UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

HEALTH CARE FOR ALL, INC., *et al.*, **Plaintiffs,** **v.** **GOVERNOR MITT ROMNEY, *et al.*,** **Defendants.**	**CIVIL ACTION** **NO. 00-CV-10833-RWZ**

MEMORANDUM OF REASONS IN SUPPORT OF DEFENDANT STATE OFFICIALS' MOTION FOR SUMMARY JUDGMENT

Plaintiffs bring this action on behalf of themselves and others similarly situated to remedy what they perceive to be a systematic failure by the defendant state officials to properly administer the Commonwealth's Medicaid dental program, commonly known as MassHealth. Plaintiffs, who are comprised of a group of individual Medicaid recipients and an advocacy group, seek "nothing less than the complete overhaul" of the MassHealth dental program, including, but not limited to, an injunction requiring the state officials to "increase[e] dental reimbursement rates" so as to attract more service providers and thereby make dental services more accessible to eligible recipients, "improve administration of the MassHealth dental program, and otherwise bring the statewide dental program into compliance with applicable law." (2nd Am. Compl. at p.27, ¶ 4; Mem. Supp. 2nd Mot. for Class Cert. at 9).

Since the Medicaid Act itself does not authorize private causes of action, plaintiffs rely on 42 U.S.C. § 1983, which provides a vehicle for the enforcement of federal statutory rights. A recent Supreme Court decision makes clear, however, that to maintain an action under § 1983 plaintiffs must demonstrate that Congress, in enacting the Medicaid Act pursuant to its spending powers, spoke with the requisite "clear voice," manifesting its "unambiguous" intent to "create

new individual rights" subject to private enforcement. Gonzaga Univ. v. Doe, 536 U.S. 273, 280, 286 (2002). As detailed below, the text and structure of the Medicaid Act reveal no such unambiguous intent. The Act and the particular provisions on which plaintiffs rely contain no rights-creating language, have an aggregate - not individual – focus, and serve primarily to direct the Secretary of Health and Human Service's distribution of federal funds to states, like Massachusetts, that elect to participate in the Medicaid program. While individuals, like plaintiffs here, benefit from the financial assistance provided under a state Medicaid plan, § 1983 provides a vehicle only for the enforcement of unambiguously created rights, not "the broader or vaguer benefits or interests" that a federal statute may confer. Id. at 283. Accordingly, the state officials' motion for summary judgment should be allowed since, as a matter of law, plaintiffs have no privately enforceable rights under the subject Medicaid provisions. Alternatively, assuming that any such unambiguous right existed, plaintiffs' claims nevertheless fail on the merits because -- in attempting to impose substantive obligations on the state officials that Congress never intended -- they stretch the statutory language beyond its clear meaning.

I. STATEMENT OF UNDISPUTED MATERIAL 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 America 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, as far as practicable under the conditions in such 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 do accept federal funding must comply with the Act and with regulations promulgated by the Secretary of Health and Human Services ("the Secretary"). Most fundamentally, each participating state must devise and implement a plan for medical assistance that is approved by the Secretary. 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 categories of persons eligible to receive assistance and the specific types of care and services covered by the plan. 42 U.S.C. § 1396a(a)(10), (17). Broadly speaking, a state plan must provide coverage for persons who are "categorically needy" and, at the state's option, also may provide coverage for persons who are "medically needy."[1] 42 U.S.C. § 1396a(a)(10). In addition, a state plan must provide "medical assistance" for seven mandatory types of care and services. 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 id. The Act defines the term "medical assistance" as the "payment of part or all of the cost of [certain enumerated] care and services. . . ." 42 U.S.C. § 1396d(a). As relevant here, medical assistance for dental care and services is mandatory for eligible individuals under the age of 21, but optional for individuals age 21 and over. 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(4)(B), 1396d(r)(3).

To be approved by the Secretary, a state plan also must (among other things) meet the following additional conditions imposed by 42 U.S.C. § 1396a(a) –

> (1) provide that it shall be in effect in all political subdivisions of the State [*the "statewide" provision*]. . .

[1]The "categorically needy" group includes those persons who lack sufficient income to meet their basic needs. See Walsh, 538 U.S. at 651, n.4 (citing 42 U.S.C. § 1396a(a)(10)(A)(i))). The "medically needy" group includes those persons who have resources to meet most of their basic needs, but not their medical needs. Id. at n.5 citing 42 U.S.C. § 1396a(10)(C)).

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness [*the "fair hearing" provision*] . . .

(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 . . . (B) that the medical assistance made available to any [categorically needy] individual . . .

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals [who are not categorically needy] [*the "comparability" provision*] . . .

