UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

ROSIE D. et al.,

Plaintiffs,

v. 01-CV-30199-MAP

JANE M. SWIFT et al.,

Defendants.

MEMORANDUM OF LAW IN SUPPORT OF MOTION TO DISMISS

Preliminary Statement

The complaint presents this case as a dispute over the interpretation of federal Medicaid law, but it is really an argument between two different paradigms of how mental health services should be delivered to persons who need them, in this case children. The traditional paradigm, which describes not just the Massachusetts Medicaid program but the delivery of such services generally in this country to the privately insured as well as to Medicaid recipients, is that delivery of mental health services is organized around the providers; that is, persons who need such services visit mental health clinicians and other community care providers, including hospitals and other institutions when the need is acute. Plaintiffs' basic claim in this case is that Medicaid law requires the Massachusetts Medicaid program to replace that traditional approach with a new paradigm for the delivery of mental health services: a system of "intensive home-based mental health services" that would allow them to receive mental health services at home

and thereby avoid hospitalization.

Plaintiffs are nine children ranging in age from five to seventeen, each of whom is alleged to be Medicaid eligible and to have been diagnosed with two or more psychiatric, behavioral or emotional disorders. The complaint establishes that each plaintiff (with one possible exception) has received services to treat his or her condition in a manner consistent with the traditional paradigm just mentioned, including repeated hospitalizations of varying duration. Plaintiffs contend, however, that federal Medicaid law mandates that they be provided with treatment and other services in their homes rather than in any other setting, such as a hospital. More specifically, plaintiffs allege that their conditions require "intensive home-based mental health services," which they define as "behavioral support services, psychiatric and other clinical services, professionally acceptable assessments, crisis services, and case management." Recognizing that the Medicaid statute contains no reference to "intensive home-based mental health services," plaintiffs further contend that such services fall within the Medicaid program's general definition of Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") services set forth in 42 U.S.C. §§ 1396a(a)(43) and 1396d(r). They conclude that the Commonwealth must pay for "intensive home-based mental health services" for themselves and a class of Medicaid eligible children under the age of 21 who have or may have behavioral, emotional, or psychiatric disabilities or impairments.

The idea of providing children such as plaintiffs with mental health services in their homes has much to be said for it. Indeed, as the complaint itself establishes, the Commonwealth pays for some behavioral health services for Medicaid eligible children in their homes in the form of Family Stabilization Teams and Community Support Programs, and has been testing a

pilot program to pay for further home-based services on a limited basis (Complaint ¶¶ 52-53, 64). However – and this is the heart of defendants' position in this case – federal Medicaid law does not require the Commonwealth to pay for home-based services to the unlimited extent sought by plaintiffs. To the contrary, federal Medicaid law allows states to choose, within general federal parameters, how to deliver services, and gives states discretion to limit the extent of services for which they will pay. Defendants (the Commonwealth's Governor, Secretaries of the Executive Offices of Health and Human Services and of Administration and Finance, and Commissioner of the Division of Medical Assistance) therefore move to dismiss the complaint for lack of subject matter jurisdiction and failure to state a claim, pursuant to Rules 12(b)(1) and (6) of the Federal Rules of Civil Procedure, on three grounds: (1) that federal Medicaid law does not require states to adopt the paradigm of "intensive home-based mental health services" advocated by plaintiffs but instead vests them with discretion to choose the extent of services for which they will pay and how those services will be delivered; (2) that plaintiffs possess no legal right to compel the Commonwealth to adopt the paradigm they favor; and (3) that this Court lacks jurisdiction over plaintiffs' effort to force their choice upon the Commonwealth.

To take the jurisdictional point first, plaintiffs' claims are barred by the Commonwealth's Eleventh Amendment sovereign immunity (Point I of this memorandum). Even though the Ex Parte Young doctrine allows suit in some circumstances against state officers for prospective injunctive relief notwithstanding the Eleventh Amendment, the Supreme Court has held that the legal fiction recognized in Ex Parte Young is unavailable when Congress has prescribed a detailed remedial scheme that allows plaintiffs to enforce a statutorily created right by some means other than an Ex Parte Young claim. A detailed remedial scheme exists regarding those

aspects of the Commonwealth's Medicaid program that are the basis for plaintiffs' claim, and thus this Court lacks subject matter jurisdiction by application of the Eleventh Amendment.

Second, the EPSDT provisions of federal Medicaid law on which plaintiffs base their claim of entitlement to "intensive home-based mental health services" do not provide a judicially enforceable right to relief either directly or through 42 U.S.C. § 1983. The Supreme Court held in Blessing v Freestone, 520 U.S. 329, 340 (1997), that to seek redress through § 1983 a plaintiff "must assert the violation of a federal right, not merely a violation of federal law." The Court further indicated that an asserted right is not federally enforceable when it is "so 'vague and amorphous' that its enforcement would strain judicial competence" or when the federal statute alleged to give rise to the right imposes no binding obligation on the state. 520 U.S. at 340-341. Plaintiffs' claim suffers from both defects. The right they purport to assert, which amounts to a claim that the EPSDT provisions guarantee each Medicaid recipient a round-the-clock staff of clinicians and personal attendants ready to handle any need the recipient may assert, is so vague as to be practically limitless. Moreover, the EPSDT provisions do not impose a mandatory obligation on the states to pay for "intensive home-based mental health services." Plaintiffs therefore have no judicially enforceable right to relief (Point II of this memorandum).

