UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS, WESTERN DIVISION

Rosie D., *et al.*, **Plaintiffs,** **v.** **GOVERNOR MITT ROMNEY, *et al.*,** **Defendants.**	**CIVIL ACTION NO. 01-30199**

MEMORANDUM OF LAW IN SUPPORT OF DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

Preliminary Statement

Plaintiffs, a class of Medicaid eligible children who contend that the Massachusetts Medicaid program fails to provide them with home and community based services for behavioral health needs, assert four causes of action under the Federal Medicaid Act. Defendants seek summary judgment on three grounds.

First, plaintiffs' fundamental claim here focuses on a small pilot program serving approximately 70 children with behavioral health needs in Cambridge, Somerville, and several other communities, the Mental Health Services Program for Youth ("MHPSY"). MHSPY is a service delivery model that integrates multiple funding streams for children with a combination of medical/behavioral health, educational, and social service needs. Plaintiffs assert that various provisions of federal Medicaid law require that the MHSPY service delivery model be expanded statewide. What plaintiffs overlook, however, is that the MHSPY program operates under a federally-granted waiver of Medicaid law that, among other things, specifically waives the requirements of statewideness and uniformity, consistent with the general purpose of Medicaid

waivers, which is to allow states to experiment with innovative programs. Summary judgment should therefore be granted for defendants on any claim that Medicaid law requires expansion of the MHSPY service delivery model statewide.

Second, since this Court last addressed the existence of private rights of action under the Medicaid Act in denying defendants' motion to dismiss, the Supreme Court has decided Gonzaga University v. Doe, 536 U.S. 273 (2002); applying the analysis required by that decision, plaintiffs' claims do not meet the requirements for enforceable private rights of action.

Third, Count IV of the Complaint asserts claims under 42 U.S.C. § 1396u-2(b)(5), which imposes certain Medicaid provisions applicable to managed care organizations. Massachusetts, however, is exempt from those provisions by virtue of the Balanced Budget Act of 1997. For all these reasons, therefore, summary judgment should be granted for defendants.

STATEMENT OF UNDISPUTED FACTS

A. The Medicaid Act

Title XIX of the Social Security Act, codified at 42 U.S.C. §§ 1396-1396v and commonly known as the Medicaid Act, is a joint federal-state program providing "federal financial assistance to states that choose to reimburse certain costs of medical treatment for needy persons." Pharmaceutical Research & Mfrs. of Am. v. Walsh, 538 U.S. 644, 650 (2003); see also 42 U.S.C. § 1396 (the purpose of Medicaid is to "enabl[e] each State . . . to furnish . . . medical assistance on behalf of families with dependent children and of aged, blind or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services . . ."). States are not required to participate in the Medicaid program, but states that elect to do so must comply with the Act and with regulations promulgated by the federal Secretary of the Department of Health and Human Services as a condition of receiving federal

funding. Most fundamentally, each participating state must devise and implement a plan for medical assistance ("State Plan") that must be approved by the Secretary. See 42 U.S.C. § 1396; 42 C.F.R. § 430.10.

B. The Conditions Imposed on the Secretary's Approval of a State Plan

A State Plan must define the categories of persons eligible to receive assistance and the specific types of care and services covered by the plan. See 42 U.S.C. §§ 1396a(a)(10), 1396a(a)(17). Federal law establishes both mandatory and optional services. There are seven mandatory types of care and services for which the state may provide "medical assistance" in the form of payment. See 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(1)-(5), (17) and (21). At the state's option, a State Plan also may provide "medical assistance" for twenty additional types of care and services. See 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(6)-(16), (18)-(20), (22)-(27). However, for Medicaid-eligible children, the state must pay for the types of care and services included in both the mandatory and optional categories, whether or not such care or services are included in the State Plan. See 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(4)(B), 1396d(r)(5). Effectively, for eligible individuals under age 21, the provisions of the Act erase the distinction between what are deemed mandatory and optional services.

To be approved by the Secretary, a State Plan must (among other things) meet the following additional conditions imposed by the designated sections of 42 U.S.C. § 1396a(a):

> (8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals . . . [the "*reasonable promptness provision*"]
>
> (10) provide for making medical assistance available for . . . [1396d(a)(4)(B)] early and periodic screening, diagnostic, and treatment services (as defined in subsection (r)(5) of [1396d]) for individuals who are eligible under the plan and are under the age of 21.

> Subsection 1396d(r)(5) defines "early and periodic screening, diagnostic, and treatment services" to mean: "Such other necessary health care, diagnostic services, treatment, and other measures described in [1396d(a) – which defines the term "medical assistance"] 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. [collectively, the *"EPSDT medical assistance" provision*]
>
> (30) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . .as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area . . . [the *"equal access" provision*]
>
> (43) provide for –
> (A) informing all persons in the State who are under the age of 21 and who have been determined to be eligible for medical assistance including services described in section 1396d(a)(4)(B) of this title, of the availability of early and periodic screening, diagnostic, and treatment services as described in section 1396d(r) of this title . . .
> (B) providing or arranging for the provision of such screening services in all cases where they are requested,
> (C) arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services, and
> (D) reporting to the Secretary [certain required information each fiscal year relating to the utilization of services provided under this provision] [the *"EPSDT program administration" provision*]

42 U.S.C. § 1396a(a)(8), (10), (30)(A), (43).

In addition, since the passage of the Balanced Budget Act of 1997 ("BBA") and its implementing regulations, the Act has permitted states to require eligible individuals to enroll with a managed care entity as a condition of receiving medical assistance. See 42 U.S.C. § 1396u-2(a). States that exercise that option must comply with the requirements established in Section 1396u-2, including 1396u-2(b)(5), which provides:

> Each Medicaid managed care organization shall provide the state and the Secretary with adequate assurances (in a time and manner determined by the

> Secretary) that the organization with respect to a service area, has the capacity to serve the expected enrollment in such service area, including assurances that the organization –
>
> (A) offers an appropriate range of services and access to preventive and primary care services for the population expected to be enrolled in such service area, and
> (B) maintains a sufficient number, mix and geographic distribution of providers of services [*the "managed care access" provision*]

C. The Massachusetts 1115 Waiver (and Other Federal Waiver Authority)

In 1994, the Commonwealth submitted a waiver application to the United States Department of Health and Human Services, Center for Medicare and Medicaid Services (then known as the Health Care Finance Administration, hereafter "CMS"). See Statement of Undisputed Facts ("Statement"), ¶ 16; Affidavit of Beth Waldman ("Waldman Aff."), Ex. 1. Among other things, the Commonwealth requested the Waiver to allow the state to expand Medicaid eligibility to populations not otherwise eligible, and to allow the Commonwealth to require eligible members to enroll in managed care. See Statement, ¶ 17; Waldman Aff., Ex. 1 at 8. The Social Security Act authorizes the Secretary to approve a request by a state to perform a demonstration project if, in the Secretary's judgment, such a project is likely to assist in promoting the objectives of the federal Medicaid Act. See 42 U.S.C. § 1315(a) (commonly referred to as an "1115 Waiver" because 42 U.S.C. § 1315(a) is Section 1115 of the Social Security Act). The statute authorizes the Secretary to waive compliance with any requirement of 42 U.S.C. § 1396a, which enumerates required State Plan provisions. See 42 U.S.C. § 1315(a)(1). The statute also authorizes the Secretary to authorize federal payments for some or all of the costs of a demonstration project that would not otherwise be eligible for federal funding under the Medicaid Act. See 42 U.S.C. § 1315(a)(2)(A).

