UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

HEALTH CARE FOR ALL, INC., et al. Plaintiffs, v. MITT ROMNEY, et al., Defendants.	C.A. No. 00CV-10833RWZ PLAINTIFFS' OPPOSITION TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

Four years of litigation has exposed the widespread failures of the MassHealth dental program. Now, on the eve of trial, the defendants charge that the plaintiffs have no private right of action to enforce *any* of their claims under 42 U.S.C. § 1983. Yet courts have long recognized that section 1983 provides Medicaid beneficiaries a private right of action for violations of the Medicaid Act, 42 U.S.C. §1396 *et seq*. The asserted legal basis for Defendants' Motion for Summary Judgment is primarily their interpretation of two cases, *Gonzaga University v. Doe*, 536 U.S. 273 (2002), and *Long Term Care Pharmacy Alliance v. Ferguson*, 362 F. 3d 50 (1st Cir. 2004). Neither case, properly read, supports granting summary judgment for defendants on all counts of Plaintiffs' Second Amended Complaint ("Complaint"). This court should exercise its discretion to deny defendants' motion in its entirety and let the case proceed to trial as scheduled.

I. STATEMENT OF FACTS

Defendants style their motion as one for summary judgment. However, the court should treat the motion as seeking judgment on the pleadings under Fed. R. Civ. P. 12(c). *See, e.g., Williams v. Cessna Aircraft Corp.*, 376 F. Supp. 603, 605 (N.D. Miss. 1974) (motion designated as for partial summary judgment treated as Rule 12(c) motion where no evidentiary matters outside pleadings presented); *accord Gallardo v. Bd. of County Commissioners*, 885 F. Supp

236, 237 (D. Kan. 1995). Defendants do not rely on facts and they do not cite any factual support outside the pleadings. Rather, defendants cite provisions of law that they deem applicable to disposition of their motion. See Memorandum of Reasons in Support of Defendant State Officials' Motion for Summary Judgment ("D. Mem.") at 2-7. Because defendants have submitted no evidentiary support for their motion and its outcome turns on the court's interpretation of the law only, plaintiffs have omitted a statement of facts.[1]

II. ARGUMENT

A. Plaintiffs have the right to seek redress for violations of the Medicaid Act.

1. *Gonzaga* does not support defendants' construction of the Medicaid Act

In *Blessing v. Freestone*, 520 U.S. 329, 340 (1997), the Supreme Court reiterated its prior decisions, in stating that 42 U.S.C. § 1983 provides a cause of action for violations of federal statutes, provided the plaintiff asserts a "violation of a federal *right*, not merely a violation of federal law." Five years later, in *Gonzaga University v. Doe*, 536 U.S. 273 (2002), the Court clarified the requirements for discerning a Congressionally-conferred right in a federal statute. The Court did not, however, overrule its prior decisions, as defendants would have this court believe. *See Sabree v. Richman*, 367 F.3d 180, 182 (3d Cir. 2004) (reaffirming vitality of *Blessing* and other cases cited in *Gonzaga*).[2]

Blessing set out a three-prong test to determine whether a federal statute creates a right enforceable under § 1983: 1) Congress must have intended that the statute benefit the plaintiff; 2) the right protected must not be too vague and amorphous for judicial enforcement; and 3) the

[1] Should the court require it, plaintiffs will submit such a statement. Plaintiffs refer the court to the Joint Pretrial Memorandum, which outlines in detail the evidence in support of plaintiffs' claims as well as any undisputed facts. *See* Doc. No. 64, at 8-9, 40-41, 44-50.

statute must unambiguously impose a binding obligation on the states. 520 U.S. at 340-341. *Gonzaga* affirmed this analysis but elucidated the first prong, making clear that for a court to find a private right of action, Congress must have "unambiguously conferred" a federal right on the individuals seeking relief. 536 U.S. at 283. In reaching this conclusion, the Court cited favorably its analysis and conclusions in two prior cases in which it had found private rights of action, *Wilder v. Virginia Hospital Ass'n*, 496 U.S. 498 (1990), and *Wright v. City of Roanoke Redevelopment and Housing Authority*, 479 U.S. 418 (1987). Significantly, *Wilder* addressed a claim brought under a provision of the Medicaid Act.