(30) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title) 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" provision*]

42 U.S.C. § 1396a(a)(1), (3), (8), (10)(B), (30)(A), (43).

Subsection 1396d(r), in turn, states that EPSDT "means the following items and services," including, in relevant part, dental services –

> (A) which are provided --
> (i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and
> (ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and
> (B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.

42 U.S.C. § 1396d(r)(3). Section 1396d(r) further provides that the "Secretary shall . . . develop and set annual participation goals for each State for participation of individuals who are covered under the State plan . . . in [EPSDT] services." 42 U.S.C. § 1396d(r) (last paragraph). Each state is required to include in the annual report submitted pursuant to § 1396a(a)(43)(D) that "State's results in attaining the participation goals" set by the Secretary for that particular state. 42 U.S.C. § 1396a(a)(43)(D)(iv).

C. The Secretary's Ongoing Enforcement Authority

If, after a 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 (emphasis added). Until the Secretary is so satisfied, "he shall make no further payments to such State. . . ." Id.

D. The Massachusetts Medicaid Plan

Massachusetts participates in the Medicaid program (referred to in Massachusetts as MassHealth), and its dental plan is applied consistently in all parts of the state. See 2nd Am.

Comp. at ¶ 34; 130 C.M.R. § 420.400 et seq. Regardless of where an individual recipient lives, MassHealth provides medical assistance or coverage for dental care and services to all eligible individuals under age 21. See 2nd Am. Comp. at ¶ 31. Prior to March 2002, MassHealth provided optional coverage for a broad range of adult dental care and services. Id. As a result of fiscal constraints, MassHealth reduced the scope of its optional coverage for adult dental care and services in March 2002 and again in January 2003. Id. At present, only those adults who meet the criteria for "special circumstances" continue to be eligible for a broader range of optional dental coverage.[2] Id. In addition, MassHealth provides transportation for eligible recipients. 130 C.M.R. § 407.400 et seq.

In accordance with 42 U.S.C. § 1396a(a)(3), Massachusetts has established a fair hearing procedure, 130 C.M.R. §§ 610.000-610.093, whereby "any individual whose claim for medical assistance . . . is denied or is not acted upon with reasonable promptness" may obtain administrative review. See 130 C.M.R. § 610.032 (listing the multiple grounds upon which administrative review may be sought). An 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 state Administrative Procedures Act, G.L. c. 30A. 130 C.M.R. § 610.092.

E. Plaintiffs' Substantive Allegations

Based largely on their personal experiences in obtaining dental treatment, see 2nd Am. Compl. at ¶¶ 36-80, plaintiffs allege that the MassHealth dental program "is not operated uniformly in all areas of the state" because there is a shortage of participating dentists in certain geographic regions of the state, and eligible persons in these areas have to travel to Boston for dental services. Id. at ¶¶ 82, 84. This shortage of participating dental providers allegedly has resulted in delays in obtaining dental treatment and unequal access among eligible recipients to

[2]Special circumstances exist where an individual has a "severe, chronic disability" that is likely to continue indefinitely and result in the individual being unable to maintain oral hygiene, or a "clinical condition (such as human immunodeficiency virus or cancer) that has advanced to a stage where an infection resulting from oral disease would likely be life-threatening." 130 C.M.R. § 420.410(D).

dental services. Id. at ¶¶ 82, 88. Plaintiffs further allege that the state officials' administration of the MassHealth dental program discourages dentists from participating in the program by requiring them, among other things, to comply with "complex claims processing" and prior authorization requirements. Id. at ¶ 89. In addition, despite past increases, plaintiffs allege that the reimbursement rates that MassHealth currently pays for dental services nevertheless are "well below the levels needed to enlist sufficient numbers of providers." Id. at ¶ 93. Based on the foregoing allegations, plaintiffs charge that the state officials are violating the statewide, reasonable promptness, comparability, and equal access provisions of the Medicaid Act. Id. at ¶¶ 99-104, 107 (Counts I-III, V).[3] Additionally, plaintiffs contend that the state officials are not undertaking sufficient "outreach" efforts to inform eligible children of the availability of EPSDT services and are not providing eligible children with "adequate dental screening and treatment" in accordance with the Act's EPSDT provisions. Id. at ¶¶ 83, 109-112 (Counts VI-VII).

II. ARGUMENT

A. 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 and 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

[3]Plaintiffs have voluntarily withdrawn Count IV of the Complaint, recognizing (but not conceding) that no private right exists under that provision of the Medicaid Act. See Joint Pre-trial Mem. at 23.

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."[4] 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." See id. at 287; 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's Ass'n of N. Shore, Inc. v. Bullen, 93 F.3d 997 (1st Cir. 1996), 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 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. . . ."[5] Gonzaga,

[4] 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.