By letter dated April 24, 1995, CMS approved the Commonwealth's 1115 Waiver application. See Statement, ¶ 21; Waldman Aff., Ex. 3. The approval was subject to responses to certain questions posed by CMS, including a description of the behavioral health diversionary

services for which the Commonwealth's 1115 waiver application requested the Secretary to authorize federal funding. See Statement, ¶ 22; Waldman Aff., Ex. 2. Approval was also subject to certain special terms and conditions and CMS approval of a protocol that would describe more specifically the manner and method by which the Commonwealth would administer the Waiver as the "MassHealth Demonstration." See Statement, ¶ 23; Waldman Aff., Ex. 3 (attaching "Special Terms and Conditions"). The special terms and conditions specifically authorized federal funding for state expenditures for certain behavioral health services, including: acute residential treatment programs for substance abuse; acute residential treatment programs for children and adolescents (mental health); structured outpatient addiction programs; partial hospitalizations; family stabilization team services ("FST"); and community support programs ("CSP"). See Statement, ¶ 24; Waldman Aff., Ex. 3, at "Special Terms and Conditions" ¶ 48. According to CMS, federal funding is available for these services based exclusively on the authority of the 1115 Waiver. See Statement, ¶ 25; Waldman Aff., Ex. 7.

Under the Waiver, to permit Massachusetts to require eligible members to enroll in managed care, CMS *waived* certain provisions of 42 U.S.C. § 1396a, including the following pertinent provisions:

1. Statewideness/Uniformity – Section 1902(a)(1) – To enable the Commonwealth to provide managed care plans (or certain types of managed care plans) only in certain geographic areas of the Commonwealth.
2. Amount, Duration and Scope of Services – Section 1902(a)(10)(B) – To authorize the Commonwealth to offer different services based on different managed care arrangements or on the absence of managed care arrangements.
3. Freedom of Choice – Section 1902(a)(23) – To enable the Commonwealth to restrict freedom of choice of providers.

See Statement, ¶ 26; Waldman Aff., Ex. 3 at 1-3. The 1115 Waiver was approved for a five-year period beginning April 15, 1995, and ending April 30, 2001. See Statement, ¶ 27; Waldman

Aff., Ex. 3 at 1. In accordance with the provisions of 42 U.S.C. § 1315(e), Massachusetts applied for and received a three-year extension of the term of the 1115 Waiver. See Statement, ¶ 28; Waldman Aff., Ex. 5 at 1. The 1115 Waiver is now scheduled to expire on June 30, 2005. See Statement, ¶ 29; Waldman Aff., Ex. 5 at 1. Massachusetts is in the process of seeking an additional extension in accordance with the provisions of 42 U.S.C. §1315. See Statement, ¶ 30; Waldman Aff., ¶ L.

In addition to the 1115 Waiver authority, the federal Secretary has the authority to grant a waiver to permit states to offer an array of home and community based services that an individual may need to avoid institutionalization. However, the Commonwealth does not currently have a home and community based services waiver that includes a population such as the plaintiffs. See Statement, ¶ 32; Waldman Aff., ¶ M.

In accordance with the special terms and conditions and CMS' approval, the state developed a protocol document that describes the state's administration of the MassHealth Demonstration. See Statement, ¶ 33; Waldman Aff., Ex. 4. The original protocol document and all of its amendments have been approved by CMS. See Statement, ¶ 34; Waldman Aff., ¶ G. As described in applicable regulations, the Commonwealth offers MassHealth-eligible members a choice of managed care options. See Statement, ¶ 35; see also 130 C.M.R. § 450.117.[1] The state currently contracts with four managed care organizations that provide both medical and behavioral health services: BMC/HealthNet, Cambridge Health Alliance, Neighborhood Health Plan and Fallon Health Plan ("the MCOs"). See Statement, ¶ 3; Norton Aff., Ex. 1-4. Each of the four MCOs is under contract to perform case management activities and to provide behavioral health covered services. See Statement, ¶ 39; Norton Aff., Ex. 1 at Appendix C Ex. 2 (BMC/HealthNet), Ex. 2 at Appendix C Ex. 2 (Cambridge Health Alliance), Ex. 3 at Appendix C

[1] Members who are not eligible for managed care obtain services on a "fee for service" basis. See 130 CMR 508.004; see also Statement, ¶ 36. The vast majority of children obtain behavioral health services through a managed care provider. See Statement, ¶ 37; Affidavit of Michael Norton ("Norton Aff."), ¶ L.

Ex. 2 (Neighborhood Health Plan), Ex. 4 at Appendix C Ex. 2 (Fallon Health Plan). Each of the MCO contracts includes the following provisions concerning early and periodic screening, diagnostic and treatment services ("EPSDT Services"):

> The Contractor shall operate a proactive program to deliver well child screens in accordance with the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Medical Protocol and Periodicity Schedule as contained in 130 CMR 450.140 et seq. At a minimum such efforts shall include:
>
> a. education of, and outreach to, Enrollees regarding the importance of well child care;
> b. education of PCPs [primary care clinicians] regarding [MassHealth's] EPSDT requirements and for the delivery of well child care;
> c. coordination with school-based providers; and
> d. a process to measure and assure compliance with the EPSDT schedule.

See Statement, ¶ 40; Norton Aff. Ex. 1 at 86 (BMC/HealthNet), Ex. 2 at 81-82 (Cambridge Health Alliance), Ex. 3 at 75 (Neighborhood Health Plan), Ex. 4 at 70 (Fallon Health Plan).

Alternatively, as described in applicable regulations, the state allows MassHealth members to enroll in the state-managed Primary Care Clinician Plan ("the PCC Plan"). See Statement, ¶ 41; see also 130 C.M.R. § 450.117. Members who select the PCC Plan may select a primary care clinician ("PCC") from among the primary care clinicians who are approved by the state. See Statement, ¶ 42; see also 130 CMR 508.005. Similar to the MCO contracts, each PCC's contract includes the following provision concerning EPSDT Services:

> The PCC shall:
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> Inform all MassHealth Standard Enrollees under age 21 about the EPSDT program, including the benefits of preventative health care, the services available under the EPSDT program and where and how to obtain these services;
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> Inform all MassHealth Standard Enrollees under age 21 that services are available without cost, except as may be provided under federal law, and that necessary transportation and scheduling assistance is available upon request;
>
> Screen all Enrollees under age 21 and provide or refer such Enrollees to diagnosis and treatment services in accordance with the Division's EPSDT medical protocol and periodicity schedule;
>
> Ensure that all MassHealth Standard Enrollees under age 21 are provided or referred for all Medically Necessary care in accordance with EPSDT requirements.

See Statement, ¶ 43; Norton Aff. Ex. 5 at § 3.2.A (Second Amended and Restated Primary Care Clinician (PCC) Plan Provider Contract).

The state contracts with a specialty managed care provider, currently the Massachusetts Behavioral Health Partnership ("MBHP"), to arrange behavioral health services for both members who select the PCC Plan and children in the care or custody of the Commonwealth (the "Behavioral Health Carve-Out Provider" or "BH Carve-Out Provider"). See Statement, ¶ 44; Norton Aff. ¶ K and Ex. 6**.** The MCOs and the BH Carve-Out Provider are under contract to provide over forty-nine behavioral health covered services.[2] See Statement, ¶ 44; Norton Aff. ¶ M and Ex. 6 at App. C. As further discussed below, eligible MassHealth members under age 21 are not limited to these behavioral health services, but may request MassHealth coverage for any medically necessary service within the categories of "medical assistance" defined in the Medicaid Act. See Statement, ¶ 44; Norton Aff. ¶ E and Ex. 6.

