. This week, Defendants informed Fishing Point that they now intend to reverse course and reimburse a portion of those recently pended claims on Monday, April 14, 2025. Even if that happens, the large volume of claims pended since October 2024, remain unreimbursed and a Preliminary Injunction is critically necessary to prevent the permanent harm of driving Fishing Point out of business.

Therefore, Plaintiffs respectfully request that this Court issue a Preliminary Injunction requiring Defendants to process claims as they did until October 2024, and barring Defendants from further deviations from established federal and state practices until such time as the Court may more fully consider and resolve the underlying case.

BACKGROUND

I. Plaintiffs' Status and Legal Entitlements

The Nansemond are the indigenous people of the Nansemond River, a 20-mile tributary of the James River in Virginia. The Nation was part of the Tsenacomoco (or Powhatan paramount chiefdom), which was a coalition of approximately thirty (30) Algonquian Indian Tribes distributed throughout the northern, southern, and western lands surrounding the Chesapeake Bay. Nansemond lived in settlements on both sides of the Nansemond River where they fished ("Nansemond" means "fishing point"), harvested oysters, hunted, and farmed in fertile soil, raised families and conducted ceremony.

The Nation is a federally recognized Indian Tribe, and Fishing Point is its Tribally chartered Tribal Health Program. *See* Compl. ¶¶ 94–96; 104. Fishing Point operates under a Title I Self-Determination Contract under ISDEAA, known as a "638 Contract," 25 U.S.C. §§ 5301–5423, and provides comprehensive health services to the Nation's Tribal citizens, other eligible AI/AN beneficiaries, and AI/AN and non-AI/AN Medicaid beneficiaries across southeastern Virginia. *See* Compl. ¶¶ 104–07.

Under the 2021 CMS-approved Tribal Reimbursement SPA, *see* Compl. ¶¶ 100–01; Exhibit 3, Defendants are legally obligated—not optionally permitted—to reimburse Tribal Health Programs operating under ISDEAA Contracts at the Federal AIR for all covered Medicaid services provided "by or through" those Programs. *See* Compl. ¶¶ 85, 100–01. This includes up to five (5) encounters per patient per day and applies equally to both AI/AN and non-AI/AN Medicaid beneficiaries. *Id*. at 100–01. Upon approval by CMS, the Tribal Reimbursement SPA became binding federal law, requiring Defendants to fully integrate Tribal Health Programs into Virginia's Medicaid framework, adhere to all federal statutes and

regulations regarding such programs, and provide reimbursement consistent with the Tribal Reimbursement SPA's explicit terms. *Id*. at 103. By seeking and obtaining CMS approval of the Tribal Reimbursement SPA, Defendants expressly accepted the Federal AIR annual publications as the binding reimbursement methodology for Tribal Health Programs serving both AI/AN and non-AI/AN Medicaid beneficiaries. In doing so, they also acknowledge that the Tribal Reimbursement SPA carries the force of federal law. *Id*. at 100–01, 103. Thus, the Tribal Reimbursement SPA is not a suggestion—it is a binding condition of Virginia's participation in the Medicaid program, hardwired into the Commonwealth's State Medicaid Plan. *Id*. at 103. Defendants know—and have long known—their obligation to reimburse Plaintiffs under the Tribal Reimbursement SPA. *See, supra,* note 1.

II. Defendants' Pattern of Retaliation and Obstruction

During its first year of operation, Fishing Point functioned effectively, delivering critical services to Medicaid beneficiaries in full compliance with the clear reimbursement framework governing Tribal Health Programs. In mid-2024, however, Defendants abruptly shifted course. State officials declared that PCA services no longer qualified for the Federal AIR—even though the Commonwealth had previously and routinely reimbursed Plaintiffs at that rate without objection. When Fishing Point immediately attempted to clarify the Commonwealth's unfounded assertion, it responded by cutting off reimbursements—an unlawful withholding that persists to this day. *See* Compl. ¶¶ 213–17, 299–301.

More than five months ago, a federal Payment Error Rate Measurement ("PERM") audit confirmed that Fishing Point's billing practices comply with Virginia's State Medicaid Plan, that the applicable reimbursement rate is the Federal AIR, and that Defendants have underpaid—and continue to underpay—Fishing Point for PCA services. Defendants reviewed and agreed with the

audit's findings, including the conclusion that underpayments occurred. *See* Declaration of Lance Johnson in Support of Motion for Preliminary Injunction ("Johnson Decl.") ¶¶ 68–69. Yet despite this clear confirmation, Defendants concealed the audit results and refuse to release the overdue reimbursements or remedy the acknowledged shortfall, continuing to deprive Fishing Point and its patients of lawfully owed Medicaid funds. *See* Compl. at ¶¶ 249–55.

Publicly, Defendants have attempted to deflect attention by falsely characterizing Plaintiffs' billing as a 'potentially fraudulent scheme'—even as their own records confirm compliance. In truth, it is the Defendants' ongoing refusal to release federal funds to a duly authorized Tribal Health Program—after acknowledging those reimbursements are owed—that raises serious questions about the misuse of federal Medicaid dollars and potentially fraudulent conduct under federal law.

Defendants are also targeting Fishing Point's new dental clinic—fully staffed and ready to address the acute shortage of Medicaid dental providers in southeastern Virginia—by indefinitely placing its enrollment application in "pended" status without justification or explanation. *See id.* at ¶¶ 157–67, 260–63. This obstruction prevents the clinic from serving Medicaid patients, despite clear federal and state policy goals encouraging increased access to oral healthcare for underserved populations.

To facilitate a solution, Plaintiffs proposed a budget-neutral arrangement under which Fishing Point would cover the Commonwealth's share of *all* Medicaid reimbursements for non-AI/AN patients. Defendants rejected that offer without counterproposal, opting instead to entrench their obstruction. *See id.* at ¶¶ 227, 252. At the same time, Defendants advanced a budget amendment that unlawfully conditions a Tribal Health Program's reimbursement rate on

a patient's AI/AN status—openly contradicting the "one facility, one rate" principle enshrined in federal Medicaid law and long recognized by CMS. *Id*. at ¶¶ 274–87.