The First Circuit has considered only two cases since *Gonzaga* that involve beneficiaries seeking to enforce Medicaid Act claims under section 1983, and it found a private right of action in both. *See Rolland v. Romney*, 318 F. 3d 42, 47-51 (1st Cir. 2003) (Nursing Home Reform Act amendments) and *Bryson v. Shumway*, 308 F.3d 79, 89 (1st Cir. 2002) (42 U.S.C. §1396a(a)(8)).[3] More recently, the Third Circuit carefully reviewed the viability of Medicaid Act claims under section 1983, concluding that Congress unambiguously conferred the rights that the plaintiff beneficiaries sought to enforce. *Sabree*, 367 F. 3d at 193-94 (allowing claims under 42 U.S.C. §§ 1396a(a)(8), (a)(10) and (a)(17)). Because *Gonzaga* did not address the second and third *Blessing* prongs and only refined, but did not overrule, the first prong of *Blessing*, many pre-*Gonzaga* cases in which Medicaid beneficiaries sued under section 1983 continue to be good authority. *See, e.g., Evergreen Presbyterian Ministries, Inc. v. Hood*, 235 F.3d 908, 926 (5th Cir. 2000) (noting that Congress must "unambiguously confer" individual entitlement in finding right

[2] For other cases finding that *Gonzaga* clarified but left intact prior Supreme Court decisions, *see, e.g., McCree v. Odum*, No. 4:00- CV-173(H)(4) (E.D.N.C., Nov. 26, 2002) (Howard, J.), attached as **Exh. A**, at 27, n. 7; *Masterman v. Goodno*, 2004 WL 51271, *8 (D. Minn. 2004); *Kenny A. v. Perdue*, 218 F.R.D. 277, 290 (N.D. Ga. 2003).

of action for beneficiaries under §1396a(a)(30)); *Ark. Med. Soc'y, Inc. v. Reynolds*, 6 F.3d 519, 523-28 (8th Cir. 1993) (applying same test to find private right for beneficiaries and providers under §1396a(a)(30)); *see also Doe v. Chiles*, 136 F. 3d 709, 713-19 (11th Cir. 1998) (carefully applying *Blessing/Wilder* principles to find private right of action under §1396a(a)(8)).

Plaintiffs voluntarily dismiss Count I of the Complaint. Applying the appropriate post-*Gonzaga* analysis to the remaining claims before the court, Counts II, III, VI and VII unquestionably confer private rights of action on the plaintiffs. While Count V presents a greater analytical challenge in light of *Long Term Care Pharmacy Alliance*, this court should find that plaintiffs, as Medicaid *beneficiaries*, have a private right of action under §1396a(a)(30).[4]

1. The history of the Medicaid Act shows Congress' intent to create a private right of action for beneficiaries

Defendants attempt to recast the Medicaid Act as a mechanism for the transfer of federal dollars to states, with enforcement the exclusive province of the Secretary of Health and Human Services (HHS). D. Mem. at 2-5, 11-15. This view of the Medicaid program ignores 39 years of history and judicial precedent. Since 1965, Medicaid has provided medical services to eligible needy individuals. Medicaid has been consistently viewed as an entitlement, which imposes a legal obligation on participating states to provide, arrange and fund health services for eligible persons. *See Schweiker v. Gray Panthers* 453 U.S. 34, 36-37 (1981); *see also Masterman v. Goodno*, 2004 WL 51271, *8 (D. Minn. 2004). With the entitlement nature of Medicaid comes the beneficiaries' legal right to enforce the Act's requirements against non-compliant states. The

[3] The First Circuit recently rejected a private right of action for providers under 42 U.S.C. § 1396a(a)(30) in *Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50 (1st Cir. 2004). Plaintiffs discuss the inapplicability of this decision to Medicaid beneficiaries in Section II(B)(4) of this Memorandum.