In addition, the 1115 Waiver authorizes the state to administer the "Mental Health Services Program for Youth" pilot ("MHSPY"). See Statement, ¶ 46; Waldman Aff. Ex. 4 at § 3.2.2.2.4.3. The pilot, which originally operated only in Cambridge and Somerville but has since been expanded to several additional towns, is designed for children who are enrolled in MassHealth and receiving services from multiple state agencies.[3] See Statement, ¶ 47; Waldman Aff., Ex. 4 at § 3.2.2.2.4.3.1. The MHSPY pilot is a service delivery model that integrates multiple funding streams for children who have a combination of medical/behavioral health, educational and social service needs. See Statement, ¶ 50; Waldman Aff. Ex. 4 at §

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[2] The BH Carve-Out Provides a somewhat enhanced covered services package in order to provide services particularly needed by children in the custody of the Departments of Social Services and Youth Services. See Statement, ¶ 45; Norton Aff. ¶ F and Ex. 6 at App. A-1, §§ I(C)(4), I(D)(2)-(6).

[3] In 2003, MassHealth received federal approval to expand the MHSPY pilot and to administer a second pilot called Coordinated Family-Focused Care ("CFFC"). See Statement, ¶ 48. The BH Carve-Out Provider manages CFFC, which, like MHSPY, is also designed for children who are eligible for MassHealth Standard and are receiving services from multiple state agencies. See Statement, ¶ 49; Waldman Aff. Ex. 4 at § 3.2.2.2.4.4.6

3.2.2.2.4.3.1. The MHSPY pilot is intended to test the use of a traditional managed health care organization (currently, Neighborhood Health Plan) as a single point of entry for medical, behavioral health, social and family support services. See Statement, ¶ 51; Waldman Aff. Ex. 4 at § 3.2.2.2.4.3.1. Originally, MHSPY was funded from a combination of sources, including MassHealth, the Department of Social Services ("DSS"), the Department of Education, the Department of Mental Health ("DMH") and the Department of Youth Services. See Statement, ¶ 52; Waldman Aff., Ex. 4 at § 3.2.2.2.4.3.1. Currently, DSS and DMH are the other state payor agencies, in addition to MassHealth. See Statement, ¶ 53; Norton Aff. ¶ O.

Children who are enrolled in MHSPY have access to the same MassHealth covered behavioral health services as children who obtain behavioral health services through the BH Carve-Out Provider or an MCO (including other children who obtain services from NHP and are not enrolled in MHSPY). See Statement, ¶ 54; Waldman Aff., Ex. 4 at § 3.2.2.2.4.3.1. In addition to covered behavioral health services for children, families of children who enroll in MHSPY (whether or not such family members are MassHealth Members) may obtain a number of social support services including, for example, respite care, behavioral management intervention with the family, parent aides, and other parent support. See Statement, ¶ 55; Norton Aff. ¶ Q and Ex. 3 at App. C Ex. 10, §§ B(2), C(2)(b) through (e).

In addition to covered behavioral health services, children who enroll in MHSPY may receive camping, recreation and access to "flexible funds," which may be used to purchase such items as prom dresses and "Game Boys." See Statement, ¶ 56; Norton Aff. ¶ P and Ex. 3 at App. C Ex. 10, §§ C(4)(a) and (b), F(1).

D. The Federal Secretary's Ongoing Enforcement Authority

The Secretary has ongoing enforcement authority with respect to state Medicaid programs. If, after a State Plan is approved, the Secretary finds that (1) "the plan has been changed so that it no longer complies with the provisions of section 1396a of this title" or (2) "in the administration of the plan there is a failure to comply substantially with any such provision,"

the Secretary "shall notify [the state agency in charge of the plan] that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply." 42 U.S.C. § 1396c.

The Secretary also exercises specific oversight and enforcement with respect to managed care contracts. Contracts with managed care organizations over a specified dollar amount must be approved in advance by the appropriate regional office of CMS. See 42 C.F.R. § 438.806. Federal funds are not available to the state unless the CMS regional office determines that the contract is compliant with the provisions of 42 C.F.R. § 438; see also Statement, ¶ 63. Federal funds are available to the state for expenditures under an MCO contract only if the contract complies with the Medicaid Act's statutory and regulatory requirements and only if both the state and the MCO are in compliance with the contract and regulatory requirements. See 42 C.F.R. § 438.802, Statement ¶ 65. CMS has the authority to impose sanctions directly on MCOs and to make a referral to the federal Office of the Inspector General, who may impose additional civil money penalties. See 42 C.F.R § 438.730, Statement ¶ 66.

E. Plaintiffs' Substantive Allegations

The named plaintiffs include children all of whom allegedly have "intensive mental health needs." See Complaint, ¶ 9-17. Plaintiffs allege that each named plaintiff and the other class members would benefit from access to "medically necessary intensive home-based services." See Complaint, ¶ 66. Plaintiffs assert that although such "intensive home-based services" have proven successful in Cambridge and Somerville (where the MHPSY program operates), defendants have not developed intensive home-based services and have not established

procedures to reimburse and implement such services statewide. See Complaint, ¶ 129.[4] Plaintiffs allege that defendants are violating the following provisions of the federal Medicaid Act as a result: 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(r)(5) (collectively, the "*EPSDT medical assistance" provision*), 1396a(a)43 (the *"EPSDT program administration" provision*), 1396a(a)(8) (the "*reasonable promptness"* provision), 1396a(a)(30)(A) (the *"equal access" provision*) and 1396u-2(b)(5) (the "*managed care access" provision*). At a minimum, plaintiffs seek an order requiring defendants to "provide the intensive home-based services that the plaintiffs need and that they are entitled to receive in accordance with federal law," Complaint ¶ 5.

ARGUMENT

I. Federal Medicaid Law Does Not Require Statewide Expansion of an Experimental Service Delivery Model Operated Pursuant to a Medicaid Waiver.

One of plaintiffs' basic theories is that to satisfy the requirements of federal Medicaid law the MHSPY program must be expanded statewide. This theory is only hinted at in the Complaint, which asserts that the named plaintiffs require "medically necessary, intensive home-based services" (¶ 66) and that "intensive home-based services in Cambridge and Somerville" (where MHSPY operates) have "proven success and cost-effectiveness" (¶ 129). It is more explicit in plaintiffs' experts' disclosures. Barbara J. Burns, one of plaintiffs' experts, opines that MHSPY is "generally consistent with nationally accepted mental health treatment standards for home and community-based programs," offers "full access to mental health services within a single network, which is far superior to other service models," that "confidence in the impressive findings for MA-MHSPY is strong," but that MHPSY is "not available statewide" (Burns Disclosure, pp. 7, 9, 14, 17)[5]. Bruce Kamradt, another expert for the plaintiffs, asserts that

[4] Although plaintiffs do not reference MHSPY by name, paragraph 129 of the Complaint is an apparent reference to the MHSPY pilot.

[5] Copies of all plaintiffs' expert disclosures were filed with Docket No. 120 and are available in the Clerk's office.

"Families in Massachusetts are choosing to place and keep their children in institutional settings because they are not being offered an alternative that can provide the comprehensive, long-term services needed in their home and community," and that MHPSY "is an excellent home based services program" (Kamradt Disclosure, pp. 19, 18). Carl Valentine offers an analysis of the cost of statewide expansion of home and community based services derived almost entirely from MHSPY costs (Valentine Disclosure, pp. 3-7). Marty Beyer, another expert for plaintiffs, opines that MHSPY and another program, CFFC, are the only Medicaid-funded programs in Massachusetts that offer home-based services designed to meet a child's needs in his home and community, and that elsewhere in the state "programs that provide in-home services must be created" (Beyer Disclosure, p. 17).