Although Plaintiffs repeatedly sought government-to-government consultation, Defendants refuse to engage. *See id.* at ¶¶ 178–79, 244–48. When approached by *The Washington Post* and *Law360*—both before and after suit was filed—Defendant Youngkin's office repeatedly dodged the facts and law. Instead, they baselessly accuse Fishing Point of "potential[] fraud[]," and ignore the federal audit confirming the legitimacy of Fishing Point's billing. *See* Johnson Decl. ¶¶ 66–70, Exs. H–J.

Taken together, these actions reflect a pattern of targeted interference that undermines Fishing Point's ability to deliver essential health services, obstructs the flow of federally guaranteed Medicaid funds, and imposes unlawful conditions on Tribal healthcare delivery in direct violation of federal law.

III. Public Falsehoods and Misrepresentations

After the filing of this suit, Defendants have not merely avoided accountability for their unlawful conduct; they have instead propagated inaccurate and deceptive assertions designed to misdirect accountability. On April 1, 2025, Plaintiffs filed this action. Rather than acknowledging their legal responsibilities, Defendants doubled down on rhetoric that misrepresents both Plaintiffs' conduct and the applicable law.

Soon after litigation commenced, Defendant Youngkin's spokesperson, Rob Damschen, told *The Washington Post*, Exhibit H:

> Their facility in Portsmouth, VA, bills taxpayers $801 per interaction, up to five interactions per day per patient, the vast majority of whom are non-Indians…The Commonwealth of Virginia has grave concerns about this potentially fraudulent billing scheme.

Within days, Defendant Youngkin's Press Secretary, Peter Finocchio, escalated the rhetoric, alleging that the "Nansemond Tribe [*sic*] set up a business that provides health care to non-Indians, charging the Indian rate." He further claimed that taxpayers were unfairly burdened by Medicaid costs that exceeded standard rates, and repeated that the Governor had "grave concerns about this potentially fraudulent billing scheme." Exhibit I.

These assertions are fundamentally flawed for several reasons. First, they ignore the federal trust responsibility—rooted in treaties and codified in statutes like the Snyder Act and the Indian Health Care Improvement Act ("IHCIA"), 25 U.S.C. §§ 1601 *et seq*.—which obligates the United States to provide healthcare to AI/AN communities. This responsibility is not a discretionary benefit, but a binding legal and moral obligation. Far from granting Tribal communities a "free pass," the federal government's chronic underfunding of Indian healthcare has historically left AI/AN citizens without access to necessary care.

Second, Defendants conflate this longstanding trust responsibility with Medicaid—a separate, means-tested program under Title XIX of the Social Security Act, available to both AI/AN and non-AI/AN enrollees. Under binding federal rules, a Tribal Health Program in Virginia is reimbursed at the Federal AIR for any Medicaid-enrolled patient, regardless of AI/AN status; the difference lies in the Federal Medical Assistance Percentage ("FMAP") the Commonwealth can claim afterward. *See* Compl. ¶ 197; Exhibit 41; 42 C.F.R. § 447.56(a)(1)(x); 42 U.S.C. §§ 1396d(b), (l). The so-called "Indian rate"—a term Defendants use to make a lawful federal reimbursement standard sound improper or suspect—is simply the Federal AIR. Fishing Point bills in accordance with the Tribal Reimbursement SPA, which explicitly requires the Federal AIR. Mischaracterizing this lawful billing practice as something nefarious is not only

misleading, but also reflects a broader disregard for the legal framework governing Tribal Health Programs. *See* Compl. ¶¶ 100–03; Exhibit 3.

If Defendants truly believed there was something improper about applying the Federal AIR to all Medicaid recipients, they would not have selectively targeted only PCA service claims. Yet, in October 2024, Defendants pended all PCA claims—regardless of whether the patient was AI/AN or non-AI/AN—while continuing to reimburse most other services at the Federal AIR. This selective action undermines the credibility of their sweeping fraud allegations and makes clear that the issue is not with improper billing based on AI/AN status. Rather, it is about Defendants' refusal to reimburse Fishing Point at the federally required rate for Medicaid services, as mandated under their own CMS-approved State Medicaid Plan.

Third, the Nation established Fishing Point in reliance on Virginia's Tribal Reimbursement SPA, which explicitly mandates that Tribal Health Programs bill the Federal AIR for all Medicaid-enrolled patients, regardless of each patient's AI/AN status. The suggestion that all American Indians receive Medicaid-funded care—or that they place disproportionately burden on taxpayers—reflects a fundamental misunderstanding of both the federal trust responsibility and the structure of Medicaid law. More than that, it perpetuates a harmful and inaccurate narrative that distracts from the real issue: the Commonwealth's refusal to comply with its own CMS-approved State Medicaid Plan.

Moreover, Defendants speculate—without evidence—about the number of AI/AN versus non-AI/AN beneficiaries Fishing Point serves, even though the Commonwealth admits it does not track that data, despite being federally required to do so. *See* Compl. ¶¶ 123, 137, 160, 173. It is also deeply insulting to assume that all AI/AN individuals are enrolled in Medicaid or that the AI/AN population is too small to warrant meaningful investment. Indeed, many AI/AN patients

served by Fishing Point are not enrolled in Medicaid—they may have private insurance, Medicare, or pay out-of-pocket—and receive a wide range of culturally grounded health services regardless of payer status.

This case does not involve billing impropriety; it involves a deliberate effort by Defendants to construct a misleading narrative—one that erases the diversity of AI/AN healthcare access and falsely implies misuse of public funds. For example, a Tribal citizen with private health insurance may receive care from Fishing Point without implicating the Medicaid system at all. Yet Defendants conflate all services provided by a Tribal health program with Medicaid billing and use that distortion to justify unlawful interference. Instead of addressing their own failure to comply with Virginia's CMS-approved State Medicaid Plan, Defendants rely on unsubstantiated public statements that misrepresent Indian law and misconstrue the structure of the Medicaid program. This rhetoric undermines public trust in Tribal institutions and diverts attention from the core issue: the Commonwealth's ongoing refusal to follow federal law and meet its binding obligations under its own State Plan—underscoring the urgent need for preliminary judicial relief.