[5] Moreover, it is settled that the statutory text is the sole source from which a private right may be derived. 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

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 1268, 1270 (11th Cir.), cert. denied, __ U.S. __, 124 S. Ct. 483 (2003). "Ambiguity precludes enforceable rights." Id. (citing Gonzaga, 536 U.S. at 280). 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, 520 U.S. at 342 (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.").

B. **The Gonzaga Analysis**

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 § 1983 for alleged violation of that statute's nondisclosure provisions.[6] Most importantly, the Court contrasted 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"). 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

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stated, "[a]gencies may play the sorcerer's apprentice but not the sorcerer himself." Sandoval, 532 U.S. at 291.

[6]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 education records (or personally identifiable information contained therein . . .) of students without the written consent of the parents to any individual, agency, or organization." 20 U.S.C. § 1232g(b)(1).

noncompliance -- not the "interests of individual students and parents." Id. at 287. See also Sandoval, 532 U.S. at 289 ("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 § 1983. Gonzaga, 536 U.S. at 287.

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. 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 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 § 1983. Id. at 282 (quoting Blessing, 520 U.S. at 340).

Lastly, 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. Id. 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 and 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).

C. 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 is intended to benefit a putative plaintiff to support a cause of action under § 1983. See Gonzaga, 536 U.S. at 283. Instead, the standard requires a showing that Congress unambiguously intended the Medicaid Act to confer privately enforceable rights on individual Medicaid recipients like plaintiffs. 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, 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, 318 F.3d at 44, 46, 53, n.10 (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).[7] 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. See id. But see Bryson v. Shumway, 308 F.3d 79, 88-89 (1st Cir. 2002) (discussed more fully below and finding, post-Gonzaga, a private right of action under the reasonable promptness provision).

2. Aggregate, Not Individual, Focus

Moreover, 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.[8] 42 U.S.C. § 1396a. These are matters

[7]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.

[8]The state officials 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

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. 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. 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

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(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, the state officials 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).

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. 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); 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. The Medicaid Act, therefore, itself demonstrates that "plan review by the Secretary is the central means of enforcement intended by Congress." Long Term Care, 362 F.3d at 58. 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 with the conditions imposed on Medicaid funding (i.e., through the Secretary), it is "implausible to presume" that Congress intended challenges to a state's administration of its Medicaid plan 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. Roanoke Redev. & Hous. Auth., 479 U.S. 418 (1987) and Wilder v. Virginia Hosp. Assn., 496 U.S. 498 (1990) on the ground that aggrieved individuals there "lacked any federal review mechanism" at all to ensure program compliance).[9] Section 1396a(a)(3) expressly requires all participating states to provide a means whereby Medicaid recipients may obtain administrative review of a state plan's denial of or failure to act with "reasonable promptness" upon any individual request for medical assistance. See 42 U.S.C.

[9]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).

§ 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); 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, 441 U.S. at 707 n.41 (noting that the Court has declined to imply private rights where "administrative or like remedies are expressly available" under the statute).

D. 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 the particular provisions on which plaintiffs rely. Each provision is addressed in turn.

1. Equal Access – Section 1396a(a)(30)

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 § 1983. Long Term Care, 362 F.3d at 57-59. The analysis applied by the First Circuit in Long Term Care is controlling here. 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 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. Id. at 58-59 and 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 has expressly rejected just such a distinction for substantially the same reasons identified by the First Circuit in Long Term Care. See 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).[10] In

[10]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. 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 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

Sanchez, the district 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. 1123, 1138 (E.D. Cal. 1994) (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 § 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. 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. Long Term Care, 362 F.3d at 59.

Alternatively, even if a private right existed under the equal access provision, it does not encompass the sort of claim alleged here, which is premised on plaintiffs' perception that

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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 § 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 Programs, 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").

MassHealth reimbursement rates are not high enough to attract a sufficient number of dental providers, particularly in certain regions of the state. See 2nd Am. Compl. at ¶ 93. As noted above, the equal access provision is directed at providing sufficient reimbursement rates for providers, not to claims (such as plaintiffs' here) "regarding the inadequate amount or distribution of services available [to Medicaid recipients]." Sobky, 855 F. Supp. at 1138. Nor -- again contrary to plaintiffs' claims here -- does the equal access provision require a state to adopt reimbursement rates at "levels high enough to induce [dentists] to relocate to [allegedly underserved parts of the state]. Id. (quoting H.R. Rep. 447, 101st Cong., 1st Sess. 1989)).