As described above in this Memorandum, the MHSPY program is operated pursuant to a Medicaid waiver, specifically an 1115 Waiver granted by the federal Medicaid agency. In general, the purpose of Medicaid waivers is to authorize the federal Medicaid agency to waive certain Medicaid requirements for innovative or experimental state health care programs. Townsend v. Quasim, 328 F.3d 511, 514 (9th Cir. 2003); Bryson v. Shumway, 308 F.3d 79, 82 (1st Cir. 2002) ("The waiver program is designed to allow states to experiment with methods of care, or to provide care on a targeted basis, without adhering to the strict mandates of the Medicaid system.") The MHSPY pilot is intended to test the use of a traditional managed care health organization as a single point of entry for medical, behavioral health, social and family support services.

In granting the Commonwealth's 1115 Waiver application, the federal Medicaid agency waived a number of provisions of federal law that would otherwise apply to the Massachusetts Medicaid program (above pp. 5-6). Specifically, it waived the requirements of statewideness and uniformity, thereby enabling the Commonwealth to provide managed care plans in certain geographic areas of the Commonwealth. It waived requirements with respect to the amount, duration, and scope of services, authorizing the Commonwealth to offer different services based

on different managed care arrangements, or in the absence of managed care arrangements. And it also specifically authorized federal funding for state expenditures for certain behavioral health services for which federal funding would not otherwise be available. That fact was reemphasized in a letter from CMS to the Massachusetts Medicaid program just last month (Waldman Aff., Ex. I) ("While CMS supports the goals and objectives of the MHSPY pilot project, we are required to limit federal financial participation (FFP) to services listed in the Massachusetts Medicaid Plan (State Plan) or to services for which the State has expenditure authority through the 1115 Demonstration Waiver.")

MHSPY, in short, operates pursuant to a different set of rules than the Massachusetts Medicaid program generally. For that reason, plaintiffs' contention that the MHSPY delivery system is required to be replicated statewide in Massachusetts is fatally flawed. To the contrary, far from being required by federal law, MHSPY is able to operate because of a waiver of various Medicaid provisions. The recent CMS letter, identifying a variety of MHSPY services - expressly including "Home, School and Community-Based Services" -- as ineligible for federal financial participation makes this clear. The Medicaid Act cannot be a basis for compelling a state to adopt a delivery model that, by design, includes the provision of services not eligible for federal financial participation, and that would require amendment of the state's 1115 waiver in order for FFP to be claimed. Therefore, to the extent that plaintiffs seek to have this Court order expansion of MHSPY or a MHSPY-like program statewide, defendants are entitled to summary judgment.

II. Plaintiffs Lack a Private Cause of Action Under the Medicaid Act.

A. The Gonzaga Analysis: Only Unambiguously Created Rights Are Enforceable Under Section 1983

In Gonzaga, the Supreme Court reaffirmed the longstanding principle that, "'[i]n legislation enacted pursuant to the spending power, the typical remedy for state noncompliance with federally imposed conditions is not a private cause of action for noncompliance but rather

action by the Federal Government to terminate funds to the State.'" Gonzaga, 536 U.S. at 280 (quoting Pennhurst State Sch. & Hosp. v. Halderman, 451 U.S. 1, 28 (1981)) (emphasis added). Only in rare circumstances where Congress "speaks with a clear voice, and manifests an unambiguous intent to confer individual rights" may a court deviate from this general rule by allowing a private party to maintain an individual enforcement action under § 1983. Id. at 280, 283. ("We now reject the notion that our cases permit anything short of an unambiguously conferred right to support a cause of action brought under § 1983.") (emphasis added). The Court explicitly rejected the "confusion" that had "led some courts to interpret [its prior decisions in the private rights arena] as allowing plaintiffs to enforce a statute under § 1983 so long as the plaintiff falls within the general zone of interest that the statute is intended to protect."[6] Id. at 283. "[I]t is rights" – the Court stressed – "not the broader or vaguer 'benefits' or 'interests' that may be enforced under the authority of that section." Id. (emphasis in original).

Whether Gonzaga represents "a tidal shift or merely a shift in emphasis" in the private rights arena, it nevertheless has forced courts, including the First Circuit, to re-examine their prior decisions to ensure compliance with Gonzaga's heightened emphasis on "rights-creating language" and "individually focused terminology." Long Term Care Pharm. Alliance v. Ferguson, 362 F.3d 50, 57-59 (1st Cir. 2004). Indeed, in Long Term Care, the First Circuit implicitly reversed its prior decision in Visiting Nurse Ass'n of N. Shore, Inc. v. Bullen, 93 F.3d 997 (1st Cir. 1996), cert. denied, 519 U.S. 1114 (1997), on the ground that "[i]f Gonzaga had existed prior to Bullen, the panel could not have come to the same result" with respect to the

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[6] In Blessing v. Freestone, 520 U.S. 329, 340-41 (1997), the Court formulated a three-part test to determine whether a private right of action exists. The statute must (1) be intended by Congress to benefit the plaintiff, (2) not be "vague and amorphous," and (3) impose an unambiguous "binding obligation on the States." Id. While not explicitly abandoning this test, the Court in Gonzaga clarified that nothing "short of an unambiguously conferred right [can] support a cause of action brought under § 1983." Gonzaga, 536 U.S. at 283.

existence of a private right under the Medicaid Act's equal access provision. Id. This is because, in the post-Gonzaga universe, a private right of action cannot be recognized where the "text and structure of a statute provide no indication that Congress intend[ed] to create new individual rights . . . ."[7] Gonzaga, 536 U.S. at 286. Similarly, where the "text and structure of a statute" are unclear or indefinite as to whether Congress intended to create such rights, "that means that Congress has not spoken with the requisite 'clear voice.'" 31 Foster Children v. Bush, 329 F.3d 1255, 1270 (11th Cir.), cert. denied, 540 U.S. 984 (2003). "Ambiguity precludes enforceable rights." Id. Plaintiffs bear the burden of establishing that the statute at issue confers an "individual right" enforceable by § 1983, and to identify that right with particularity. Id. at 284; Blessing v. Freestone, 520 U.S. 329, at 342 (1997) (it is "incumbent" upon plaintiffs claiming a "right" under a particular statute to articulate "well-defined claims"); see also Frison v. Zebro, 339 F.3d 994, 999 (8th Cir. 2003) ("The plaintiff bears the burden to demonstrate that the statute at issue confers a federal right on the plaintiff.").

In Gonzaga, the Court found that the "text and structure" of the Family Educational Rights and Privacy Act ("FERPA") foreclosed a private right of action under Section 1983 for alleged violation of that statute's nondisclosure provisions.[8] Significantly, the Court contrasted

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[7] Moreover, it is settled that the statutory text is the sole source from which a private right may be derived. See Bonano v. East Caribbean Airline Corp., No. 03-1843, 2004 U.S. App. LEXIS 7984, at *8 (1st Cir. Apr. 22, 2004). Although a regulation may "define" or "flesh out" the meaning of statutorily-created rights, it cannot alone "create individual rights enforceable through § 1983." Save Our Valley v. Sound Transit, 335 F.3d 932, 935-36 (9th Cir. 2003); Rolland v. Romney, 318 F.3d 42, 52 (1st Cir. 2003) ("a regulation 'may invoke a private right of action that Congress through statutory text created, but it may not create a right that Congress has not'") (quoting Alexander v. Sandoval, 532 U.S. 275, 291 (2001)). As the Supreme Court stated, "[a]gencies may play the sorcerer's apprentice but not the sorcerer himself." Sandoval, 532 U.S. at 291.