IV. Consequences of Defendants' Actions

The harm resulting from Defendants' misconduct is both immediate and far-reaching. As outlined above, Defendants publicly advanced distorted characterizations of Tribal Health Programs, inaccurately portraying the federally mandated reimbursement structure as an unjust "Indian rate." These false narratives compound the harm of the unlawful withholding of resources from a legally entitled Tribal provider.

Currently, every month Fishing Point delivers care to approximately 1,195 Medicaid beneficiaries. *See* Johnson Decl. ¶ 23. Beneficiaries include elders, individuals with chronic

conditions, and patients in rural areas where no comparable care exists. *See id.* at ¶¶ 7, 13–20, 23, 50–52. Yet, as the Commonwealth continues to block reimbursements and issue misleading statements, Fishing Point is operating on borrowed time. *See* Compl. ¶¶ 310–14; Johnson Decl. ¶¶ 24–28; Exs. H, I. If Defendants' sabotage persists, thousands of Virginians stand to lose the essential health services that no other provider in the region delivers so comprehensively. The false narratives spun by Defendants only exacerbate this crisis, misleading the public about the Program's legitimacy and obscuring the Commonwealth's refusal to comply with its own federally approved State Medicaid Plan. Disabled individuals and those in outlying rural areas—often overlooked by standard managed care—could lose coverage entirely, falling through the cracks of an already strained healthcare system.

In disregarding their trust responsibilities and undermining federal policies that Congress enacted to advance Tribal self-determination, Defendants effectively signal to other Tribal Health Programs that providing care to both AI/AN and non-AI/AN patients may subject them to punitive treatment. *See* Compl. ¶¶ 59–65, 110–11; Johnson Decl. ¶¶ 60–63. This stance runs counter to the intent of federal law. Far from seeking special treatment, Plaintiffs ask only that Defendants abide by existing law: restore all unlawfully withheld reimbursements, honor a CMS-approved State Plan, and engage in good-faith consultation with the Nation. *See* Compl. ¶¶ 75–78, 241–42.

If these tactics and baseless accusations remain unchecked, the collapse of Fishing Point's Tribal Health Program is not a hypothetical scenario—it is the inevitable outcome. In such an event, not only will Tribal citizens and other AI/AN beneficiaries lose access to critical care, but southeastern Virginia's most vulnerable communities at large will be deprived of the high-acuity, culturally competent services upon which they depend. The consequences would be

immediate and devastating for thousands of patients who rely on Fishing Point for comprehensive, accessible, and lawful healthcare delivery.

STANDARD OF REVIEW

When considering a preliminary injunction, a court "'must balance the competing claims of injury and must consider the effect on each part of the granting or withholding of the requested relief.'" *Winter v. Nat. Res. Def. Council*, 555 U.S. 7, 24 (2008) (quoting *Amoco Prod. Co. v. Village of Gambell*, 480 U.S. 531, 542 (1987)). "A preliminary injunction is an extraordinary remedy never awarded as of right." *Winter*, 555 U.S. at 24. Instead, to be granted a preliminary injunction, a plaintiff must establish four factors: (1) that the plaintiff is likely to succeed on the merits; (2) that the plaintiff is likely to suffer irreparable harm in the absence of preliminary relief; (3) that the balance of equities favors the plaintiff; and (4) that an injunction is in the public interest. *Id.* At 20. A court should examine the public consequences of granting a preliminary injunction, in particular. *Weinberger v. Romero-Barcelo*, 456 U.S. 305, 312 (1982).

ARGUMENT

I. Plaintiffs are Likely to Succeed on the Merits of their Claims

Defendants' conduct constitutes ongoing violations of multiple federal statutes. Plaintiffs assert four (4) independent claims, each of which independently justifies immediate injunctive relief. Together, these claims demonstrate Defendants' coordinated campaign to obstruct and retaliate against a lawfully operating Tribal Health Program.

A. <u>Defendants Are Violating the Supremacy Clause</u>

The U.S. Constitution makes clear that federal law is "the supreme Law of the Land," and that state officials cannot override or obstruct it. U.S. CONST. art. VI, cl. 2. Yet Defendants continue to do exactly that.

Defendants ignore binding obligations under the Medicaid Act, ISDEAA, IHCIA, and CMS guidance. They persist in freezing Fishing Point's PCA claims without any lawful justification. They continue to obstruct Medicaid enrollment for the Nation's dental facility, despite CMS approval of the Tribal Reimbursement SPA. They actively enforce a state budget provision that unlawfully conditions Federal AIR reimbursement on a patient's AI/AN status. And they repeatedly bypass the federally mandated requirement for Tribal consultation. *See* Compl. ¶¶ 48–49, 52–61.

These actions violate 42 U.S.C. §§ 1396a(a)(8) (reasonable promptness), 1396a(a)(13)(A) (adequate reimbursement), and 1396j(d) (Tribal program reimbursement), as well as 42 C.F.R. §§ 447.45 (timely claims payment), 440.90(c) (recognizing Tribal providers), and CMS policy directives, including SHO Letter #16-002 and FAQ #11817.

Defendants are attempting to replace a federally approved Medicaid plan with unlawful, ad hoc policies. This is textbook preemption: state conduct that obstructs federal law and defies CMS authority.

B. Defendants Are Interfering with Plaintiffs' ISDEAA Contract

The Nation operates Fishing Point under a Title I Self-Determination Contract that authorizes it to deliver care as a Tribal Health Program without facing any state licensing or participation rules that IHS itself would not face. *See* 25 U.S.C. § 1642. Defendants are actively obstructing Fishing Point's performance under that Contract.

By refusing to process provider enrollment for the Nation's dental clinic and withholding millions in Federal AIR reimbursements for PCA services, Defendants effectively disable Plaintiffs' ability to operate their federally authorized healthcare program. *See* Johnson Decl. ¶¶

3–6, 24, 34–38. Defendants' actions violate ISDEAA, 42 U.S.C. § 1396a(a)(8), 42 C.F.R. § 431.107, and the Tribal Reimbursement SPA.