2. Statewide – Section 1396a(a)(1)

Section 1396a(a)(1) provides that "[a] State plan for medical assistance must . . . be in effect in all political subdivisions of the state. . . ." 42 U.S.C. § 1396a(a)(1). On its face, this provision makes no reference at all to any specific right vested in any individual Medicaid recipient. See Masterman v. Goodno, No. 03-2939, 2004 U.S. Dist. LEXIS 354, at *31 (D. Minn. Jan. 8, 2004) (§ 1396a(a)(1) lacks the "unmistakably rights creating language" that Gonzaga demands and declining to follow contrary decision in Sobky, 855 F. Supp. at 1134, which was decided without benefit of Gonzaga's "clarification"). Rather, it is a provision directed at the administration of the state plan as a condition for the approval and continued receipt of federal funding. Id. Furthermore, by directing that the state plan be "in effect in all political subdivisions of the state," § 1396a(a)(1) clearly has an aggregate or systemwide focus, not an individual focus like the statutory provision at issue in Rolland. Cf. Rolland, 318 F.3d at 44, 46, 53, n.10. Moreover, even prior to Gonzaga (or, at least, without any direct reliance on Gonzaga) several courts determined that this provision and its accompanying regulation, 42 C.F.R. § 431.50, are "too vague to provide a basis for judicial enforcement." Martin v. Taft, 222 F. Supp.2d 940, 976-77 (S.D. Ohio 2002) (citing Boatman v. Hammons, 164 F.3d 286, 292 (6th

Cir. 1998)). But see Antrican v. Buel, 158 F. Supp.2d 663, 670 (E.D.N.C. 2001) (pre-Gonzaga decision, finding private right under § 1396a(a)(1)), aff'd, 290 F.3d 178 (4th Cir. 2002); Sobky, 855 F. Supp. at 1134 (although recognizing that § 1396a(a)(1) makes "no direct reference to Medicaid recipients," concluding pre-Gonzaga that recipients are the "obvious beneficiaries" of the statewide provision).

Alternatively, even if an enforceable private right existed under the statewide provision, it is not a right as broad as that invoked by plaintiffs here. Plaintiffs erroneously contend that the provision requires that access to dental services be uniformly available in all geographic regions of the state. See 2nd Am. Compl. at ¶¶ 84-85, 99. However, nothing in the plain language of § 1396a(a)(1) requires that "every Medicaid recipient in [the state] . . . be equidistant with every other from every facility that rendered services for which such a recipient might be eligible." Bruggeman v. Blagojevich, 324 F.3d 906, 909-11 (7th Cir. 2003). Rather, the provision "requires merely that the state not exclude any of its political subdivisions from the state's Medicaid plan." Id. at 911. The phrase "shall be in effect in all political subdivisions of the state," therefore, "doesn't mean that, as implemented, the plan has to assure identical convenience of service everywhere in the state." Id. This interpretation is consistent with the provision's accompanying regulations, which likewise require that a state plan provide statewide access to its offices for eligibility determinations and other administrative processes.[11] 42 C.F.R. § 431.50(b).

[11]The Supreme Court, in fact, rejected an argument similar to plaintiffs here in Suter v. Artist M., 503 U.S. 347 (1992). In Suter, the plaintiffs relied on the analogous statewide provision in Title IV-D, 42 U.S.C. § 671(a)(3) ("In order for a State to be eligible for payments under this part, it shall have a plan approved by the Secretary which . . . provides that the plan shall be in effect in all political subdivisions of the State. . . ."), to argue that the state had a substantive obligation to make "reasonable efforts" required elsewhere in the statute; if such efforts were not make, the argument went, the plan would not be "in effect." The Court rejected this argument: "[W]e think that 'in effect' is directed to the requirement that the plan apply to all political subdivisions of the State, and is not intended to otherwise modify the word 'plan.'" Suter, 503 U.S. at 359. Thus, contrary to plaintiffs' attempt here, the statewide provision's "in effect" language cannot be used "as a bootstrap for enforcing requirements imposed on [state] plans by other statutory provisions." Harris, 127 F.3d at 1011, n.27.

As applied here, it is undisputed that the MassHealth dental program is in operation in all parts of the state, and that its eligibility and coverage provisions are applied consistently throughout the state. See 130 C.M.R. § 420.400 et seq. Thus, even if a private right existed (which it does not), plaintiffs cannot prevail on their statewide claim. See Graus v. Kaladjian, 2 F. Supp.2d 540, 544 (S.D.N.Y 1998) (allowing summary judgment in favor of state defendants "because plaintiffs have not come forward with any admissible evidence that the state plan is not statewide and is not mandatory for all of the political subdivisions that administer it"); Concourse Rehabilitation & Nursing Ctr., Inc. v. Wing, 150 F.3d 185, 188-89 (2nd Cir. 1998) (assuming arguendo that a private right exists under the statewide provision and interpreting it as requiring "only that a State plan must provide that it is of statewide scope and that, when political subdivisions are called upon to administer the plan, they do not substitute their substantive regulations for those of the state plan"). Contrast Clark v. Kizer, 758 F. Supp. 572, 580 (E.D. Cal. 1990) (statewide provision violated where state plan denied access to covered services based on the recipient's county of residence – a scenario not alleged here), aff'd in part, vacated in part, Clark v. Coye, 967 F.2d 585 (9th Cir. 1992).