[4] Plaintiffs previously dismissed Count IV. *See* Joint Pretrial Memorandum, Doc. No. 65, at 30.

history and purpose of the Medicaid Act support the viability of plaintiffs' claims under 42 U.S.C. § 1983.

Congress has repeatedly rejected legislation that would proscribe beneficiaries' ability to seek redress for violations of federal statutes, including the Social Security Act and its Medicaid provisions.[5] Moreover, historically, the Supreme Court has specifically recognized that the Social Security Act may be enforced by private action under 42 U.S.C. § 1983. *See Wilder*, 496 U.S. 498; *Maine v. Thiboutot*, 448 U.S. 1 (1980). When, in *Suter v. Artist M.*, 503 U.S. 347, 358 (1992), the Court implied a weakening of this stance,[6] Congress reacted decisively by enacting 42 U.S.C. § 1320a-2:

> In an action brought to enforce a provision of the Social Security Act, such provision is not to be deemed unenforceable because of its inclusion in a section of the Act requiring a State plan or specifying the required contents of a State plan. This section is not intended to limit or expand the grounds for determining the availability of private actions to enforce State plan requirements other than by overturning any such grounds applied in *Suter v. Artist* M, 112 S.Ct. 1360 (1992), but not applied in prior Supreme Court decisions respecting such enforceability; provided, however, that this section is not intended to alter the holding in *Suter v. Artist M.* that section 471(a)(15) of the Act is not enforceable in a private right of action.

In passing the *Suter* amendment, Congress recognized that Supreme Court precedent had allowed beneficiaries of federal-state programs to bring suit against states under § 1983 for violations of the Social Security Act. Report of the Committee on Ways and Means, House of Representatives, No. 102-631, 102 Cong., 2d Sess., at 364, 364-5 (1992) (hereafter "Ways and Means Report"), attached as **Exhibit B**. Congress credited such litigation with achieving "comprehensive reforms" and "increased compliance with the mandates of the Federal statutes," and expressed concern that *Suter* could result in dismissal of these suits, including actions to enforce the

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[5] *See, e.g.*, S. 584, 97th Cong., 1st Sess. § 1 (1981) (proposing amendment of 42 U.S.C. § 1983 to limit municipal liability); S. 436, 99th Cong., 1st Sess. § 1 (1985) (same); H.R. 4314, 104th Cong., 1st Sess., § 309 (1996) (limiting liability of judicial officers under section 1983).

[6] *Suter* held that private individuals could not use section 1983 to enforce 42 U.S.C. § 671(a)(15), a provision of the Adoption Assistance and Child Welfare Act that requires states to make "reasonable efforts" to avoid foster care placements. 503 U.S. at 351.

Medicaid Act. *Id.* The bill's conferees explained:

> The intent of this provision [42 U.S.C. § 1320a-2] is to assure that individuals who have been injured by the State's failure to comply with the Federal mandates of the State plan titles of the Social Security Act are able to seek redress in federal courts to the extent they were able to prior to the decision in *Suter v. Artist M.*

H.R. Conf. Rep. No. 761, 103d Cong., 2d Sess., at 926 (1994), 1994 U.S.C.C.A.N. 2901, 3257.

> [The Suter amendment] confirms the more than two decades of Federal jurisprudence which has recognized that, in establishing the "State plan" programs under the Social Security Act, Congress meant to require State officials to administer these programs in accordance with Federal statutory standards, and to permit those injured by State officials [sic] failure to do so (including any failure, in the administration of the State plan, to comply with any provisions of, or any provision required to be included in, such a plan) to challenge, through appropriate judicial actions, that failure.

Ways and Means Report, Exh. B, at 367. The legislative history of 42 U.S.C. § 1320a-2 could not make more evident Congress' unambiguous and consistent support for private enforcement of state violations of the Medicaid Act.