Finally, even if plaintiffs had an enforceable right to relief under the EPSDT provisions of federal Medicaid law and this Court had jurisdiction to hear such a claim, the complaint would still fail to state a claim for relief. Federal Medicaid law requires states to pay for various categories of care for Medicaid recipients, but "intensive home-based mental health services" is not one of the required categories. While federal Medicaid law does establish some categories of care that include care provided in the home, it gives states discretion to limit the extent of

services they will pay for within those general categories, and it nowhere requires unlimited in-home services as sought by plaintiffs. Here, the Commonwealth has made an appropriate choice regarding the delivery of mental health services that lies squarely within the discretion afforded it under the federal Medicaid program. Furthermore, the complaint contains no allegation that specific services (in the home or otherwise) are medically necessary to any plaintiff – a prerequisite to Medicaid entitlement. For these reasons the complaint should be dismissed for failure to state a claim for relief (Point III of this memorandum).

Summary of Plaintiffs' Allegations

For purposes of this motion only defendants do not contradict plaintiffs' factual allegations. Plaintiff Rosie D. is a thirteen year old girl with post traumatic stress disorder, oppositional defiant disorder, and attention deficit hyperactivity disorder (Complaint ¶¶ 67, 70). Tyriek H. is an eight year old boy with psychosis or a psychotic condition, attention deficit disorder, oppositional defiant disorder, and bipolar disorder (Complaint ¶¶ 72, 74). Joshua D. is a twelve year old boy with a non-verbal learning disability, dysthymia disorder, anxiety disorder, oppositional defiant disorder, and pervasive developmental disorder (Complaint ¶ 78). Sheena M. is a sixteen year old girl with attention deficit hyperactivity disorder and mild mental retardation (Complaint ¶ 83). Devin E. is an eight year old boy with pervasive developmental delay, significant speech and language delays, global development delay, post traumatic stress disorder, reactive attachment disorder, oppositional defiant disorder, attention deficit hyperactivity disorder, and autism (Complaint ¶¶ 88, 91). Anton B. is an eight year old boy with attention deficit and hyperactivity disorder and bipolar disorder (Complaint ¶ 93). Nathan F. is a fifteen year old boy with attention deficit and hyperactivity disorder and a bipolar thought

disorder (Complaint ¶ 98). Shaun E. is a five year old boy with attention deficit and hyperactivity disorder, post traumatic stress disorder, and bipolar disorder (Complaint ¶¶ 106, 109). Jerry N. is a seventeen year old boy with a chromosome disorder, mild mental retardation, and attention deficit and hyperactivity disorder (Complaint ¶¶ 111, 114).

Even though all of the plaintiffs are generally alleged to require "intensive home-based mental health services" (Complaint ¶¶ 69, 76-77, 82, 87, 92, 97, 105, 110, 115), the complaint does not specify what services are needed by any particular plaintiff. The complaint does not allege that any clinician has diagnosed any particular service as medically necessary for any particular plaintiff. These omissions are significant because the Medicaid program is limited to paying for care that has been determined to be medically necessary on an individualized basis, 42 U.S.C. §§ 1396a(a)(30)(A) and 1396a(a)(33), 42 C.F.R. § 440.230(d), and that limitation is explicitly incorporated in the definitions of all EPSDT services, 42 C.F.R. § 1396d(r)(5).

The complaint fails to specify exactly what services are claimed to be medically necessary for each plaintiff; however, it does allege that all of the plaintiffs have received mental health services to treat or help alleviate their conditions, and it is apparent that those services are being (or were) provided according to the traditional delivery paradigm described above. There is no allegation that those services were improperly provided, or that Medicaid has failed to pay for them. With the exception of Shaun E., all are alleged to have been hospitalized or treated at Crisis Stabilization Units at various times when their behavior was otherwise uncontrollable (Complaint ¶¶ 68-69, 73-75, 78, 83-84, 91, 94-96, 101-103). Four of the plaintiffs (Rosie D., Tyriek H., Sheena M., and Nathan F.) currently have residential placements. Rosie D. lives at Children's House, a Department of Mental Health ("DMH") facility (Complaint ¶ 70). Tyriek

H., who presently requires hospitalization, has lived at Three Rivers residential facility since November 2000 (Complaint ¶¶ 74, 76). Sheena M. has lived at Howard House, a six-bed DMH funded residential facility, since August 1, 2001 (Complaint ¶ 86). Nathan F. lives at Granite House, a mental health residential program, but allegedly has been told that he could be discharged any day (Complaint ¶ 86).

The other five plaintiffs (Joshua D., Devin E., Anton B., Shaun E. and Jerry N.) live at home (Complaint ¶¶ 78, 91, 93, 106, 114). They, too, have received various services to treat their conditions, some clinical and some other services (such as Head Start and other educational programs). Joshua D. attended school last spring with a full-time aide (the complaint does not indicate whether he presently attends school), and he has seen numerous physicians, therapists and social workers and is presently receiving therapy (Complaint ¶¶ 78, 80, 81). Devin E. has participated in Early Intervention and school programs in the past and was hospitalized from February through May 2001; the complaint does not indicate what treatment he is presently receiving (Complaint ¶¶ 90-91). Anton B. has been receiving visits from a DMH paraprofessional for four hours per week but that contact is expected to end (Complaint ¶ 96). Shaun E. is enrolled in Head Start and sees numerous physicians, psychiatrists and social workers (Complaint ¶¶ 107, 109). Jerry N. attends the Cardinal Cushing School and Training Center and is also apparently in a day program for some portion of the day (Complaint ¶¶ 113, 114).

Consistent with plaintiffs' failure to allege that any specific service is medically necessary to any of them, the complaint contains no allegation that any particular plaintiff has requested that the Division of Medical Assistance pay for any particular service on the ground

that it is medically necessary, or that any particular plaintiff has been denied payment for any specific medically necessary service. The complaint also contains no allegation that any of the plaintiffs has at any point sought a fair hearing to challenge the denial of payment for any medically necessary service.