[8] The relevant FERPA language provided: "No funds shall be made available under any applicable program to any educational agency or institution which has a policy or practice of permitting the release of educational records (or personally identifiable information contained

the "individually focused," "rights-creating" language of Title VI of the Civil Rights Act of 1964 and Title IX of the Education Amendments of 1972 ("no person shall be subject to discrimination") with FERPA's general provisions directed to the Secretary of Education ("No funds shall be made available" to any "educational agency or institution" that has a prohibited "policy or practice"). See Gonzaga, 536 U.S. at 287. The Court found that the focus of FERPA's nondisclosure provisions was the Secretary's duty to withhold funds in the event of noncompliance – not the "interests of individual students and parents." Id. at 287; see also Alexander v. Sandoval, 532 U.S. 275, 289 (2001) ("Statutes that focus on the person regulated rather than the individuals protected create no implication of an intent to confer rights on a particular class of persons."). Plaintiffs, therefore, were "two steps removed" from any right enforceable under Section 1983.

In addition to focusing on the Secretary's obligation to withhold funds, the Court held that another reason why FERPA's nondisclosure provisions did not create a federal right was that they "[spoke] only in terms of institutional policy and practice, not individual instances of disclosure." Id. at 288. The provisions, therefore, had an aggregate focus, instead of a concern for "whether the needs of any particular person ha[d] been satisfied." Id. Also significant was the fact that institutions could "avoid termination of funding so long as they 'compl[ied] substantially' with the Act's requirements." Id. (emphasis added). Compliance in every individual case was thus not required. See id. This language was reminiscent of the Court's earlier holding in Blessing, where the Court found no basis for a private right under Title IV-D of the Social Security Act, which "required states receiving federal child-welfare funds to 'substantially comply' with requirements designed to ensure timely payment of child support." Gonzaga, 536 U.S. at 281 (citing Blessing, 520 U.S. at 343). "'Far from creating an *individual* entitlement to services, [the substantially comply] standard is simply a yardstick for the Secretary

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therein. . . .) of students without the written consent of the parents to any individual, agency, or organization." 20 U.S.C. § 1232g(b)(1).

to measure the *systemwide* performance of a State's [child welfare] program.'" Id. (quoting Blessing, 520 U.S. at 343). Statutes that focus on the "'aggregate services provided by the state,' rather than 'the needs of any particular person,'" accordingly confer no individual rights and cannot be enforced under Section 1983. Id. at 282 (quoting Blessing, 520 U.S. at 340).

Last, the Court deemed it significant that Congress "expressly authorized the Secretary of Education to "deal with violations' . . . and to 'establish or designate a review board'" for investigating and adjudicating violations of the Act. Gonzaga at 289. Without considering whether this enforcement mechanism was sufficiently comprehensive to independently foreclose a private right of action, see id. at 284-85, n.4, the Court held that its existence nevertheless "buttressed" the conclusion that no private right existed because the statute provided a means whereby "aggrieved individuals" could obtain "federal review." Id. at 289-90 & n.8. Moreover, as Justice Breyer explained in his concurring opinion, "much of the statute's key substantive language is broad and nonspecific," id. at 292 (Breyer, J., joined by Souter, J., concurring in the judgment), thereby suggesting that "exclusive agency enforcement might fit the scheme better than a plethora of private actions threatening disparate outcomes." Long Term Care, 362 F.3d at 58 (citing Justice Breyer's concurring opinion).

B. The Text and Structure of the Medicaid Act Do Not Unambiguously Confer Private Rights

Naturally, the Medicaid Act benefits those individuals who are eligible to receive medical assistance under a participating state's plan. The Gonzaga standard, however, requires more than a mere showing that the Act may benefit an individual to support a cause of action under Section 1983: it requires a showing that Congress unambiguously intended the Medicaid Act to confer privately enforceable rights on individual Medicaid recipients. See id. at 280, 283. Nothing in the text or structure of the Medicaid Act as a whole or, more particularly, in the specific statutory provisions on which plaintiffs rely, establishes any such unambiguous intent to create new private rights. See FDA v. Brown & Williamson Tobacco Corp., 529 U.S. 120, 132-33 (2000)

(courts must interpret a single statutory provision in relation to, and in harmony with, the text and purpose of the statute as a whole).

1. *No Individually Focused, Rights-Creating Language*

Like the FERPA provisions that the Court examined in Gonzaga, the Medicaid Act (at least, as relevant here) does not contain the sort of "individually focused," "rights-creating" language that is "critical to showing the requisite congressional intent to create new rights." Gonzaga, 536 U.S. at 280; contrast Rolland v. Romney, 318 F.3d 42, 44, 46, 53, n.10 (1st Cir. 2003) (post-Gonzaga, finding private right of action under the Nursing Home Reform Amendments ("NHRA") to the Medicaid Act, 42 U.S.C. § 1396r, because those amendments conferred "specific enumerated rights" on nursing home residents).[9] Rather, the Act consists of a series of directives to the federal government (to appropriate funds for the program), to the Secretary (to approve State Plans and enforce the provisions of the Act), and to the state agencies charged with designing and administering a State Plan. See 42 U.S.C. §§ 1396, 1396a, 1396c. These directives are not a proper source from which to infer private rights because, like the FERPA provisions at issue in Gonzaga, they speak only in terms of regulating the conduct of government officials and controlling the expenditure of federal funds. See Gonzaga, 536 U.S. at 287 (citing Sandoval, 532 U.S. at 289). Medicaid recipients (like the students and parents in Gonzaga) are therefore at least "two steps" removed from this statutory focus.

[9] Section 1396r(c) of the NHRA expressly states that a "nursing facility must protect and promote the rights of each resident," including the "right to choose a personal attending physician," the "right to be free from physical or mental abuse," the "right to privacy with regard to accommodations, medical treatment," the "right to confidentiality of personal and clinical records," and the "right to reside and receive services with reasonable accommodation of individual needs and preferences." 42 U.S.C. § 1396r(c)(1)(A)(i)-(v). Given this literal "laundry list of rights" extended to nursing home residents, the First Circuit did not hesitate in finding a privately enforceable right of action under § 1983. See Rolland, 318 F.3d at 53, n.10. No similarly express "rights-creating" language is at issue here.

2. *Aggregate, Not Individual, Focus*

In contrast to the sort of "individually focused terminology" that the Court held would demonstrate an unambiguous congressional intent to create "new individual rights," the enabling section of the Medicaid Act establishes that its purpose is to enable "each State, as far as practicable under the conditions in each State, to furnish" medical assistance to eligible needy persons. 42 U.S.C. § 1396 (emphasis added). Subsequent sections of the Act spell out in great detail the requirements for approval of a State Plan.[10] See 42 U.S.C. § 1396a. These are matters of administrative "policy and practice," not matters of individual rights. See Gonzaga, 536 U.S. at 288. Additionally, when a state's compliance with the Act is in question, the focus of the Secretary's inquiry is on the plan or administration of the plan, not on individual instances of noncompliance. See 42 U.S.C. § 1396(c)(1)-(2) ("If the Secretary . . . finds that the plan has been changed so that it no longer complies . . . or that in the administration of the plan there is a failure to comply. . . .") (emphasis added). And, even then, compliance in every individual case is not required; rather, the statute requires only that a state's plan and the state's administration of its plan "comply substantially" with the requirements of the Medicaid Act. See 42 U.S.C. § 1396c(2). As the Court in Gonzaga stated, "'[f]ar from creating any individual entitlement to services, the [comply substantially] standard is simply a yardstick for the Secretary to measure systemwide performance of [the state] program.'" Gonzaga, 536 U.S. at 281 (quoting Blessing, 520 U.S. at 343) (emphasis in original). The Medicaid Act therefore has an "aggregate" focus, concerned with addressing the overall administration of a public spending program, as opposed to addressing the particular needs of individual recipients. See id. at 288; see also Alexander v.