Despite their denials, D. Mem. at 12, n. 8, defendants' position implicates the *Suter* amendment. Their lengthy discussion of the "text and structure" of the Act, with selective depiction of its contents, *see* D. Mem. at 2-6, confirms their essential position: as long as the state plan contains the requisite provisions, plaintiffs have no private right of action. Defendants' effort to defeat plaintiffs' claims based on *Suter* cannot stand in light of 42 U.S.C. § 1320a-2.

3. The Medicaid Act does not vest enforcement authority exclusively in the Secretary

Lumping together the complex parts of a very detailed statute, defendants represent the Medicaid Act as a "series of directives" to the federal government, the Secretary of HHS and state agencies. D. Mem. at 12. Defendants highlight the state-focused language in the enabling section of the Act, selectively ignoring the law's clear designation of intended beneficiaries ("families with dependent children," "aged, blind or disabled individuals") and its beneficiary-

directed purpose ("to furnish medical assistance . . . to help such families and individuals"). *See* 42 U.S.C. § 1396. In further keeping with their vision, defendants argue that plaintiffs must seek enforcement of the state plan conditions through the Secretary. Defendants' assertion, if accepted, would advance a misguided effort to eliminate the established right of Medicaid beneficiaries to seek meaningful reform when states violate their rights.

Defendants portray the Secretary's authority to require states to "comply substantially" with plan provisions as precluding recognition of beneficiaries' private right of action. D. Mem. at 13, *citing* 42 U.S.C. §1396c(2). First, plaintiffs have not brought claims under this provision of the Act. Moreover, nothing in the language or history of the Medicaid Act requires that the authority to enforce states' compliance rests exclusively with the Secretary. *See* Ways and Means Report, Exh. B, at 367. The Medicaid Act does not create an elaborate enforcement mechanism with a private right to seek review by a federal body, as did the remedial scheme discussed in *Gonzaga*. *See Wilder*, 496 U.S. 498 (Secretary's authority to terminate state funding did not defeat private right of action under Medicaid Act). The many cases upholding a private right of action under the Medicaid Act make clear that the Secretary's enforcement powers and the private right of action of beneficiaries are compatible with one another.

B. Defendants' motion should be denied with respect to each of plaintiffs' claims

This court must assess the specific provisions relied on by plaintiffs to determine whether each one creates an enforceable right under section 1983. *See Blessing,* 520 U.S. at 342. Plaintiffs assert claims under 42 U.S.C. §§ 1396a(a)(8), (a)(10)(B), (a)(30), (a)(43), and 1396d(a)(4)(B) and (r)(3). Careful analysis reveals that plaintiffs have stated causes of action under each of the remaining Counts (II, III, V, VI, VII) and, therefore, defendants' motion should be denied.

1. 42 U.S.C. § 1396a(a)(8) unquestionably confers a private right of action on plaintiffs

In Count II of the Complaint, plaintiffs assert a claim under 42 U.S.C. §1396a(a)(8), the "reasonable promptness" provision, which provides:

> 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*.

(Emphasis added.) Defendants argue that this provision does not unambiguously confer federal rights on individual recipients. (D. Mem. at 11). This contention should be soundly rejected.

Since *Gonzaga*, the First Circuit and other courts have held that §1396a(a)(8) creates a private right enforceable by Medicaid beneficiaries under §1983. *See Bryson v. Shumway*, 308 F.3d 79, 89 (1st Cir. 2002); *Mendez v. Brown*, 311 F. Supp. 2d 134, 140 (D. Mass. 2004); *see also Sabree*, 367 F.3d at 182; *McCree v. Odum*, No. 4:00-CV-173 (H)(4) (E.D. N.C. Nov. 26, 2002), at 29-30, **Exhibit A.** Of particular note, in *McCree*, after considering *Gonzaga*, the district court upheld its earlier finding, *Antrican v. Buell*, 158 F. Supp. 2d 663, 670-71(E.D.N.C. 2001), *aff'd* 90 F.3d 178(4th Cir. 2002), that §1396a(a)(8) (as well as §§ 1396a(a)(10)(B), (a)(30) and (a)(43), all raised by plaintiffs here) confers rights under section 1983 on EPSDT-eligible children that seek dental services.[7] *See* Exh. A, at 29-30. In advancing their argument to dismiss Count II, defendants rely on *M.A.C. v. Betit*, 284 F. Supp. 2d 1298 (D. Utah 2003), *see* D. Mem. at 22, n.13, which closely followed the district court decision in *Sabree*, 245 F. Supp. 2d 653 (E.D. Pa.