Summary of Plaintiffs' Claims

Plaintiffs' essential position is that federal Medicaid law requires the Commonwealth, through the Medicaid program, to pay for "intensive home-based mental health services" in their homes rather than in any other setting. Federal Medicaid law nowhere refers to "intensive home-based mental health services" as a type of service for which states must pay. Because of this, plaintiffs assert four causes of action referencing a plethora of different sections of the federal Medicaid statutes and its implementing regulations that they contend support their claim of entitlement to "intensive home-based mental health services," but none of which by their express terms contain such a requirement.

Plaintiffs' first cause of action (Complaint ¶¶ 132-137) asserts that "intensive home-based mental health services" are required (1) by 42 U.S.C. § 1396a(a)(10)(A), which is the section of the Medicaid statute that defines the persons eligible for Medicaid; (2) by 42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4)(B), and 1396d(r)(5), which are the sections of the Medicaid statute that define the EPSDT program; and (3) by 42 C.F.R. §§ 441.50, 441.56(a), and 441.61(b), which are federal regulations implementing the EPSDT program.

Plaintiffs' second cause of action (Complaint ¶¶ 138-142) presupposes that the Commonwealth must pay for "intensive home-based mental health services" based upon those sections referenced in their first cause of action, and then asserts that they are not being afforded

those services with reasonable promptness, in purported violation of 42 U.S.C. § 1396a(a)(8) and 42 C.F.R. § 435.930(a).

Plaintiffs' third cause of action (Complaint ¶¶ 143-145) likewise presupposes that the Commonwealth must pay for "intensive home-based mental health services" based upon those statutes referenced in their first cause of action, and then asserts that the Commonwealth is not administering the Medicaid program so as to ensure a sufficient supply of providers of "intensive home-based mental health services," in purported violation of 42 U.S.C. § 1396a(30)(A).[1]

Finally, plaintiffs' fourth cause of action (Complaint ¶¶ 146-148) again presupposes that the Commonwealth must pay for "intensive home-based mental health services" based upon those statutes referenced in their first cause of action, and then asserts that the Commonwealth has failed to ensure that the managed care entity providing mental health services to Massachusetts Medicaid recipients, the Massachusetts Behavioral Health Partnership (Complaint ¶ 47), maintains sufficient capacity to offer "intensive home-based mental health services," in purported violation of 42 U.S.C. § 1396u-2(b)(5). Obviously, as shown below, plaintiffs' second, third, and four causes of action fail upon the demonstration that their first cause of action – that federal Medicaid law requires the Commonwealth to pay for "intensive home-based mental health services" – is without legal basis.

Plaintiffs seek certification of a class defined as "all current or future Medicaid-eligible residents of Massachusetts under the age of twenty-one who have or may have a behavioral, emotional, or psychiatric disability or impairment and who need or may need intensive home-

[1]So in complaint – believed to be a typographical error for 1396a(a)(30)(A).

based services, including professionally acceptable assessments, special therapeutic aides, crisis intervention, and case management services, in order to treat or ameliorate their disability or impairment" (Complaint ¶ 22). Plaintiffs seek declaratory and injunctive relief requiring defendants to pay for "intensive home-based mental health services" and request that the Court retain jurisdiction over this case for an undefined period to monitor the Commonwealth's efforts in that respect.

The Medicaid Program

The Medicaid program was created in 1965 when Congress added Title XIX to the Social Security Act, 79 Stat. 343, as amended, 42 U.S.C. § 1396 et seq., for the purpose of providing federal financial assistance to states that choose to reimburse certain costs of medical treatment for needy persons. The Act creates a cooperative federal-state program entitled "Grants to States for Medical Assistance Programs" that pays for statutorily-authorized health care services to economically disadvantaged individuals. A state that chooses to participate in the Medicaid program must develop a plan describing the scope of its medical assistance program and submit that plan to the Secretary of the United States Department of Health and Human Services ("HHS") for approval. Upon approval of a state's plan, HHS allocates financial grants to help the state defray its cost. 42 U.S.C. § 1396b.

While participation in the Medicaid program is optional, states that choose to participate are required to comply with the requirements of Title XIX. A state's plan must provide assurance that it will be administered in conformity with federal law. 42 C.F.R. § 430.10. Massachusetts has chosen to participate in the Medicaid program, and its Division of Medical Assistance ("DMA") is the state agency responsible for administration and regulation of the

Medicaid program in conformity with Title XIX. Mass. G.L. c. 118E, §§ 1 and 9.

The Medicaid statute contains no provision permitting Medicaid eligible persons to bring suit against states that fail to comply with Medicaid law. Instead, the Medicaid statute provides two other means by which Medicaid law may be enforced against non-compliant states. First, the Secretary of HHS retains the authority to monitor each participating state's performance and to limit or terminate payments to any state if he finds less than substantial compliance with any plan provision. 42 U.S.C. § 1396c. Section 1396c specifically authorizes the Secretary to exercise this authority both as to entire state plans and as to non-complying categories or parts of such plans, and further authorizes him to continue to limit or withhold payments until he is "satisfied that there will no longer be any such failure to comply."

Medicaid law also allows an individual who believes that a state Medicaid program has wrongly declined to pay for medically necessary care to challenge such a decision. It does so not by creating a private cause of action in federal court – there is no such provision in the Medicaid statute – but rather by requiring states that participate in Medicaid to grant hearings to individuals who believe that they have been wrongfully denied payment for care. State Medicaid plans must provide an opportunity for a fair hearing "to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness." 42 U.S.C. § 1396a(a)(3). Massachusetts has a fair hearing procedure, 130 C.M.R. §§ 610.001 et seq., and an individual who remains dissatisfied after that process can exercise a further right to judicial review in state court in accordance with Mass. G.L. c. 30A, 130 C.M.R. § 610.092.