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[10] Defendants do not contend that the provisions at issue here are unenforceable simply because they are included in a section requiring or specifying the contents of a State Plan. See 42 U.S.C. § 1320a-2 (precluding such reliance); Rabin v. Wilson-Coker, 362 F.3d 190, 202 (2nd Cir. 2004) (rejecting argument that no private right existed where argument was based solely on the fact that provision was included in plan requirements section). Rather, defendants contend that the provisions at issue here are unenforceable for all of the other reasons detailed above and relied on by the Supreme Court in Gonzaga. See Harris v. James, 127 F.3d 993, 1002-03 (11th Cir. 1997) (discussing the limited applicability of § 1320a-2 and recognizing similar distinction).

Choate, 469 U.S. 287, 303 (1985) (". . . Medicaid programs do not guarantee that each recipient will receive that level of health care precisely tailored to his or her particular needs. Instead, the benefit provided through Medicaid is a particular package of health care services, such as [coverage for dental services]").

3. *Multiple Enforcement Mechanisms*

The conclusion that Congress did not intend to create new private rights under the Medicaid Act is further bolstered by the mechanisms it chose to provide for its enforcement. See Gonzaga, 536 U.S. at 289; Long Term Care, 362 F.3d at 58 ("the presence of an explicit enforcement mechanism weighs against inferring private rights of action"). Initially, of course, the Secretary can enforce compliance with Medicaid conditions by withholding approval of a State Plan. See Long Term Care, 362 F.3d at 56 (citing 42 C.F.R. § 430.15); see also 42 U.S.C. § 1316(a). After a State Plan has been approved, the Secretary maintains enforcement authority and is expressly empowered to cut off or reduce funding to any state whose plan "no longer complies with the provisions of § 1396a" or whose "administration of the plan" fails to "comply substantially with any such provision." 42 U.S.C. § 1396c (emphasis added); see also Long Term Care, 362 F.3d at 56 and 58 (noting that the Medicaid Act "decidedly is not a situation lacking an outside watchdog"). Significantly, the Secretary may restore such funding only when he or she is "satisfied that there will no longer be any such failure to comply." 42 U.S.C. § 1396c. By its own language, the Medicaid Act establishes that "plan review by the Secretary is the central means of enforcement intended by Congress." Long Term Care, 362 F.3d at 58. In addition, the Medicaid Act requires the Secretary to monitor strictly all aspects of managed care contracting and managed care contract compliance, to withhold funds from states and impose sanctions on non-compliant MCOs. See 42 C.F.R. § 438; see also Walsh, 538 U.S. at 675 (". . . the remedy for a State's failure to comply with the obligations it has agreed to undertake under the Medicaid Act . . . is set forth in the act itself: termination of funding by the Secretary. . . .") (Scalia, J., concurring); id. at 679-80 (Thomas, J., concurring).

Because Congress chose to provide a centralized enforcement mechanism to ensure State Plan compliance, compliance with waivers of such State Plan requirements and compliance with managed care requirements, it is "implausible to presume" that Congress intended challenges to a state's administration of its Medicaid plan, 1115 Waiver administration or managed care contracts to be subject to "a plethora of private actions threatening disparate outcomes." Gonzaga, 536 U.S. at 290 and 292 (Breyer, J., concurring). Indeed, broad-based challenges of the sort brought here "essentially invite[] the District Court to oversee every aspect" of the state Medicaid program and, thereby, intrude impermissibly upon the authority that Congress has vested in the Secretary to police State Plan compliance with the Medicaid Act. See Blessing, 520 U.S. at 341 (holding that a request by plaintiffs for a "broad injunction requiring the director of Arizona's child support agency to achieve 'substantial compliance'" with Title IV-D requirements and "[a]ttributing the deficiencies in the state's program to staff shortages and other structural defects" inappropriately "invited the District Court to oversee every aspect of" the state program). Thus, where a group of persons (like plaintiffs here) claim that the state has failed to administer its plan in conformity with the conditions imposed by the Medicaid Act, they "must seek enforcement of the Medicaid conditions" through the authority conferred on the Secretary under § 1396c(1)-(2) – "and may seek and obtain relief in the [federal] courts only when the denial of enforcement is 'arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.'" Walsh, 538 U.S. at 675 (Scalia, J., concurring, emphasis added) (quoting 5 U.S.C. § 706(2)(A)).

Congressional intent to foreclose private rights of action challenging a state's administration and management of its Medicaid plan is further demonstrated by the review mechanism that Congress provided for challenges to individual plan decisions. See Gonzaga,

536 U.S. at 289-90 (distinguishing Wright v. City of Roanoke Redev. & Hous. Auth., 479 U.S. 418 (1987) and Wilder v. Virginia Hosp. Ass'n., 496 U.S. 498 (1990) on the ground that aggrieved individuals there "lacked any federal review mechanism" at all to ensure program compliance).[11] Section 1396a(a)(3) expressly requires all participating states to provide a means whereby Medicaid recipients may obtain administrative review of a state's denial of or failure to act with "reasonable promptness" upon any individual request for medical assistance. See 42 U.S.C. § 1396a(a)(3) (fair hearing plan requirement). Massachusetts has such an administrative review procedure, see 130 C.M.R. § 610.032 (listing the multiple grounds upon which a fair hearing may be requested under the MassHealth plan, which include adverse determinations made by MCOs); and, any individual who is "dissatisfied with the final decision of the hearing officer" in such a proceeding may obtain judicial review of that decision pursuant to the Massachusetts Administrative Procedures Act. See 130 C.M.R. § 610.092. Although these administrative procedures may not be sufficiently comprehensive to independently preclude private enforcement under § 1983 in and of themselves, see Wilder, 496 U.S. at 521, the fact that Congress included them in the Medicaid Act nevertheless "further counsel[s] against . . . finding a congressional intent to create individually enforceable private rights." Gonzaga, 536 U.S. at 290 and n.8; see also Cannon v. University of Chicago, 441 U.S.677, 707 n.41 (1979) (noting

[11] The fact that Congress chose to rely on state – not federal – administrative review procedures for challenges to individual Medicaid plan decisions is not surprising given the joint federal-state nature of the Medicaid program. Nor is this a legitimate basis upon which to distinguish the result reached in Gonzaga (which, of course, did not involve such a joint federal-state program). As Gonzaga makes clear, the critical consideration in determining whether a private right should be implied is not whether the review is state or federal, but whether it provides an adequate mechanism pursuant to which an aggrieved individual may obtain relief. See Gonzaga, 536 U.S. at 280 and 290 (distinguishing those situations where a private right of action was found because the statutory scheme provided no meaningful opportunity for administrative review); Cannon v. University of Chicago, 441 U.S. 677, 707 n.41 (1979) (same).

that the Court has declined to imply private rights where "administrative or like remedies are expressly available" under the statute).