CMS provides no authority for Defendants to impose new conditions or restrict reimbursement through policy changes disguised as "clarifications." Yet Defendants pursue this tactic anyway—sending draft SPAs to the wrong addresses, evading required Tribal consultation, and weaponizing enrollment and reimbursement systems to retaliate against Plaintiffs for asserting their legal rights.

C. Defendants Are Violating the Sovereignty of the Nation

Defendants are not simply violating programmatic rules—they are attempting to undermine the Nation's fundamental sovereign rights. Federal law protects Tribal self-governance and prohibits state interference with essential Tribal government functions. *See White Mountain Apache Tribe v. Bracker*, 448 U.S. 136, 148–49 (1980); 25 U.S.C. § 1680c(c)(2).

Defendants' refusal to reimburse PCA claims, process enrollment, or honor Federal AIR reimbursement for non-AI/AN patients reflects the Commonwealth's intention to assert control over a sovereign entity operating pursuant to a federal Contract. Their conduct violates 42 U.S.C. § 1396j(d), 25 U.S.C. §§ 5301 *et seq.*, and CMS policy requiring "one facility, one rate" regardless of a patient's AI/AN status. *See* Compl. ¶¶ 12, 281.

Defendants also refuse to engage in meaningful consultation, despite the mandatory requirements in 42 U.S.C. § 1396a(a)(73), 25 U.S.C. § 1672, and 42 C.F.R. § 431.408(b). These are not isolated incidents—they reflect an escalating pattern of interference and disregard for the Nation's legal status and federally protected rights.

D. Defendants Are Violating 42 U.S.C. § 1983

Federal law authorizes private parties to seek redress for violations of federally secured rights. 42 U.S.C. § 1983. Plaintiffs invoke this statute because Defendants, under color of state law, are depriving them of clear, enforceable federal rights.

Those rights include prompt reimbursement under 42 U.S.C. § 1396a(a)(8); fair treatment under the Medicaid Act; equal reimbursement for all Medicaid patients under the Tribal Reimbursement SPA; and the right to operate a Tribal Health Program free from coercion, discrimination, and political retaliation. *See Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 520–24 (1990); *Antrican v. Odom*, 290 F.3d 178, 186–87 (4th Cir. 2002); *cf. Health & Hosp. Corp. of Marion Cnty. v. Talevski*, 599 U.S. 166, 180–81 (2023).

These violations are not accidental—they are active, ongoing, and deliberate. They do not arise from any ambiguity in the law, but from a willful refusal to comply with clear federal mandates. The record provides compelling support for relief under 42 U.S.C. § 1983.

II. Plaintiffs Will Suffer Irreparable Harm Absent Immediate Injunctive Relief

Federal courts consistently recognize that irreparable harm exists where plaintiffs face imminent threats to financial viability, reputational harm, loss of statutory rights, disruption to essential services, or sovereign interference. *See Elrod v. Burns*, 427 U.S. 347, 373 (1976); *Rodde v. Bonta*, 357 F.3d 988, 999 (9th Cir. 2004); *White Mountain Apache Tribe*, 448 U.S. at 149–51; *Children's Hosp. of the King's Daughters, Inc. v. Price*, 258 F.Supp.3d 672, 689 (E.D. Va. 2017), aff'd, 896 F.3d 615 (4th Cir. 2018); *Am. Hosp. Ass'n v. Becerra*, 142 S. Ct. 1896, 1903 (2022).

Here, Plaintiffs meet—and exceed—each of these thresholds. Since October 2024, Defendants continue to withhold millions in federally obligated Medicaid reimbursements,

including for PCA services that CMS affirms are properly billed. *See* Compl. ¶ 313. Fishing Point continues to provide PCA services for its patients, despite not being reimbursed a single dollar for them in over six (6) months. The Commonwealth's refusal to reimburse Fishing Point imposes acute financial and operational strain on the Nation, which is forced to cover salaries, transportation costs, medical supplies, and infrastructure expenses entirely out of pocket. *See* Johnson Decl. ¶¶ 26, 28, 33.

This harm is neither abstract nor remote—it is immediate, destabilizing, and profoundly personal. Fishing Point provides essential care to more than 1,195 Medicaid beneficiaries every month, including both AI/AN and non-AI/AN elders, individuals with disabilities, and patients living with chronic or life-threatening conditions. For many of these patients, Fishing Point is not simply just a healthcare provider—it is their sole source of care, their only lifeline. *See id*. at ¶¶ 9, 23, 50–52. The services Fishing Point delivers go beyond standard clinical treatment: its providers manage home-based care, behavioral health counseling, chronic disease stabilization, pharmacy delivery, transportation coordination, and cultural support that no other provider in the region offers. *Id*. at ¶¶ 8, 23.

Despite not receiving reimbursement since October 10, 2024, Fishing Point continues to deliver all services in full compliance with federal requirements. That said, each day without reimbursement forces the Nation to deplete its limited general funds, reassign critical personnel, and delay other pressing Tribal priorities to sustain clinic operations. This trajectory is not sustainable. Absent relief, the ongoing financial hemorrhaging will to lay off staff, cancel home visits, shutter facilities, and ultimately dismantle a core function of their federally authorized Tribal Health Program. *See id*. at ¶¶ 26, 33, 48–52. Not only is the loss financial, but it threatens to unravel the Nation's intergenerational investment in self-governed healthcare. No court can

later reconstruct that harm through monetary damages. Injunctive relief remains the only remedy that can prevent permanent and irreversible injury.