The general structure of the Medicaid program is that federal law defines two categories of services – those for which states must pay for all Medicaid recipients and those for which

states may choose to pay – and leaves it to each state to determine how to deliver those services within general federal parameters such as the requirement that medical assistance be provided with reasonable promptness, 42 U.S.C. § 1396a(a)(8), and that the state administer its program so as to maintain availability of services, 42 U.S.C. § 1396a(a)(30)(A). The list of required and optional services under the Medicaid program is set forth as part of the definition of "medical assistance" in 42 U.S.C. § 1396d(a), which sets out twenty-seven categories of services. Pursuant to § 1396a(a)(10)(A), seven of those categories (those described in paragraphs 1-5, 17, and 21 of the statute) are mandatory for all Medicaid recipients, while states may choose whether to pay for the remaining twenty. Massachusetts has chosen to pay for the optional as well as the mandatory categories.

One category of services for which states must pay is early and periodic screening, diagnostic and treatment ("EPSDT") services for Medicaid eligible children under the age of 21. 42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4)(B). Five categories of EPSDT services are defined by 42 U.S.C. § 1396d(r): screening, vision, dental, and hearing services, and a fifth category consisting of "[s]uch other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan." 42 U.S.C. § 1396d(r)(5). The fifth category thus refers back to § 1396d(a) and incorporates the twenty seven categories of services listed in that statute.

States' duties with respect to EPSDT services are further spelled out in federal regulations, 42 C.F.R. §§ 441.50-441.62. Section 441.56 of 42 C.F.R. specifies that the EPSDT

program requires states to engage in five types of required activities: informing, screening, providing diagnosis and treatment, maintaining records to ensure accountability, and setting standards to ensure timely provision of services. With respect to the nature of the diagnosis and treatment that states must provide pursuant to the EPSDT program, § 441.56 provides as follows:

> (c) Diagnosis and treatment. In addition to any diagnostic and treatment services included in the plan, the agency must provide to eligible EPSDT recipients, the following services, the need for which is indicated by screening, even if the services are not included in the plan –
>
> (1) Diagnosis and treatment for defects in vision and hearing, including eyeglasses and hearing aids;
>
> (2) Dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health; and
>
> (3) Appropriate immunizations. (If it is determined at the time of screening that immunization is needed and appropriate to provide at the time of screening, then immunization must be provided at that time.)

Pursuant to 42 C.F.R. § 441.57, it is discretionary with states whether to pay for any other treatment in addition to that specified above: "Under the EPSDT program, the agency may provide for any other medical or remedial care specified in part 440 of this subchapter, even if the agency does not otherwise provide for these services to other recipients or provides for them in a lesser amount, duration, or scope."[2]

The federal regulations implementing the EPSDT program thus make no reference to "intensive home-based mental health services" as a category of services for which states must

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[2]While § 441.57 might arguably be read as authorizing states to provide less than § 1396d(r) guarantees, Massachusetts pays for all the categories of services set forth in § 1396d(a) for Medicaid eligible children.

pay, nor do they require payment for any services in recipients' homes. To the contrary, the federal regulations expressly contemplate that EPSDT services may not be provided in recipients' homes, as reflected in their requirement that states to offer the recipient (or her family) assistance with transportation to and from providers. 42 C.F.R. § 441.62, 431.53.

Massachusetts pays for EPSDT services through its Medicaid plan. 130 C.M.R. §§ 450.140-450.149. The Massachusetts EPSDT program pays for both periodic and interperiodic visits to health care providers by recipients. Periodic visits, which take place according to a schedule established by DMA in consultation with the Massachusetts Chapter of the American Academy of Pediatrics, Massachusetts Department of Public Health, dental professionals, the Massachusetts Health Quality Partners, and other organizations concerned with children's health, are for the purpose of performing exams, assessments, screening, and laboratory work, 130 C.M.R. §§ 450.141, 450.143(B). Interperiodic visits are any visits for screening or treatment in addition to those required by the schedule, 130 C.M.R. §§ 450.141, 450.143(C). Under the Massachusetts program, EPSDT diagnosis and treatment services consist of "all medically necessary services" listed in 42 U.S.C. §§ 1396d(a) and (r) that are "required to correct or improve conditions discovered as a result of a medical screening," and "reimbursable for MassHealth Standard members under age 21 years, if the service is determined by the Division to be medically necessary." 130 C.M.R. § 450.144(A). There is no limit to the number of medically necessary interperiodic visits that a recipient may make. 130 C.M.R. § 450.145(C)(1).

ARGUMENT

I. PLAINTIFFS' CLAIMS ARE BARRED BY SOVEREIGN IMMUNITY.

The Eleventh Amendment to the United States Constitution confirms principles of state sovereign immunity by barring citizens from bringing suits in federal court against their own states. Board of Trustees v. Garrett, 121 S. Ct. 955, 962 (2001); College Savings Bank v. Florida Prepaid Postsecondary Education Expense Board, 527 U.S. 666, 669-670 (1999); Seminole Tribe of Florida v. Florida, 517 U.S. 44, 54 (1996). This immunity also bars suits in which state officers are the named defendants when "the State is the real, substantial party in interest." Pennhurst State School & Hospital v. Halderman, 465 U.S. 89, 101 (1984). The Supreme Court has recognized an exception to Eleventh Amendment immunity for certain suits seeking declaratory and injunctive relief against state officers in their individual capacities designed to remedy ongoing violations of federal law. Idaho v. Coeur D'Alene Tribe of Idaho, 521 U.S. 261, 269 (1997), citing Ex parte Young, 209 U.S. 123 (1908). "Ex parte Young allows a way around the bar to federal jurisdiction erected by the Supreme Court's Eleventh Amendment jurisprudence only in cases where prospective declaratory or injunctive relief is sought under federal law." Mills v. State of Maine, 118 F.3d 37, 54 (1st Cir. 1997). This case is barred by the Eleventh Amendment unless it is deemed to be within the Ex parte Young exception.