[7] Defendants attempt to distinguish *Bryson*, *Mendez* and *Sabree* on the grounds that plaintiffs in the instant case are not a "discrete class of recipients." D. Mem. at 23. While the plaintiff classes in these cases may have been smaller than the proposed plaintiff class (and subclass) here, this distinction has no bearing on whether Congress intended to confer a federal right on plaintiffs. Large classes of Medicaid recipients seeking dental services have been permitted to proceed under section 1983 in a number of cases. See, e.g., *Clark v. Kizer*, 758 F.Supp. 572 (E.D. Cal. 1990), *aff'd in part and vacated in part on other grounds sub nom Clark v. Coye*, 967 F.2d 585 (9th Cir. 1992); *McCree v. Odum*, Exh. A.

2003). The Third Circuit's reversal of that decision, after careful analysis of *Gonzaga*'s impact, calls *Betit* into serious question.

Defendants urge the court to disregard pre-*Gonzaga* decisions addressing §1396a(a)(8). D. Mem. at 22, 26. However, three such decisions in this Circuit alone are valid sources of support. *See Boulet v. Cellucci*, 107 F. Supp.2d 61, 73 (D.Mass. 2000) (right of developmentally disabled MassHealth recipients to reasonably prompt residential placements); *Rolland v.Cellucci*, 52 F. Supp. 2d 231, 238-40 (D.Mass. 1999) (right of action for mentally retarded adults to community-based services under §§ 1396a(a)(8) and (a)(10)(B)); *see also Rancourt v. Concannon*, 175 F. Supp.2d 60, 61 (D.Me. 2001). *Boulet* and *Rolland* carefully applied Supreme Court precedent affirmed in *Gonzaga* to find that section 1396a(a)(8) confers federal rights upon Medicaid recipients.[8]

Once the right to sue is established, section 1983 creates a presumption that plaintiffs have a remedy. *Gonzaga*, 536 U.S. at 285, n. 4. The state may rebut this presumption only by showing that Congress prohibited private enforcement explicitly, or that it created a comprehensive remedial scheme incompatible with a private right of action. *Id.* Title XIX contains no provision explicitly precluding individual actions. *Sabree*, 367 F. 3d at 193. However, defendants assert that 42 U.S.C. § 1396a(a)(3), "counsels against the recognition of a new private right of action." D.Mem. at 25. This section requires a state to "provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under this plan is denied or is not acted upon with reasonable promptness Defendants propose that the fair hearing process required by 42 U.S.C. § 1396a(a)(3) is evidence

[8] Thoughtful pre-*Gonzaga* decisions on this point outside the First Circuit include *Lewis v. New Mexico Dept. of Health*, 94 F. Supp. 2d 1217 (D. N.M. 2000), *aff'd on other grounds*, 261 F.3d 970 (10th Cir. 2001); *Sobky v. Smoley*, 855 F. Supp. 1123, 1146-47 (E.D.Cal.1994).

of such a scheme. This contention must be rejected.