The imminent closure of Fishing Point and the economic drain on the Nation constitutes irreparable harm. Courts consistently find that injury short of total collapse can still warrant equitable relief where the business at issue delivers vital public services or where the underlying harm implicates public health, statutory rights, or organizational survival. *See Rodde*, 357 F.3d at 999 (holding that denial of services to disabled patients constituted irreparable harm even without total institutional failure); *Pashby v. Delia*, 709 F.3d 307, 329 (4th Cir. 2013) (finding irreparable harm where changes in Medicaid policies reduced beneficiaries' access to medically necessary care). The irreparable harm standard is met when a plaintiff absorbs unreimbursed expenses, faces systemic underpayment, and is forced to scale back services core to its mission. The harm is especially acute for a Tribal Health Program exercising self-determination rights under ISDEAA, where financial loss directly translates into sovereign impairment and long-term disruption to healthcare access for both AI/AN and non-AI/AN patients.

Fishing Point was established in 2023 after CMS approved Virginia's Tribal Reimbursement SPA. As it did not exist at the time of that approval in 2021, the Commonwealth's implication that Fishing Point acted deceptively or bears responsibility for implementation failures is factually incorrect. Fishing Point built a vital, community-centered healthcare resource—only to face punitive action from the state, not because of any fraud or noncompliance, but as a means to cover up the state's own mismanagement and internal disarray. *See* Compl. ¶¶ 135–42, 289–93.

The strain on the Nation's ISDEAA Contract compliance is equally unsustainable. Defendants' refusal to process enrollment, manipulation of claims systems, and delays in

provider recognition force the Nation to divert general funds and personnel toward tasks the Commonwealth's Medicaid program is legally obligated to perform. *See* Johnson Decl. ¶¶ 24, 35, 60–61. This dysfunction created by the state threatens the integrity of the Nation's sovereignty.

Defendants' actions violate clear federal mandates, including the prompt payment clause under 42 U.S.C. § 1396a(a)(37), and protections guaranteed under IHCIA and ISDEAA.[2] Ongoing violations of federally protected rights, particularly where no sufficient legal remedy is available, meets the standard for irreparable harm. *See Elrod*, 427 U.S. at 373; and *Melendres v. Arpaio*, 695 F.3d 990, 1002 (9th Cir. 2012).

Meanwhile, potentially libelous and unfounded representations by spokespeople for Defendant Youngkin exacerbate this harm. *See* Exs. H, I. Public comments from Defendant Youngkin's office cast suspicion on the legitimacy of Fishing Point's operations and discourage providers, patients, and agencies from working with the clinic. Courts recognize that public statements by government officials can deter lawful conduct, damage reputations, and limit access to critical services. *See Int'l Refugee Assistance Project v. Trump*, 857 F.3d 554, 603–04 (4th Cir. 2017); *Backpage.com, LLC v. Dart*, 807 F.3d 229, 238–39 (7th Cir. 2015); *Okwedy v. Molinari*, 333 F.3d 339, 343–33 (2d. Cir. 2003) (noting that statements by public officials that

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[2] *See* 42 U.S.C. § 1396a(a)(37)(A) (requiring states to provide for "prompt payment" of 90% of clean claims within 30 days and 99% within 90 days); *see also* 42 C.F.R. § 447.45(d); 25 U.S.C. § 1621e(h) (recognizing Tribal Health Programs as eligible providers for purposes of Medicaid); 25 U.S.C. § 5304(l) (defining Tribal organizations authorized to operate under ISDEAA); CMS State Medicaid Director Letter #01-24 (Jan. 18, 2001) (clarifying that states must reimburse Tribal Health Programs at the AIR for services provided to all Medicaid-eligible individuals, not just AI/ANs); CMS State Health Official Letter #21-002 (Jan. 14, 2021) (reaffirming the "one facility, one rate" policy and CMS's position that states may not impose limitations inconsistent with federal law on Tribal Health Program reimbursement).

can be reasonably interpreted to suggest adverse regulatory action against a complaining group can give rise to constitutional violation).

Finally, the harm to Medicaid beneficiaries—AI/AN and non-AI/AN alike—is immediate and compounding. Without intervention, patients will miss critical appointments, be deprived of necessary medications, and lose continuity of care with trusted providers. Courts consistently find such disruptions to be irreparable. *See Rodde*, 357 F.3d at 999; and *Pashby*, 709 F.3d at 329.

This Court recognizes that the loss of access to Medicaid care creates precisely the kind of irreparable harm warranting preliminary relief. In *Children's Hospital*, Your Honor found that policy changes undermining Medicaid reimbursement jeopardized a provider's ability to deliver services, explaining that "a hospital cannot retroactively treat its patients." 258 F.Supp.3d at 689. That reasoning applies with even greater urgency here. Fishing Point is not a large hospital system—it is a Tribal Health Program sustained in large part by Medicaid funding. It lacks the cash reserves, institutional backing, or regulatory influence that larger institutions may rely upon. Yet it remains the sole point of care for over a thousand beneficiaries in southeastern Virginia. As in *Children's Hospital*, this Court should once again recognize that threats to continuity of care, particularly for high-risk Medicaid beneficiaries, constitute irreparable harm and justify immediate intervention.

III. The Balance of Equities Strongly Favor Injunctive Relief

To meet the third *Winter* factor—that "the balance of equities tips in the plaintiff's favor"—plaintiffs must show that the harm they would suffer without a preliminary injunction outweighs any harm Defendants would suffer from the injunction being granted. *Winter*, 555 U.S. at 20. The Fourth Circuit consistently reinforces that this factor must independently support relief. *See Pashby*, 709 F.3d at 328–29.

Here, Plaintiffs continue to experience ongoing concrete, imminent, and well-documented harm. Defendants face no legally cognizable harm beyond complying with existing federal law. If a plaintiff's injuries involve core sovereign rights, medical access, and compliance with federal program conditions—and a defendant's resistance stems from unlawful or self-inflicted policies—the balance of equities favors the plaintiff. *See League of Women Voters of N.C. v. North Carolina*, 769 F.3d 224, 247 (4th Cir. 2014). Further, when weighing health versus financial concerns, courts should find in favor of the party with health concerns. *Pashby*, 709 F.3d at 329 (finding the balance of equities tipped in favor of the plaintiffs, a group of Medicaid beneficiaries who were at risk of losing personal care services due to a state's enactment of a new State Medicaid Plan Amendment, because the health concerns of the plaintiffs outweighed the harm of the funds the state would lose by granting a preliminary injunction: "The State is free to exercise considered judgment and reduce Medicaid benefits. Yet it may not do so for purely budgetary reasons." (internal quotations omitted) (citing *Cal. Pharmacists Ass'n v. Maxwell Jolly*, 596 F.3d 1098, 1115 (9th Cir. 2010)).