The Ex parte Young doctrine is premised upon what the Supreme Court has described as a "fiction": the notion that when a state officer violates federal law, he is stripped of his official character, thus losing the "cloak" of sovereign immunity. Idaho v. Coeur D'Alene Tribe of Idaho, supra, 521 U.S. at 281, 288; Pennhurst, supra, 465 U.S. at 104. While authorizing the use of this "fiction" to permit vindication of federal rights, Pennhurst, supra, 465 U.S. at 105, the Supreme Court has recognized the reality that a state will have a continuing interest in litigation whenever state policies or procedures are at stake, regardless of whether it or its officers are the

nominal defendants. Idaho v. Coeur D'Alene Tribe of Idaho, supra, 521 U.S. at 269. Acknowledging that "the need to promote the supremacy of federal law must be accommodated to the constitutional immunity of the States," the Supreme Court has therefore strictly limited the relief available in a case premised upon the Ex parte Young doctrine. Pennhurst, supra, 465 U.S. at 105-106.

The Pennhurst decision itself establishes two important limitations on the Ex parte Young doctrine: (1) that it is not available to support a claim against state officers for retroactive relief, and (2) that it is likewise inapplicable in a suit against state officers in federal court alleging the violation of state law. Id. at 105-106. In subsequent cases the Supreme Court has imposed other limitations upon use of Ex parte Young. The limitation relevant here involves the available remedial scheme in federal Medicaid law that precludes application of Ex parte Young: "where Congress has prescribed a detailed remedial scheme for the enforcement against a State of a statutorily created right, a court should hesitate before casting aside those limitations and permitting an action against a state officer based upon Ex parte Young." Seminole Tribe of Florida v. Florida, supra, 517 U.S. at 74.

In the Seminole case, the Supreme Court contrasted the limited remedial provisions available in the event of violations by states of the Indian Gaming Regulatory Act ("IGRA"), 25 U.S.C. § 2701 et seq., with the more complete relief that an Ex parte Young action would afford. The Court noted that IGRA (which provides for negotiation between states and Indian tribes of compacts governing gambling) afforded Indian tribes aggrieved by a state's failure to negotiate in good faith only a "quite modest set of sanctions," none of which could ultimately bind the state, and contrasted that limited remedy with "the full remedial powers of a federal court,

including, presumably, contempt sanctions" that would be available in an action under Ex parte Young. The Court concluded that "the fact that Congress chose to impose upon the State a liability that is significantly more limited than would be the liability imposed upon the state officer under Ex parte Young strongly indicates that Congress had no wish to create the latter," and thus Ex parte Young was inapplicable. 517 U.S. at 74-76.

Since Seminole, federal courts have found Ex parte Young claims for injunctive relief under a variety of federal statutes barred by the Eleventh Amendment because those federal statutes provided for relief more limited than would be available in an Ex parte Young action. Joseph A. v. Ingram, 262 F.3d 1113, (10th Cir. 2001) (comprehensive statutory and regulatory provisions governing Titles IV and XX of the Social Security Act establish that Congress meant to preclude reliance on the broad provisions of an Ex parte Young suit to enforce the federal standards governing state child adoption and welfare services); Bragg v. West Virginia Coal Ass'n, 248 F.3d 275, 297 (4th Cir. 2001) (existence of state court remedy enacted in conformity with Surface Mining Control and Reclamation Act made Ex parte Young remedy unnecessary); Bell Atlantic MD, Inc. v. MCI Worldcom, Inc., 240 F.3d 279, 297-298 (4th Cir.), cert. granted in part, 121 S. Ct. 2548 (2001) (limited federal remedy provided by Congress for violations of the Telecommunications Act of 1996 rendered Ex parte Young fiction unavailable); ANR Pipeline Co. v. LaFaver, 150 F.3d 1178, 1191 (10th Cir.), cert. denied, 525 U.S. 1122 (1999) (limited relief available under Tax Injunction Act renders Ex parte Young suit unavailable).

Significantly, in addition to the above illustrative cases, the reasoning of Seminole has been applied to the provisions of federal Medicaid law that govern the EPSDT program and are at issue here, 42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4)(B), and 1396d(r). Westside Mothers v.

Haveman, 133 F.Supp.2d 549, 574-575 (E.D. Mich. 2001). As required by Seminole, the Court in Westside Mothers examined the remedial scheme prescribed by Congress to permit enforcement against a state of rights created by the Medicaid statute. The Court noted that "the Medicaid statute contains a specific, limited remedy that may be used against non-compliant States: the HHS secretary may withhold funds from those States that she believes are not meeting their contractual responsibilities under the federal-state cooperative agreement," a remedy "far more limited than that which this court might order under Ex parte Young." The Court concluded that "the existence of a limited remedy in the Medicaid statute precludes the use of Ex parte Young to enforce the statutory scheme by other means." 133 F. Supp.2d at 575.