A review of the relief sought by the plaintiffs reveals that the plaintiffs are, in essence, seeking nothing less than the wholesale transformation of the state's Medicaid system as it relates to children with mental or behavioral health issues. Among other things, plaintiffs are seeking to have this Court issue an injunction to "establish and implement policies, procedures, and practices for screening and evaluating the plaintiffs and members of the plaintiff class to determine whether intensive home-based services are medically necessary to treat or ameliorate their behavioral, emotional, or psychiatric conditions." Complaint, Ad damnum clause, para. 2; Plaintiffs' response to Defendants' First Set of Interrogatories, Response to Interrogatory No. 18 (among the specific decisions plaintiffs challenge are those "to limit the duration, intensity, and capacity of FST and CSP"; "not to substantially expand MHSPY"; "to limit CFFC to six locations"; "not to include intensive home-based services, behavioral specialists, community therapeutic activities and after school support services in the Medicaid State Plan or Rehabilitation Plan or waiver"; "not to invest in intensive home-based services and to instead invest in costly in-patient hospitalization, and residential programs"; and "not to continue pre-filing settlement discussions on the *design and structure of a statewide home-based services model*.") In sum, there can be no question that this is a challenge to the Commonwealth's administration and management of its Medicaid plan; as such, no private right of action is available.

C. Two of the Particular Medicaid Provisions on which Plaintiffs Rely Do Not Unambiguously Confer Private Rights

The conclusion that Congress did not unambiguously create private rights under the Medicaid Act is further confirmed by analysis of the text and structure of two of the particular provisions on which plaintiffs rely. Each provision is addressed in turn.

1. *Equal Access – §1396a(a)(30) (Complaint Count III)*

The First Circuit recently held, in an action brought by a group of Medicaid service providers, that the equal access provision provides no private right of enforcement under Section 1983. See Long Term Care, 362 F.3d at 57-59. The analysis applied by the First Circuit in Long Term Care is controlling here.[12] As the Court there noted, the equal access provision has "no 'rights-creating language' and identifies no discrete class of beneficiaries – two touchstones in Gonzaga's analysis . . . and of those earlier cases on which Gonzaga chose to build." Id. at 57. "The provision focuses instead upon the state as 'the person regulated rather than individuals protected . . . , suggesting no 'intent to confer rights on a particular class of persons,' or at least not providers." Id. (internal citations omitted). Indeed, "read literally" the equal access provision does not make its criteria (avoiding overuse, efficiency, quality of care, and geographic

[12] District court cases from other circuits have reached different conclusions, but the reasoning in these decisions is flawed. For example, in Memisovski v. Maram, No. 92 C 1982, 2004 WL 1878332, at * 5-7 (N.D. Ill. Aug. 23, 2004), the court relied on 42 U.S.C. § 1320a-2 in concluding that the Medicaid Act's equal access provision conferred a private right of action. Section 1320a-2 provides in pertinent part: "[a provision] is not deemed unenforceable because of its inclusion in a section of this chapter requiring a State plan . . ." Based on this statute, the court reasoned that a provision elaborating on what a State Plan must include cannot be deemed enforceable. However, this reasoning ignores a significant threshold issue: the provision must still create an unambiguous private right in the first place. Section 1320a-2 merely provides that an *otherwise* enforceable right shall not be deemed unenforceable merely because it appears in a statute mandating that participating states include a particular provision in their State Plans. See id. at *6 (citing Messier v. Southbury Training Sch., 916 F. Supp. 133, 144 (D. Conn. 1996) ("[T]he fairest reading of Section 1320a-2 is that Congress was concerned only that a court should not eviscerate an otherwise enforceable right merely because it appears in a statute mandating that participating states include a particular provision in their state plans.")). The court's secondary argument based solely on Section 1396a(30)(A) and its legislative history entailed similarly flawed reasoning. The court argued (in the negative) that Section 1396a(30)(A) "is not phrased in indirect terms" and had it been, "that might suggest that no single beneficiary is entitled to quality care or equal access." Id. at *6 (internal quotation marks omitted). The court also argued that the absence of language in legislative history specifically prohibiting Medicaid recipients from filing private actions indicates that Congress did not intend to foreclose these types of suits. These types of argument in the negative fall far short of the Gonzaga requirement that a statute create an *unambiguous* private right. See also Clark v. Richman, 339 F. Supp.2d 631, 639-40 (M.D. Pa. 2004) (adopting arguments set forth in Memisovski and holding that Section 1936a(30)(A) grants private right of action).

equality) "directly applicable to individual state decisions; rather state plans are to provide 'methods and procedures' to achieve these general ends." Id. at 58. The statute, therefore, has an aggregate or systemwide focus, not an individual focus. See id. Moreover, the "generality of the goals and the structure for implementing them suggests that plan review by the Secretary is the central means of enforcement intended by Congress." Id. For all of these reasons, the Court declined to follow a number of circuit court decisions issued prior to Gonzaga that reached the opposite conclusion and effectively overruled its prior (contrary) decision in Bullen. See id. at 58-59 & n.5.

Plaintiffs likely will contend that Long Term Care is not controlling here because they are a group of Medicaid recipients, not providers. Although the First Circuit arguably left some room for making this sort of distinction (since the "rights" of Medicaid recipients were not at issue there), see Long Term Care, 362 F.3d at 57; the distinction does not withstand scrutiny for the same reasons identified above. Indeed, at least one district court in Massachusetts has expressly rejected just such a distinction. See Health Care for All v. Romney, No. 00-10833-RWZ, slip op. (D. Mass. Oct. 1, 2004) (copy attached) (Following Long Term Care, holding MassHealth members have no private right of enforcement of equal access provision in lawsuit concerning EPSDT dental services) (see also Sanchez v. Johnson, 301 F. Supp.2d 1060, 1063-64 (N.D. Cal. 2004) (post-Gonzaga, Medicaid recipients have no private right of enforcement under equal access provision); Sanders ex rel. Rayl v. Kansas Dep't of Soc. & Rehabilitative Servs., 317 F. Supp.2d 1233, n.5 (D. Kan. 2004) (same conclusion, in dicta).[13] In Sanchez, the district

[13] In an earlier decision, another district court from the same circuit as the Sanchez Court held that the economy and efficiency criteria of the equal access provision were aimed at benefiting the state, and thus did not confer any private right on Medicaid providers or recipients. See Clayworth v. Bonta, 295 F. Supp.2d 1110, 1122 (E.D. Cal. 2003). The Clayworth Court proceeded to hold, however, that the quality care and equal access criteria of the same provision

court concluded that "[w]hile § 30(A) benefits both recipients and providers of [Medicaid] services, the language of the statute does not clearly confer an enforceable right on either." Id. at 1063. Instead, "Section 30(A) has an aggregate focus[,]" reflecting a Congressional intent to set forth the "State's obligation to develop 'methods and procedures' of providing medical services." Id. at 1064. As such, it does "not reflect a congressional intent to create a private right of action." Id.

Moreover, even prior to Gonzaga, courts observed that the equal access provision was primarily "directed at prohibiting the payment of insufficient reimbursement rates to providers." Sobky v. Smoley, 855 F. Supp. at 1138 (emphasis added); see also Long Term Care, 362 F.3d at 57 (noting that "some traces of legislative history suggest that Congress assumed or favored the ability of providers to get relief for inadequate payment rates," but nevertheless finding no private right for providers to sue for such rates under Section 1396a(a)(30)(A)). While increased reimbursement rates for providers of Medicaid services may indirectly benefit the recipients of such services by (theoretically) encouraging more providers to participate in the State Plan, Medicaid recipients, like the parents and students in Gonzaga, are at least "two steps removed" from this goal. See Gonzaga, 536 U.S. at 287. Indeed, Medicaid recipients are even more removed than the providers themselves, whom the First Circuit explicitly held have no private right of enforcement under this provision. See Long Term Care, 362 F.3d at 59.