3. Reasonable Promptness – Section 1396a(a)(8)

Section 1396a(a)(8) provides that "[a] State plan for medical assistance must . . . 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." 42 U.S.C. § 1396a(a)(8). A corresponding provision and regulation provide that the responsible state agency must, among other things," "[f]urnish Medicaid promptly to recipients without any delay caused by the agency's administrative procedures," and "[c]ontinue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible." 42 C.F.R. § 450.930(a)-(b); 42 U.S.C. § 1396a(a)(3). Another regulation states that "[t]he agency must establish time standards for determining eligibility and inform the applicant

of what they are." 42 C.F.R. § 435.911(a). These periods are not to exceed "[n]inety days for applicants who apply for Medicaid on the basis of a disability" or "[f]orty-five days for all other applicants." 42 C.F.R. § 435.911(a)(1)-(2). Moreover, the agency "must not use time standards" as a "waiting period." 42 C.F.R. § 435.911(e)(1).

Several courts, including the First Circuit, have held – post-Gonzaga -- that the reasonable promptness provision creates a private right enforceable under § 1983.[12] See Bryson, 308 F.3d at 88-89 (citing Gonzaga in passing, but holding that reasonable promptness provision creates private right because "it benefits 'eligible individuals'" and is not too vague to be enforced);[13] Mendez v. Brown, No. 03-30160, 2004 U.S. Dist. LEXIS 5127, at **14-15

[12]Courts in this circuit reached this conclusion pre-Gonzaga. See, e.g., Rancourt v. Concannon, 175 F. Supp.2d 60, 61-62 (D. Me. 2001) (pre-Gonzaga, holding that private right existed under reasonable promptness provision), Boulet v. Cellucci, 107 F. Supp.2d 61, 72 (D. Mass. 2000) (same); Rolland v. Cellucci, 52 F. Supp.2d 231, 239 (D. Mass. 1999) (same). Significantly, in concluding that a private right existed under the reasonable promptness provision, the district courts in Rancourt, Boulet, and Rolland relied, to varying degrees, on Bullen – a decision that the First Circuit recently held cannot be reconciled with Gonzaga. Long Term Care, 362 F.3d at 59.

Courts in other jurisdictions likewise reached the same conclusion prior to or without any reliance on Gonzaga. See, e.g., Doe v. Chiles, 136 F.3d 709, 715 (11th Cir. 1998) (pre-Gonzaga, finding private right of action under reasonable promptness provision because, among other things, the provision is phrased in terms of benefiting Medicaid eligible individuals); Rabin v. Wilson-Coker, 266 F. Supp.2d 332, 342 (D. Conn. 2003) (finding a private cause of action under reasonable promptness provision, but doing so without reference to Gonzaga), rev'd on other grounds, 362 F.3d 190 (2nd Cir. 2004); White v. Martin, No. 02-4154, 2002 U.S. Dist. LEXIS 27281, at *15 (W.D. Mo. Oct. 3, 2002) (finding private right under reasonable promptness provision but without reference to Gonzaga and based almost exclusively on the fact that several other courts had reached this conclusion pre-Gonzaga); Alexander v. Novello, 210 F.R.D. 27, 35 (E.D.N.Y. 2002) (same); Sobky, 855 F. Supp. at 1146-47 (pre-Gonzaga finding private right under reasonable promptness provision); Antrican, 158 F. Supp.2d at 670-71 (relying on Chiles to find that private right, despite concern that phrase "reasonable promptness" might be "so vague and amorphous as to be unenforceable"). Like Bullen, the decisions in these cases are of little weight in the post-Gonzaga private rights universe. See Long Term Care, 362 F.3d at 59.