Westside Mothers correctly applied the analysis required under Seminole and other Supreme Court decisions (including Board of Trustees v. Garrett, supra, 121 S. Ct. at 962, Kimel v. Florida Board of Regents, 528 U.S. 62, 72-73 [2000], and College Savings Bank v. Florida Prepaid Postsecondary Education Expense Board, supra, 527 U.S. at 669-670) which emphasize that the Eleventh Amendment is no dead letter but a fundamental principle of federal constitutional law. The Medicaid statute contains no statutory right of action to force a state to provide benefits, nor do plaintiffs contend to the contrary. Rather, plaintiffs rely upon 42 U.S.C. § 1983 as the procedural vehicle by which to assert their claims (Complaint ¶¶ 6-7). As noted in Westside Mothers, the only remedies the Medicaid statute provides are (1) the withholding of money from a recalcitrant state and (2) fair hearings with the possibility that state law may afford judicial review of hearing results (as does Massachusetts). 133 F. Supp.2d at 554, 575. These remedies are clearly less comprehensive than those that would be available in an Ex parte Young action.

In short, an Ex parte Young analysis of the Medicaid statute – Westside Mothers, supra – demonstrates that this Court should decline to apply the Ex parte Young exception to the Eleventh Amendment jurisdictional bar. The limited nature of the remedies Congress has chosen to provide for violations of the Medicaid statute means that this case rests squarely within the holding in Seminole – "the fact that Congress chose to impose upon the State a liability that is significantly more limited than would be the liability imposed upon the state officer under Ex parte Young strongly indicates that Congress had no wish to create the latter," 517 U.S. at 75-76. Accord: Joseph A. v. Ingram, supra, 262 F.3d at 1122-1123 (provisions of Social Security Act providing for withholding of federal funds from recalcitrant states is a limited remedy that precludes Ex parte Young relief). Since the Ex parte Young exception is inapplicable here, this Court lacks subject matter jurisdiction over plaintiffs' claims.

II. THE EPSDT PROVISIONS OF FEDERAL MEDICAID LAW CREATE NO INDIVIDUAL RIGHTS ENFORCEABLE PURSUANT TO 42 U.S.C. § 1983.

Because the Medicaid statute contains no provision authorizing an action such as this, plaintiffs invoke 42 U.S.C. § 1983 as the procedural vehicle asserting their claim that the EPSDT provisions of federal Medicaid law entitle them to "intensive home-based mental health services." Complaint ¶¶ 6, 7. However, that plaintiffs rely upon federal law as the basis for their claims does not necessarily mean that they have a cause of action under § 1983. To the contrary, as the Supreme Court held in Blessing v. Freestone, 520 U.S. 329, 340 (1997), "[i]n order to seek redress through § 1983, however, a plaintiff must assert the violation of a federal right, not merely a violation of federal law." (emphasis in original)

The first step in determining whether a complaint asserts an enforceable federal right is to break the complaint down into "manageable analytic bites." Blessing, 520 U.S. at 342. Here,

while plaintiffs invoke a host of different sections of the Medicaid statute, their claim of entitlement to "intensive home-based mental health services" turns on the three sections that define the EPSDT program and comprise the "support" for their first cause of action: §§ 1396a(a)(43), 1396d(a)(4)(B), and 1396d(r)(5). The Medicaid sections that plaintiffs invoke in their other three causes of action govern only how services must be provided, not what services must be provided. For example, plaintiffs' second cause of action, which asserts a right to receive "intensive home-based mental health services" with reasonable promptness as purportedly required by 42 U.S.C. §§ 1396a(a)(8), is illusory unless plaintiffs are correct in their assertion that the EPSDT provisions afford them a right to "intensive home-based mental health services" in the first place. Whether plaintiffs in fact have an enforceable right to "intensive home-based mental health services" therefore requires application of the analysis set forth in Blessing to the three EPSDT provisions, §§ 1396a(a)(43), 1396d(a)(4)(B), and 1396d(r).

Under Blessing, three factors determine whether a particular statutory provision gives rise to an enforceable federal right: (1) whether Congress intended that the provision in question benefit the plaintiff; (2) whether the right assertedly protected by the statute is so vague and amorphous that its enforcement would strain judicial competence; and (3) whether the statute unambiguously imposes a binding obligation on the states. 520 U.S. at 340-341. This Court is familiar with the required analysis. Andrew S. ex rel. Margaret S. v. School Committee, 59 F. Supp.2d 237, 241-246 (D.Mass. 1999) (Individuals with Disabilities Education Act, 20 U.S.C. § 1400 et seq., does not create an enforceable right); National Telecommunication Advisors, Inc. v City of Chicopee, 16 F. Supp.2d 117, 120-121 (D.Mass. 1998) (Telecommunications Act of 1996, 47 U.S.C. § 151 et seq., creates enforceable right). Here, plaintiffs lack an enforceable

right because their claims fail to satisfy the second and third requirements set forth in Blessing.

In a case very similar to this one, another federal district court recently considered whether rights assertedly created by the EPSDT provisions were sufficiently specific to be enforceable in federal court, as required by the second Blessing factor, and concluded that they were not. Charlie H. v. Whitman, 83 F. Supp.2d 476, 497-499 (D.N.J. 2000).[3] Noting that the plaintiffs in that case asserted a right "to receive any and all treatments deemed necessary by a qualified medical professional conducting any of the . . . periodic examinations," the Court found the asserted right "not unlike the claim examined in Blessing wherein the plaintiffs urged that Title IV-D of the Social Security Act granted them 'individual rights to all mandated services delivered in substantial compliance with Title IV-D and its implementing regulations.'" Id. It concluded that the asserted right was "too vague and amorphous to lend itself to proper judicial administration," because "to allow such a right would improperly require this Court to oversee the entire State plan developed pursuant to 42 U.S.C. § 1396a." Charlie H., 83 F. Supp.2d at 498-499.