A. Plaintiffs Face Ongoing, Irreparable Harm Absent Relief

Fishing Point remains a vital lifeline and continues to deliver Medicaid-covered services to over 1,195 patients monthly. Johnson Decl. ¶ 23. These services include home-based personal care, behavioral health, transportation, pharmacy, and wraparound support for high-need and medically vulnerable patients. *Id*. at ¶¶ 8–9. Despite not receiving reimbursement for PCA services since October 10, 2024, Fishing Point continues to provide medically necessary care to its PCA patients, demonstrating the Nation's commitment to meeting urgent community health needs. *Id*. ¶ 22–24, 26. This ongoing service, delivered without reimbursement, imposes a significant and escalating financial burden on the Nation.

The consequences compound daily. Defendants have frozen more than 130,000 PCA encounters. *Id*. at ¶ 24 n.1. These encounters amount to millions of dollars unlawfully held. Defendants also continue to block dental enrollment despite no legal or factual justification. *Id*. at ¶¶ 23–24, 34–35. These ongoing actions force the Nation to divert scarce sovereign resources to sustain Fishing Point's operations—funds that should instead support Tribal governance, housing, education, and future health infrastructure. *Id*. at ¶¶ 26–27, 33, 60–61.

Fishing Point serves more than Medicaid beneficiaries. It also provides care to AI/AN patients who are eligible for services under federal law but are not enrolled in Medicaid. Many of these individuals fall through the cracks of state-run systems. Defendants' obstruction forces the Nation to absorb those costs entirely and places unjust strain on Fishing Point's clinical, administrative, and financial operations.

The harm also directly undermines the Nation's ability to fulfill its obligations under its ISDEAA Contract. As a federally recognized 638 Tribal Health Program, the Nation operates Fishing Point to meet the federal trust responsibility to deliver healthcare. When Defendants obstruct reimbursement and delay enrollment, they impair the Nation's ability to carry out federal mandates and exercise sovereign control over its healthcare delivery system.

The Fourth Circuit holds in *Pashby* that Medicaid recipients facing the loss of necessary services suffer concrete harms that outweigh the state's administrative concerns. 709 F.3d at 329. The same principle governs here. Defendants' actions jeopardize access to essential services, interfere with Tribal self-determination, and unlawfully burden Plaintiffs with the costs of care.

This harm also implicates sovereign rights and legal entitlements. *See White Mountain Apache Tribe*, 448 U.S. at 148–49; *McClanahan v. Ariz. State Tax Comm'n*, 411 U.S. 164, 172–73 (1973). Federal law guarantees AI/AN individuals' access to care through IHS and Tribal

Health Programs. *See* 25 U.S.C. §§ 1601 *et seq.*; IHCIA § 3; 42 U.S.C. § 1396j(d); 42 C.F.R. § 438.14(c)(2).

Defendants compound this harm by spreading misinformation. On April 1, 2025, Rob Damschen publicly alleged a "potentially fraudulent billing scheme." *See* Exhibit H. On April 4, 2025, Peter Finocchio publicly claimed Fishing Point charged "the Indian rate" to non-Indian patients and that Defendant Youngkin has "grave concerns about the about this potentially fraudulent billing scheme." *See* Exhibit I. These false statements distort federal law, discourage provider collaboration, and inflict reputational harm on a sovereign Nation lawfully operating a federal healthcare program. *See Roso-Lino Beverage Distribs., Inc. v. Coca-Cola Bottling Co. of N.Y.*, 749 F.2d 124, 125–26 (2d Cir. 1984); *Wells Am. Corp. v. Ziff-Davis Publ'g Co.*, 900 F.2d 258, 1990 WL 33532, at *2 (4th Cir. 1990) (unpublished).

Fishing Point's continued delivery of care despite Defendants' obstruction illustrates the real and irreparable nature of the harm—it is anything but theoretical. The strain on the Nation's healthcare system grows each day that Defendants withhold reimbursement and stall Medicaid enrollment. In the absence of judicial relief, the damage will escalate—placing critical care for both Medicaid and non-Medicaid patients at risk and threatening the Nation's capacity to fulfill its obligations under its federal compact. These harms far outweigh any burden the Commonwealth may claim. *See Roso-Lino Beverage Distribs., Inc.*, 749 F.2d at 125–26; *Ziff-Davis Publ'g Co.*, 1990 WL 33532, at *2.

B. <u>Defendants Face No Harm from Compliance with Federal Law</u>

By contrast, Defendants suffer no legally cognizable harm from being compelled to comply with federal law. A preliminary injunction does not impose new obligations on the Commonwealth. It simply requires Defendants to do what they are already legally obligated to

do: reimburse valid Medicaid claims, process a pended provider enrollment, and follow the reimbursement structure codified in their CMS-approved State Plan. As the Fourth Circuit has recognized, "[t]he Government is in no way harmed by issuance of a preliminary injunction which prevents [it] from enforcing restrictions likely to be found unconstitutional." *Int'l Refugee Assistance Project*, 857 F.3d at 603 (quoting *Centro Tepeyac v. Montgomery Cnty*., 722 F.3d 184, 191 (4th Cir. 2013) (en banc) and *Giovani Carandola, Ltd. v. Bason*, 303 F.3d 507, 521 (4th Cir. 2002)).

Defendant Glenn Youngkin commenced official responsibilities as Governor on January 15, 2022. Although CMS-approved the Tribal Reimbursement SPA in 2021—prior to his inauguration—the Commonwealth has continued to implement and rely on that SPA throughout his administration. The SPA imposes binding obligations, including mandatory reimbursement at the Federal AIR for all Medicaid services provided "by or through" Tribal Health Programs. *See* Compl. ¶¶ 100–03. CMS confirms that this reimbursement applies regardless of the patient's AI/AN status. *See* SHO Letter #16-002; CMS FAQ #11817.