[13]Although Bryson remains binding precedent in this circuit, its analysis of whether a private right exists does not comport with the rigorous standard demanded by the Court in Gonzaga. See M.A.C. v. Betit, 284 F. Supp.2d 1298, 1307-08 (D. Utah 2003) (rejecting Bryson's "superficial" analysis of "Gonzaga's categorical requirement that a statute contain rights-creating language"). It is also telling that the First Circuit in its recent decision in Long

(D. Mass. Mar. 26, 2004) (Magistrate Judge Neiman holding, in an unpublished decision, that the reasonable promptness provision conferred a private right on "all eligible individuals"); see also Sabree v. Richman, No. 03-1226, 2004 U.S. App. LEXIS 9180, at *2 (3rd Cir. May 11, 2004) (holding post-Gonzaga that reasonable promptness provision provides a private cause of action); but see Betit, 284 F. Supp. 2d at 1307-08 (holding that there is no clearly stated private right under the reasonable promptness provision). The circumstances presented in Bryson, Mendez and Sabree, however, are markedly different from those presented here. In each of those cases, plaintiffs were a discrete class of Medicaid recipients who were denied (or placed on a waiting list to receive) medical assistance for specific services to which they were entitled under the subject state plan. See Bryson, 308 F.2d at 81 (plaintiffs, a group of Medicaid eligible disabled persons, challenged the State of New Hampshire's failure to fill available slots for placement in a model home care treatment program based, in relevant part, on the contention that the State's use of a waiting list for such placements denied these individuals their right to obtain medical assistance with "reasonable promptness"); Sabree, No. 03-1226, 2004 U.S. App. LEXIS 9180, at *2 (plaintiffs, a class of mentally retarded adults, were undisputedly entitled to medical assistance for placement in an intermediate care facility, but the state failed to provide such assistance); Mendez, No. 03-30160, 2004 U.S. Dist. LEXIS 5127, at **14-15 (plaintiffs, a discrete group of clinically obese women, were denied medical assistance for a specific medical procedure - breast reduction surgery). Here, in contrast, plaintiffs' asserted "right" to reasonable promptness is nowhere near as definite as the claims at issue in Bryson, Sabree or Mendez. See Blessing, 520 U.S. at342 ("[i]t was incumbent upon [plaintiffs] to identify with particularity the

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Term Care, where the Court held that there was no unambiguous private right of action for providers under the equal access provision, did not even cite Bryson as authority. See Long Term Care, 362 F.3d at 58. At best, therefore, Bryson should be interpreted as being confined to its particular facts.

rights they claimed, since it is impossible to determine whether [the statute], as an undifferentiated whole, gives rise to undefined 'rights.'").

Plaintiffs' complaint, in fact, is not directed at the state officials' denial or failure to act on any individual request for medical assistance, but rather is an across-the-board assault on the state officials' administration of the entire MassHealth dental program. Essentially, plaintiffs seek to use the reasonable promptness provision as a means for obtaining system-wide reform of the MassHealth dental program. To allow such a complaint to proceed would improperly "transform[] § 1983 from a vehicle to vindicate personal rights into a *qui tam* mechanism" to prosecute perceived violations of federal law. See Sabree, 2004 U.S. App. LEXIS 9180, at *18 (citing Blessing, 520 U.S. at 340). This is fundamentally contrary to the Court's holding in Gonzaga and prior cases. See Gonzaga, 536 U.S. at 282 ("'To seek redress through § 1983 . . . a plaintiff must assert the violation of a federal right, not merely the violation of federal law.'") (quoting Blessing, 520 U.S. at 340) (emphasis added). It also is contrary to Congress's demonstrated intent to vest the Secretary – not private individuals -- with systematic oversight of state Medicaid plan compliance. 42 U.S.C. § 1396c; Supra at section C(3).

Alternatively, even assuming that a private right existed under the circumstances presented here, plaintiffs nevertheless overstate that right by contending that it requires the state to provide dental services with reasonable promptness. See 2nd Am. Compl. at ¶¶ 86-88. The statute and corresponding regulations make clear that what is required is that the state provide "medical assistance" - meaning the payment for services - with reasonable promptness, not the actual medical or dental services themselves. See 42 U.S.C. §§ 1396a(a)(8) and 1396d(a) (defining "medical assistance" as the "payment of part or all of the cost" of obtaining care and services); see also Bruggeman, 324 F.3d at 910 ("the statutory reference to 'assistance' appears to have reference to *financial* assistance rather than to actual medical *services*," although noting that this "distinction was missed" in Bryson and Chiles). Medicaid is after all "a payment

scheme, not a scheme for state-provided medical assistance as through state owned hospitals." Id. Thus, what is required under the reasonable promptness provision "is a prompt determination of eligibility and prompt provision of funds to eligible individuals to enable them to obtain the covered medical services that they need" – not the direct provision of medical services. Id. (citing 42 C.F.R. §§ 435.911(a), .930(a)-(b)). But see Sobky, 865 F. Supp. at 1147 (holding that reasonable promptness provision extends to services as well as eligibility determinations).