Here, the right that plaintiffs assert is protected by the EPSDT provisions is their right to receive "intensive home-based mental health services," Complaint ¶ 1. That claimed right is even more vague and amorphous than the right asserted in Charlie H., since the plaintiffs' asserted right apparently includes, for each recipient of services, a squad of care providers standing ready around-the-clock to "support the child in her natural or foster home, and in any

[3]The Court in Westside Mothers v. Haveman, supra, 133 F. Supp.2d at 575-585, reached the same conclusion following a different analysis.

other educational, after-school, or treatment setting where the child spends part of her day," as well as to "assist the child at home, in school, after school, and at other times" with "discrete clinical and other daily living issues." This amorphous right also purportedly includes "certain other supports to achieve desired outcomes" including "professionally adequate assessments," "crisis services," and "case management." Complaint ¶¶ 49-51. In short, the claim is that the EPSDT provisions guarantee each Medicaid recipient a personal staff ready to handle at home any need the recipient may assert. It is impossible to imagine a more vague and amorphous demand.

Just as in Charlie H., enforcement of the plaintiffs' envisioned right would require constant judicial intervention – a point plaintiffs explicitly recognize, as reflected in their demand that this Court "monitor compliance with the Court's injunction and with the requirements of the Medicaid program" for an unstated period (Complaint p. 46, ¶ 3). This case exemplifies the assertion of a right so vague and amorphous that its enforcement would "strain judicial competence" as that term is used in Blessing, 520 U.S. at 340-341. The "right" plaintiffs seek to assert is simply not enforceable under § 1983.

Although there are other federal decisions finding that the EPSDT provisions create enforceable federal rights, those decisions are distinguishable from the plaintiffs' claims here. Several of them predate the Supreme Court's decision in Blessing and therefore are not persuasive authority regarding the application of Blessing to the EPSDT provisions. Miller by Miller v. Whitburn, 10 F.3d 1315, 1319 (7th Cir. 1993) and Wellington v District of Columbia, 851 F. Supp. 1, 5-6 (D.D.C. 1994). Others are distinguishable because the claimed right protected by the EPSDT provisions was neither vague nor amorphous, but concrete and specific.

Memisovski v. Patla, 2001 W.L. 1249615 (N.D.Ill. 2001) (right to pediatrician visits); Dajour B. v. City of New York, 2001 W.L. 830674 * 10 (S.D.N.Y. 2001) (right to screening and treatment for asthma); Antrican v. Buell, 158 F. Supp.2d 663, 672-673 (E.D.N.C. 2001) (right to dental screening and treatment).

Unlike the rights recognized in Memisovski and the other cases just cited, the plaintiffs' asserted right to "intensive home-based mental health services" is so vague as to be practically without limits. Enforcement of such a right would require this Court to determine what specific services are medically necessary for every member of the proposed plaintiff class. Oversight by this Court regarding just the nine named plaintiffs -- whose ages range from five to seventeen and whose conditions vary from post traumatic stress disorder as a sequel to physical and sexual abuse, to psychosis, to attention deficit hyperactivity disorder with mild mental retardation – raises a serious question under Blessing. An even more significant "strain on judicial competence" is implicated when this vagueness is multiplied by the proposed plaintiff class, which plaintiffs have not even attempted to number but merely assert is "numerous," Complaint ¶ 23. In short, under Blessing, plaintiffs' purported right is not federally enforceable pursuant to § 1983.

Plaintiffs' asserted right to "intensive home-based mental health services" is also not federally enforceable because the EPSDT provisions do not "unambiguously impose a binding obligation on the States" to provide "intensive home-based mental health services" as required by Blessing, 520 U.S. at 341. To the contrary, federal Medicaid law creates no general category of "intensive home-based mental health services" that are a required element of the EPSDT program.

As described earlier in this memorandum at pages 11-12, the definition of EPSDT services set forth in 42 U.S.C. § 1396d(r) requires states to provide five categories of EPSDT services: screening, vision, dental, and hearing services, plus a fifth category consisting of "[s]uch other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan." 42 U.S.C. § 1396d(r)(5). The fifth category of EPSDT thus incorporates all twenty seven of the categories of services set forth in 42 U.S.C. § 1396d(a).

"Intensive home-based mental health services" is not one of the five categories of services set forth in § 1396d(r), nor is it one of the twenty seven categories of services set forth in § 1396d(a). Federal regulations implementing the EPSDT program likewise do not require "intensive home-based mental health services," 42 C.F.R. §§ 441.56(c), 441.57, and they in fact expressly contemplate that such services will generally be provided elsewhere than in the patient's home, as shown by the provision for transportation assistance to recipients and their families, 42 C.F.R. § 441.62 – assistance that would be unnecessary if, as plaintiffs assert, there were a general presumption in favor of having clinicians and other service providers visit the recipient at home.

In sum, while the Commonwealth pays for an array of mental health services for Medicaid eligible children, it has no duty at all to pay for "intensive home-based mental health services." Thus, plaintiffs' claim of an enforceable right to such services under § 1983 fails and the complaint should be dismissed.

III. THE COMPLAINT FAILS TO STATE A COGNIZABLE CLAIM UNDER FEDERAL MEDICAID LAW.

As shown above, both the Eleventh Amendment and the absence of an enforceable federal right under § 1983 should bar plaintiffs from attempting to assert their claim of Medicaid entitlement to "intensive home-based mental health services." However, even absent those two impediments, either of which provides sufficient ground for dismissing this action as a matter of law, the complaint would still fail to state a claim for relief, for two reasons. First, Medicaid law does not require the Commonwealth to pay for unlimited in-home services as sought by plaintiffs. Second, plaintiffs have not alleged that any services, in-home or otherwise, are medically necessary to them, which is a prerequisite to any claim of entitlement to Medicaid benefits. For both these reasons the complaint fails to state a claim for relief and should be dismissed.