Fishing Point did not exist when CMS approved the Tribal Reimbursement SPA. The Nation established the facility in 2023—well after the Commonwealth submitted the SPA's terms for federal approval. Yet Defendants now act as though Fishing Point engaged in deception or exploited a loophole, suggesting that the Commonwealth is somehow being taken advantage of. This narrative is not only false—it misdirects blame for the Commonwealth's own failure to anticipate the implement the very reimbursement framework it proposed and secured. Fishing Point was created in direct reliance on the legal framework that the Commonwealth helped create. There is no evidence of misrepresentation, nor any policy shift by the provider.

The only change is that a Tribal health provider began delivering high-quality, culturally responsive care at scale, in full compliance with federal and state requirements.

Rather than support that success, Defendants move to suppress it: They pend claims, block enrollment, propose misleading SPAs, and endorse a discriminatory budget amendment. *See* Compl. ¶¶ 147–55, 213–17, 235, 242–43, 276, 281. They intentionally concealed a November 2024 CMS audit verifying that Fishing Point's billing complied with federal standards and determining that DMAS had underpaid for previous claims. *Id*. at ¶¶ 249–55. Defendants' actions are not an oversight, but targeted retaliation.

The Fourth Circuit and other courts have rejected similar state arguments that attempt to reframe resistance to federal law as a legitimate administrative concern. *See Pashby*, 709 F.3d at 329; *Lopez v. Heckler*, 713 F.2d 1432, 1437 (9th Cir. 1983); *Child.'s Hosp. of the King's Daughters, Inc.*, 258 F.Supp.3d at 689. The Commonwealth cannot claim hardship from being prohibited from continuing unlawful conduct.

Defendants' resistance to the Tribal reimbursement terms they previously proposed and voluntarily adopted does not amount to cognizable harm—it reflects an internally inconsistent and self-created position. Courts have made clear that compliance with federal mandates—particularly those grounded in civil rights and healthcare access—is not an undue burden. Instead, failure to comply harms vulnerable populations and erodes the legitimacy of federally funded programs. While Defendants evade these obligations, Plaintiffs shoulder the escalating costs: financial harm from unreimbursed claims, operational disruption from enrollment delays, and reputational damage from state-propagated misinformation. Plaintiffs' injuries are real, measurable, and ongoing. The balance of equities not only favors Plaintiffs—it demands immediate relief.

IV. The Public Interest Decisively Supports Relief

The public interest overwhelmingly supports the issuance of a Preliminary Injunction. Courts have long held that where federal rights, sovereign interests, and access to life-sustaining healthcare are at stake, the public interest favors preserving the status quo and ensuring compliance with federal law. *See Winter*, 555 U.S. at 20; *Pashby*, 709 F.3d at 331.

In *Pashby*, the Fourth Circuit held that the public interest supports injunctive relief where it preserves access to Medicaid-funded care and prevents harm to vulnerable individuals. 709 F.3d at 331. The court specifically held that protecting individuals' access to medical services—particularly where the loss of those services would lead to physical or emotional suffering—constitutes a compelling public interest. *Id*. at 331–32. The Court further agreed with the Eighth and Ninth Circuits that there is a "robust public interest in safeguarding access to health care for those eligible for Medicaid," and that state budgetary concerns cannot be "the conclusive factor in decisions regarding Medicaid." *Id*. (citing *Indep. Living Ctr. of S. Cal., Inc.*, 572 F.3d 644, 659 (9th Cir. 2009), vacated on other grounds, 565 U.S. 606 (2012) and *Ark. Med. Soc'y v. Reynolds*, 6 F.3d 519, 531 (8th Cir. 1993)). This interest is even more pronounced where, as here, constitutional rights are also at stake. *See Int'l Refugee Assistance Project*, 857 F.3d at 604 ("Upholding the Constitution undeniably promotes the public interest." (quoting *Giovani Carandola, Ltd.*, 303 F.3d at 521). While budgetary trade-offs are often unavoidable, the Court concluded that "the public interest in this case lies with safeguarding public health rather than with assuaging [the state's] budgetary woes." *Pashby*, 709 F.3d at 332.

That conclusion carries even greater weight here. The public interest supports immediate relief to prevent further disruption of care to the AI/AN and non-AI/AN Medicaid beneficiaries who rely on Fishing Point for their medical care, including homebound elders, disabled adults,

and individuals with chronic conditions. *See* Johnson Decl. ¶¶ 7–8, 23, 48. These patients receive personal care, behavioral health services, chronic disease management, transportation, and home-based support. *Id.* at ¶¶ 7–8. Without relief, these patients face immediate risks: missed medications, lapses in care, and irreversible deterioration in their health. *Id*. at ¶¶ 50–52.

Fishing Point cannot retroactively deliver missed services. As Your Honor recognized in *Children's Hospital*, "[d]isrupting the hospital's ability to provide medical treatment cannot be likened to interrupting a typical business's ability to turn a profit. The typical business can catch up on lost profits in the future, but a hospital cannot retroactively treat its patients." 258 F.Supp.3d at 689. The same principle applies with even greater force to a sovereign Tribal Health Program operating under a 638 Contract.

Fishing Point is not merely a Medicaid provider—it is a Tribal health system that embodies the Nation's exercise of sovereign self-governance under federal law. *See* 25 U.S.C. §§ 1601 *et seq*.; 42 U.S.C. § 1396j(d). The continued operation of the facility supports not only direct patient care, but the public interest in honoring Tribal sovereignty, enforcing intergovernmental agreements, and fulfilling federal trust and treaty obligations. Defendants' dereliction undermines all of the above. *See* Johnson Decl. ¶¶ 4–5, 53; Compl. ¶¶ 40–61.

Allowing state officials to continue obstructing Fishing Point's operations would send a dangerous message: that states may dismantle Tribal Health Programs in violation of federal law, without consultation, accountability, or consequence. Such an outcome is not only unlawful—it is deeply destabilizing and runs directly counter to the national interest in strengthening Indian healthcare delivery systems and honoring federal trust responsibility. *See* SHO Letter #16-002.