Accordingly, plaintiffs' claims under the reasonable promptness provision (which are premised on the perception that the lack of participating dentists, particularly in some parts of the State, has resulted in delays in obtaining dental services) fail as a matter of law. See Bruggeman, 324 F.3d at 910 (reasonable promptness provision "is not infringed by the maldistribution (as it seems to the plaintiffs) of [treatment services] across the state). But see Kizer, 758 F. Supp. at 580 (granting summary judgment on reasonable promptness claim where undisputed declarations of state officials established that plaintiffs "frequently experience delays in obtaining appointments for regular and emergency dental care with those providers participating in [state plan]"). Moreover, even assuming that the reasonable promptness provision extended to the provision of dental services (i.e., not just coverage for such services), the Act explicitly provides a remedy – which has not been invoked by plaintiffs here -- for a state plan's alleged failure to provide such services with "reasonable promptness." 42 U.S.C. § 1396a(a)(3) (the fair hearing provision). As in Gonzaga and Long Term Care, the existence of this individual administrative enforcement mechanism further counsels against the recognition of a new private right of action under § 1983. See Gonzaga, 536 U.S. at 289; Long Term Care, 362 F.3d at 58.

4. Comparability – Section 1396a(a)(10)(B)

Section 1396a(a)(10)(B) requires that "[a] State plan for medical assistance must . . . provide" that the medical assistance made available to one recipient is not "less in amount, duration, or scope than the medical assistance made available to" other recipients. Kizer, 758 F.

Supp. at 580; see also Rodriguez v. City of New York, 197 F.3d 611, 615 (2nd Cir. 1999) (the comparability provision requires that "if a state elects to provide Medicaid to the medically needy, it must also provide it to the categorically needy and that it may not provide more assistance to the former group than to the latter"), cert. denied, 531 U.S. 864 (2000). Although this provision does speak in terms of "individual" Medicaid recipients, it contains none of the other specific rights-creating language identified by the Court in Gonzaga or Rolland. Cf. Gonzaga, 536 U.S. at 690; Rolland, 318 F.3d at 53. A statute does not create new enforceable rights merely because it refers generally to individuals or even because (as is not the case here) it "speaks in terms of 'rights.'" Gonzaga, 536 U.S. at 289, n.7 (quoting Pennhurst, 451 U.S. at 18-20). The statute instead must unambiguously demonstrate that Congress intended to create such rights. Id. at 280. Here, Congress did not speak with the requisite "clear voice." Id. It is equally plausible that Congress intended the comparability provision to impose a procedural requirement on a State's administration of a Medicaid plan as it is that Congress intended to create new enforceable rights in a "particular class" of Medicaid recipients. See id. at 287-88; 31 Foster Children, 329 F.3d at 1272 (statutory references to individual children made in the context of describing procedure for establishing case review system for foster care placement failed to confer private rights enforceable by § 1983). Ambiguity of this sort precludes the recognition of private rights of action. 31 Foster Children, 329 F.3d at 1270 (citing Gonzaga, 536 U.S. at 280). But see Mendez, 2004 U.S. Dist. LEXIS 5127, at **14-15.[14]

Alternatively, even if such an unambiguous private right existed, the comparability provision applies only where a state plan provides medical assistance to some recipients, but not others. Rodriquez, 197 F.3d at 616. Plaintiffs here contend that the state officials'

[14]Although courts have held – either pre-Gonzaga or without reference to Gonzaga – that the comparability provision creates a private right, the decisions reached in those cases do not withstand Gonzaga's emphasis on unambiguously conferred statutory rights. See, e.g., Martin, 222 F.Supp.2d at 977 (without reference to Gonzaga, concluding that § 1396a(a)(10)(B) creates a private right enforceable under § 1983); Antrican, 158 F. Supp.2d at 671 (same result pre-Gonzaga); Sobky, 855 F. Supp. at 1134 (same); Rolland, 52 F. Supp.2d at 239 (same).

administration of the MassHealth dental plan violates the comparability provision because the plan does not ensure uniform access to dental services in all regions of the state. See 2nd Am. Compl. at ¶¶ 84-88, 103. Uniform access to covered services, however, is not what the comparability provision requires of a state plan. See Bruggeman, 324 F.3d at 911 (finding "even less plausible" the plaintiffs contention under the comparability provision that "lack of uniform proximity to medical facilities constitutes discrimination among Medicaid recipients"). Instead, the provision is intended to ensure that if a state plan provides "medical assistance" or coverage for a particular type of service or treatment, it provides the same coverage to all other eligible Medicaid recipients. There is no contention here that the coverage provided under the MassHealth dental plan varies among different eligibility categories of Medicaid recipients under age 21. To the contrary, the applicable regulations establish that the same dental coverage is provided under the MassHealth dental plan to all eligible Medicaid recipients under age 21. See 130 C.M.R. § 420.400 et seq.