This memorandum has already explained (above at pp. 23-24) that federal Medicaid law creates no general category of "intensive home-based mental health services" as part of the EPSDT program. However, some of the categories of services that are created by federal medicaid law can be provided in recipients' homes, including physician house calls (§ 1396d[a][5][A]), home health care services (§ 1396d[a][7] and 42 C.F.R. § 440.70[a][1]), private duty nursing services (§ 1396d[a][8] and 42 C.F.R. § 440.80[c][1]), "other diagnostic, screening, preventive, and rehabilitative services," (§ 1396d[a][13]), and personal care services (§ 1396d[a][24]). While these services are optional under the Medicaid statute, Massachusetts has chosen to pay for them. Plaintiffs invoke several of these provisions in support of their claim of entitlement to unlimited in-home services, and appear to contend that because "other states" unnamed in the complaint allegedly pay for such services without limitation and on a round-the-clock basis, the Commonwealth must do so too (Complaint ¶¶ 39, 49-51).

Contrary to plaintiffs' claim, Medicaid law confers on the Commonwealth discretion to limit the extent of services for which it will pay. The Supreme Court has expressly held that such discretion is conferred by 42 U.S.C. § 1396a(a)(17), which requires state Medicaid plans to include "reasonable standards" for determining "the extent of medical assistance under the plan" in Beal v. Doe, 432 U.S. 438, 444 (1977). In Beal, the Supreme Court interpreted that language as conferring "broad discretion on the States to adopt standards for determining the extent of medical assistance, requiring only that such standards be 'reasonable' and 'consistent with the objectives' of the Act." Id. The Commonwealth, in other words, has broad discretion to determine the extent of the services for which it will pay within the general categories set forth in the Medicaid statute. That interpretation is confirmed 42 U.S.C. § 1396, which provides that the federal government will appropriate money to enable states to furnish medical assistance "as far as practicable under the conditions in such State." It is also confirmed by federal regulations, which provide that the Commonwealth has discretion to determine the extent of the services for which it will pay and may "place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures," 42 C.F.R. § 440.230(d).

Plaintiffs' assertion that the Commonwealth pays for limited in-home mental health services to Medicaid recipient children through Family Stabilization Teams and Community Support Programs rather than the unlimited in-home services that plaintiffs allege are paid for by other, unnamed states (Complaint ¶¶ 49-54) thus states no violation of federal Medicaid law. To the contrary, federal Medicaid law expressly gives the Commonwealth discretion to limit the services for which it will pay. That other states may have made a different choice about the extent of services for which they will pay in no way compels the Commonwealth to march in

lock-step. To the contrary, Medicaid law expressly contemplates that state Medicaid programs will vary, as different states make different choices about the level of service they can afford, see 42 U.S.C. § 1396 (federal government will appropriate money to assist states in affording medical assistance "as far as practicable under the conditions in such State."). Plaintiffs' allegations therefore fail to state a claim for violation of the Medicaid law.

Plaintiffs' allegations also fail to state a claim for relief on an additional ground as well. One of the limitations that federal law expressly authorizes states to place upon the services for which they will pay is that such services be medically necessary. States are generally required to set up their Medicaid plans so as to "safeguard against unnecessary utilization of such care and services," 42 U.S.C. § 1396a(a)(30)(A), and to provide for review of the "appropriateness" of care, 42 U.S.C. § 1396a(a)(33), and may limit services based on medical necessity, 42 C.F.R. § 440.230(d). EPSDT services are explicitly limited to those that are medically necessary. 42 C.F.R. § 1396d(r)(1) through (5). Massachusetts EPSDT diagnosis and treatment services are limited to medically necessary services. Mass. G.L. c. 118E § 15; 130 C.M.R. § 450.144(A).

Here, the complaint contains no allegation that any service, including any in-home services, is medically necessary for any of the plaintiffs. Since medical necessity is a prerequisite to any claim of entitlement to Medicaid services under the statutes and regulations just cited, the absence of any such allegation means that plaintiffs simply have no claim of entitlement to any services. On this ground as well, therefore, the complaint should therefore be dismissed for failure to state a claim.

IV. DISCLOSURE AND DISCOVERY SHOULD BE STAYED PENDING A DECISION ON THIS MOTION.

The Supreme Court has held that the state sovereign immunity protected by the Eleventh

Amendment is an immunity from suit rather than a mere defense from liability, "and like an absolute immunity, it is effectively lost if a case is erroneously permitted to go to trial." Puerto Rico Aqueduct and Sewer Authority v. Metcalf & Eddy, 506 U.S. 139, 144 (1993). It has also held that qualified immunity from suit "includes protection from the burdens of discovery." Harlow v. Fitzgerald, 457 U.S. 800, 818 (1982); see also Hegarty v. Somerset County, 25 F.3d 17, 18 (1st Cir. 1994). The same should be equally true of Eleventh Amendment immunity, and for that reason disclosure and discovery in this case should be stayed while defendants' motion to dismiss on Eleventh Amendment grounds is pending. See Abril v Commonwealth of Virginia, 145 F.3d 182, 191 (4th Cir. 1998) (no abuse of discretion in denying discovery absent waiver of Eleventh Amendment immunity).

CONCLUSION

Disclosure and discovery should be stayed pending a decision on defendants' motion to dismiss, and the complaint should be dismissed.

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