Local officials and service organizations voice strong support for Fishing Point's continued operation. Oasis Social Ministry in Portsmouth wrote "Fishing Point has been a vital

resource for the individuals we serve, filling critical gaps in care that many traditional service providers struggle to address." *See* Johnson Decl. ¶ 15. Newport News City Council Member John R. Eley III stated that "Fishing Point has made a significant impact on the health and well-being of many individuals who would otherwise be underserved." *Id*. at ¶ 17. Newport News Health and Rehabilitation emphasized, "What has always made Fishing Point the best (yes, I said it), best health care agency is the extra incentives which only Fishing Point offers." *Id*. at ¶ 20. These declarations provide evidence of Fishing Point's effectiveness and the extent to which the public relies on its services. The public interest here is neither abstract or speculative—it is personal, immediate, and rooted in the daily realities of the affected community.

The public also has a strong interest in enforcing federal program integrity. The Commonwealth receives billions of dollars in Medicaid funding from the federal government. Acceptance of that funding imposes a duty to adhere to the conditions set forth by federal law. *See Arlington Cent. Sch. Dist. v. Murphy*, 548 U.S. 291, 296 (2006). The Commonwealth cannot receive those funds while disregarding its own CMS-approved State Plan, violating federal Medicaid statutes, and discriminating against providers based on their Tribal status.

CONCLUSION

For the foregoing reasons, Plaintiffs respectfully request that this Court issue a Preliminary Injunction requiring Defendants to do the following:

1. **Approve and Expedite Enrollment**: Promptly process and approve Fishing Point for Medicaid enrollment—including its dental clinic—ensuring Fishing Point may immediately serve Medicaid beneficiaries in accordance with Virginia's federally approved State Medicaid Plan.

2. **Reimburse at the Federally Mandated All-Inclusive Rate**: Reimburse Fishing Point for all covered Medicaid services at the Federal Air, as set forth in Virginia's federally approved State Medicaid Plan. This includes services for which Fishing Point has not yet been fully reimbursed (e.g., PCA, behavioral health, and additional covered services).

3. **Apply Uniform Reimbursement to All Beneficiaries**: Prohibit any reimbursement distinction based on a Medicaid beneficiary's AI/AN status. Comply with the "one facility, one rate" principle mandated by federal law and CMS guidance.

4. **Lift Suspensions and Promptly Reimburse All Pended Claims**: Unpend or otherwise process all outstanding Medicaid claims submitted by Fishing Point for covered services, and tender reimbursement in compliance with the IHS All-Inclusive Rate and other relevant federal requirements.

5. **Maintain the Status Quo of Federal Approvals**: Refrain from making or enforcing any modification—direct or indirect—to the State Plan, reimbursement methodology, or other policies affecting Tribal Health Programs without first (a) obtaining all necessary federal approval, and (b) engaging in meaningful, pre-decisional Tribal consultation, as required by 42 U.S.C. § 1396a(a)(73), 42 C.F.R. § 431.408, and Virginia SPA 21-011.

6. **Adhere to Good-Faith Tribal Consultation**: Conduct pre-decisional, government-to-government consultation with Plaintiffs regarding any proposed change affecting Tribal participation or reimbursement, consistent with 42 U.S.C. § 1396a(a)(73), 42 C.F.R. § 431.408, and Virginia SPA 21-011.

7. **Identify and Resolve All Underpayments**: Work directly with Fishing Point to identify and promptly reimburse any outstanding underpayments for prior services, including personal care assistance and other Medicaid-covered services confirmed by CMS audits or otherwise demonstrated to have been underpaid, ensuring accurate and timely resolution.

8. **Fully Comply with All Federal Requirements:** Uphold every provision of the Medicaid Act, 42 U.S.C. §§ 1396 et seq., including coverage authorized under 42 C.F.R. § 440.90(c) and 42 C.F.R. § 1905(c); ISDEAA, 25 U.S.C. §§ 5301–5423; IHCIA, 25 U.S.C. §§ 1601–1683, and binding CMS guidance (such as SHO #16-002 and FAQ #11817). Defendants shall not impose additional licensure, enrollment, or reporting requirements beyond those that federal law imposes on IHS itself. Specifically, Defendants must:
   a. Recognize that all Medicaid-covered services delivered by or through Fishing Point—including offsite care, home- and community-based services, and services to non-AI/AN patients—qualify for reimbursement at the Federal AIR.
   b. Refrain from imposing any licensure, "provider type," or managed-care participation mandates beyond those applied to IHS facilities or allowed by federal law.
   c. Process and reimburse all "clean claims" without imposing new edits or extended pended periods not equally applied to IHS-operated programs.
   d. Do not implement any plan amendment, budget provision, or "clarification" that reduces or denies the Federal AIR based on patient status, service location, or budget concerns without federal approval and Tribal consultation.
   e. Abstain from conduct that interferes with the Nation's authority under its Title I Contract to provide comprehensive healthcare services. Defendants may not

reduce or deny coverage for properly authorized services under an ISDEAA contract absent lawful federal approval.

f. Remove any indefinite "pended" holds on Fishing Point's enrollment (including dental, pharmacy, or other service lines). Process all credentialing steps with "reasonable promptness" (42 U.S.C. § 1396a(a)(8); 42 C.F.R. Part 455) and without conditioning participation on unapproved policy amendments.

These measures are necessary to ensure that Defendants comply fully with binding federal laws, regulations, and Virginia's federally approved Tribal Reimbursement SPA; refrain from imposing undue administrative or licensing hurdles; and safeguard the self-determination and healthcare mission of the Nansemond Indian Nation and its Tribal Health Program.

Dated: April 10, 2025

Respectfully submitted,

/s/ Jessie Barrington

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CERTIFICATE OF SERVICE

I certify that on this 10th day of April, 2025, a true and correct copy of the foregoing was served on all registered counsel of record via Notice of Electronic Filing through the Court's CM/ECF system.

/s/ Jessie Barrington
Jessie Barrington (VSB No. 100685)