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did confer a private right on Medicaid recipients (but not providers), despite the court's acknowledgment that, "as to [recipients], the language of Section 30A is not the paragon of rights-creating language." See also Association of Residential Resources v. Minnesota Comm'r of Human Resources, No. 03-2438, 2003 U.S. Dist. LEXIS 15056, at **24-25 (D. Minn. Aug. 29, 2003) (holding, in connection with ruling on preliminary injunction and relying on Eighth Circuit precedent issued prior to Gonzaga, that the equal access provision created a private right enforceable by Medicaid providers and recipients). The Clayworth Court's analysis cannot be squared with Gonzaga's unambiguous rights requirement or the First Circuit's holding in Long Term Care. Nor is there any basis under settled rules of statutory construction for the Clayworth Court's unusual parsing of Section 30A's text, which appears to have impermissibly isolated selected portions of the text from its surrounding language. See Bath Iron Works Corp. v. Director, Office of Workers' Compensation Progs., U.S. Dep't of Labor, 136 F.3d 34, 44 (1st Cir. 1998) ("we must read statutes as a whole, rather than focus on isolated phrases").

2. *Managed Care Access Provision – §1396u-2(b)(5) (Complaint Count IV)*

Applying the analysis articulated in Gonzaga and Long Term Care, the *managed care access provision* provides no private right of enforcement under Section 1983. As is true of the *equal access provision,* the *managed care access provision* has no "rights creating language" and identifies no discrete class of beneficiaries; the language focuses on the entities to be regulated – the managed care organization and the state – suggesting "no intent to confer rights on a particular class of persons." See, e.g., Long Term Care, 362 F.3d at 59 (internal citations omitted). The provision requires states to obtain from any managed care organization with which they contract, "assurances" that the MCO has the "capacity" to serve "expected enrollment." It requires that the MCO offer an "appropriate range of services" and "access" for the "population expected to be enrolled," and, using language similar to that found in Section 1396a(a)(30)(A), that the MCO maintains a "sufficient number, mix and geographic distribution of providers of services." This language has an aggregate or a system wide focus, not an individual one. See id. Moreover, the generality of the goals and the structure for implementing them – which includes direct reporting from the MCOs to the state and review by the Secretary of Health and Human Services – strongly suggest that Secretary is the means of enforcement intended by Congress. This is particularly true where CMS prior approves MCO contracts, where federal funding is directly linked to substantial compliance with this provision and where CMS has authority to directly impose civil penalties on MCOs and refer MCOs to the Office of the Inspector General for noncompliance with the provision. Where the text of the *managed care access* provision demonstrates that the provision focuses on the entity to be regulated – the state and the managed care organization – the goals of the provision are system wide, and not focused on establishing an individual right, and where the Secretary maintains multiple and specific enforcement mechanisms, there is no private enforcement of the provision and defendants are entitled to summary judgment as a matter of law.

III. The Managed Care Access Provision, §1396u-2(b)(5), Is Inapplicable.

The Balanced Budget Act of 1997 (the "BBA") explicitly exempts Massachusetts, and other states with 1115 Waivers, from provisions within the managed care statute that were covered under the state's 1115 Waiver, thus "grandfathering" the approved Waiver notwithstanding the BBA. As discussed below, Massachusetts' 1115 Waiver is grandfathered with respect to the provisions of 1396u-2(b)(5), which is the basis for Count IV of the Complaint.

Section 1396u-2 was passed as part of a major piece of Medicaid reform legislation contained within the BBA. Prior to the passage of the BBA, states could not require Medicaid enrollees to enroll in managed care without obtaining a waiver from CMS of a number of applicable provisions of Section 1396a(a) of the Act (e.g., 42 U.S.C. §1396a(a)(1) – statewideness; §1396a(a)(10)(B) – amount, duration, scope of services; § 1396a(a)(23) – freedom of choice). The BBA allows states to require Medicaid enrollees to enroll in managed care subject to the provisions of § 1396u-2 and other applicable statutory and regulatory provisions not relevant here. See 42 U.S.C. § 1396u-2.

When Congress enacted the BBA, it was mindful of the disruption that changes in the managed care rules could have on the 1115 research and demonstration waivers then in effect in number of states, including Massachusetts. The BBA explicitly exempts states with 1115 Waivers from provisions within the managed care statute that were covered under the state's 1115 Waiver, thus "grandfathering" the approved Waiver notwithstanding the BBA. Section 4710(c) of the BBA (the grandfathering provision) establishes that:

> Nothing in this [managed care] chapter shall be construed as affecting the terms and conditions of any waiver, or the authority of the Secretary of Health and Human Services with respect to any such waiver, under section 1115 . . . of the Social Security Act.

42 U.S.C. § 1396u-2.

The grandfathering provision clearly reflects the congressional intent that states be free to operate under the terms of the 1115 Waiver – once approved – notwithstanding the provisions of the BBA statute and regulations. In addition to the grandfathering provision itself, Congress included in the BBA an amendment to the 1115 Waiver statute specifically to provide for continuation of an approved waiver through a streamlined waiver extension process. See 42 U.S.C. §1315(e). CMS recognizes the grandfathering provision applies to the regulations it promulgated to implement the BBA and, as a result, the terms of the Waiver are to take precedence over those regulations. See 67 Fed. Reg. at 40993-40994 and 41072-41073 (discussing the BBA grandfathering provision).

Massachusetts' 1115 Waiver was in effect at the time the BBA was passed and remains in effect until June 30, 2005, pursuant to an extension the state obtained under 42 U.S.C. § 1315(e)(6). See Statement, ¶ 28; Waldman Aff., Ex. 5 at 1. In accordance with the "grandfathering" provisions of the BBA, CMS reviewed the MassHealth 1115 Waiver to determine the effect of the BBA on it. See Waldman Aff., Ex. 5. By letter dated October 10, 2003, CMS determined that a number of the regulations would have a "potential impact on the current terms and conditions of the MassHealth 1115 Demonstration Waiver" and that the state "was exempt from those regulations through the end of June 30, 2005." Id. The letter goes on to state:

> In conducting this review, we ensured that the provisions are specifically addressed in the state's waivers, special terms and conditions, operational protocol, or other official state policy or procedure approved by CMS.

The statute at issue here, § 1396u-2(b)(5), and implementing regulations 42 C.F.R. § 438.200-438.242, were among the provisions CMS identified as inapplicable based on the grandfathering provisions of the BBA. See id. at 4.

Since the BBA currently grandfathers the Commonwealth's waiver provisions, Massachusetts is not subject to the provisions of 42 U.S.C. § 1396u-2(b)(5) and plaintiffs cannot rely on those provisions to support a claim against the state defendants. As a result, defendants are entitled to summary judgment as a matter of law on Count IV of the Complaint.

CONCLUSION

For all of the foregoing reasons, defendants' motion for summary judgment should be granted.

Respectfully submitted,

THOMAS F. REILLY
ATTORNEY GENERAL

Attorney for Defendants

/s/ Deirdre Roney

Deirdre Roney, BBO No. 652886
Adam Simms, BBO No. 632617
John R. Hitt, BBO No. 567235
Assistant Attorneys General
Government Bureau
One Ashburton Place – Room 2019
Boston, MA 02108
(617) 727-2200 Ext. 2093, 2052

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