5. EPSDT – Sections 1396a(a)(43), 1396d(a)(4)(B), 1396d(r)(3)

Among the mandatory types of care and services for which a state plan must provide "medical assistance" are EPSDT services as defined in 42 U.S.C. § 1396d(r) for eligible individuals under age 21. 42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4)(B). Section 1396d(r)(3) defines EPSDT dental services, in relevant part, as those services that are provided "at intervals which meet reasonable standards of dental practice. . . ." 42 U.S.C. § 1396d(r)(3). In addition, a state plan must provide for "informing all persons in the State" who are under 21 and "have been determined to be eligible for medical assistance" of the "availability" of EPSDT services and for "providing or arranging for the provision of such screening services" upon request. 42 U.S.C. § 1396a(a)(43)(A)-(B). Plaintiffs here contend that the MassHealth dental plan fails to provide EPSDT services with the frequency required by § 1396d(r)(3)'s reasonableness standard, and

Section 1396a(a)(43) likewise has a broad programmatic focus by providing that "all persons in the state" who are under 21 and eligible receive information about EPSDT services. The accompanying EPDST regulations further demonstrate that the goal of this provision is to regulate the State's administration of the EPSDT program, not to confer "specific, individually enforceable rights" on a particular class of persons. See Gonzaga, 536 U.S. at 281; 42 C.F.R. § 441.56(a)(1)-(2) (state agency must "[p]rovide for a combination of written and oral methods designed to inform effectively all EPSDT eligible individuals . . . about the EPDST program" by "using clear and nontechnical language" describing the "benefits of preventive health care," the "services available under the EPSDT program[,] and where and how to obtain those services").

The statutory text therefore reveals that the focus of both EPDST provisions is on the state "'as the person regulated rather than the individuals protected.'" Long Term Care, 362 F.3d at 57 (quoting Sandoval, 532 U.S. at 289). This regulatory focus is not a source from which privately enforceable rights may be derived. Gonzaga, 536 U.S. at 287. Although one district court – in a decision issued post-Gonzaga -- has reached the opposite conclusion, see Kenny A v. Perdue, 218 F.R.D. 277, 293 (N.D. Ga. 2003) (Medicaid recipients have private right of enforcement under EPSDT provisions), the court's analysis in that case failed to give due weight to the Supreme Court's command that nothing "short of an unambiguously conferred right [can] support a cause of action brought under § 1983."[15] Gonzaga, 536 U.S. at 283. Indeed, contrary to the Court's admonition that interests or benefits alone are not sufficient to create new federal

[15]Pre-Gonzaga, several other courts likewise concluded that the EPSDT provisions created a private right, but those decisions are of limited value since they did not address whether the statute contained the required clear and unambiguous rights-creating language that Gonzaga demands. See, e.g., Pediatric Specialty Care v. Arkansas Dep't of Human Servs., 293 F.3d 472, 478 (8th Cir. 2002) (in a pre-Gonzaga decision, the State of Arkansas conceded that Medicaid recipients were "intended beneficiaries" of EPSDT provisions); Westside Mothers v. Haveman, 289 F.3d 852, 863 (6th Cir. 2002) (holding -- pre-Gonzaga and without substantive analysis -- that 42 U.S.C. § 1396a(a)(10)(A) was "clearly intended to benefit the putative plaintiffs, children who are eligible for the screening and treatment services" and that 42 U.S.C. § 1396d(r) is "not so vague and amorphous as to defeat judicial enforcement"); Antrican, 158 F. Supp.2d at 672 (holding pre-Gonzaga that since EPSDT provisions were "intended to benefit plaintiffs" they created a private right enforceable under § 1983).

rights, the court in Kenny A. relied almost exclusively on its assessment that eligible children under 21 are the "intended beneficiaries" of the EPSDT provisions, without identifying any sort of "rights-creating language" such as that relied on by the First Circuit in Rolland. Compare Kenny A., 218 F.R.D. at 294 with Rolland, 318 F.3d at 53. The Court in Kenny A. also incorrectly observed that "there is no enforcement mechanism through which an aggrieved individual can obtain review." Id. at 294. As noted in subsection C(3) above, there are several enforcement options available under the Medicaid Act that further counsel against the recognition of new private rights under the subject EPSDT provisions. See Long Term Care, 362 F.3d at 56, 58.

III. CONCLUSION

For all of the foregoing reasons, the state officials' motion for summary judgment should be allowed, and judgment should enter in their favor on all counts of plaintiffs' complaint.

Respectfully submitted,

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CERTIFICATE OF SERVICE
I hereby certify that a true copy of the above document was served upon the attorney of record for each other party by mail-hand on 6-1-04