First, an individual suing under Section 1983 does not have to exhaust administrative remedies. *See Patsy v. Board of Regents of Florida*, 457 U.S. 496, 516 (1982); *see also Wilder*, 496 U.S. at 523. Moreover, the Medicaid fair hearing provision is not intended to address the situation faced by plaintiffs: not a denial, termination or reduction in assistance, requiring an individual solution, *see* 130 CMR 610.032 (defining appealable actions), but a system-wide failure of access due to an extreme shortage of providers and inadequate administration. As the Third Circuit correctly concluded, the administrative hearing required by § 1396a(a)(3) is "the only remedial component of [the Medicaid Act], and clearly falls short" of the remedial schemes found by the Supreme Court to preclude private enforcement. See *Middlesex Co. Sewerage Auth. v. National Sea Clammers Ass'n*, 453 U.S. 1, 13-15 (1981) (discussing "unusually elaborate enforcement provisions" of Federal Water Pollution Control Act and Marine Protection, Research and Sanctuaries Act of 1972) and *Smith v. Robinson*, 468 U.S. 992, 1009-12 (1984) (citing comprehensive procedures and guarantees in Education of the Handicapped Act); *see also Wilder*, 496 U.S. at 520-23 (Medicaid Act has no significant administrative means of enforcing state plan requirements). The court should reject this line of argument by defendants.[9]

2. 42 U.S.C. § 1396a(a)(10)(B) clearly confers a private right of action on plaintiffs

Plaintiffs' Count III asserts a claim under 42 U.S.C. § 1396a(a)(10)(B) (the "comparability" provision). Various courts since *Gonzaga* have upheld private enforcement of

[9] In a final attack on plaintiffs' §1396(a)(8) claim, defendants state: "Plaintiffs' complaint . . . 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." D. Mem. at 24. Defendants confuse whether plaintiffs have a private right of action with whether and to what extent plaintiffs may obtain a system-wide remedy. *Id.* ("...[P]laintiffs seek to use the reasonable promptness provision as a means for obtaining system-wide reform of the MassHealth dental program.") This argument has no place at this juncture.

this requirement. *See Mendez*, 311 F. Supp. 2d at 140; *McCree*, Exh. A at 30; *Sabree*, 367 F. 3d at 194; *see also Martin v. Taft*, 222 F.Supp. 940, 977 (S.D. Oh. 2002). Section 1396a(a)(10)(B) requires that Medicaid services be available and provided equitably among eligible beneficiaries:

> A State plan for medical assistance must…provide… that the medical assistance made available to *any individual* described in subparagraph [42 USC 1396a(a)(10)] (A) *shall* not be less in amount, duration, or scope than the medical assistance made available to *any other such individual…*" (Emphases added.)

Section 1396a(a)(10) explicitly defines the individuals eligible for Medicaid, and requires that the State provide them with comparable levels of services. Like § 1396(a)(8), which it frequently accompanies, the comparability provision contains the necessary rights-creating language and "readily survive[s] any heightened analysis which *Gonzaga* requires." *Mendez*, 311 F. Supp. 2d at 140.

Defendants acknowledge that subsection 1396a(a)(10) speaks in terms of "individual" Medicaid recipients. Nonetheless, they maintain that the statute does not contain the "rights-creating" language required by *Gonzaga.* Def. Br. at 26. Defendants attempt to distinguish *Rolland v. Romney*, 318 F.3d 42 (1st Cir. 2003), in which the court held that the Nursing Home Reform Amendments to the Medicaid Act create a private right of action. As the First Circuit explained, however, rights-creating language "can be characterized as language that 'explicitly confer[s] a right directly on a class of persons that includes the plaintiffs'" or language that identifies "the class for whose *especial* benefit the statute was enacted." *Id.* at 52 (citations omitted). Section 1396a(a)(10)(B) satisfies this test, speaking in terms that identify the class for whose especial benefit the statute was enacted -- Medicaid-eligible individuals – who are clearly defined in § 1396a(a)(10)(A).

Invoking 42 U.S.C. § 1396, the Medicaid Act's enabling provision, defendants also

contend that 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." D. Mem. at 26. The *Sabree* court carefully considered and rejected this approach:

> . . . the statutory language, despite countervailing structural elements of the statute, unambiguously confers rights which plaintiffs can enforce. We conclude that Section 1396, . . . cannot neutralize the rights-creating language of Section[] 1396a(a)(10) . . [and 1396a(a)(8)].

367 F.3d at 192 (relying on affirmance of *Wright* and *Wilder* in *Gonzaga*). As with 42 U.S.C. §1396a(a)(8), there is no reliable legal support for defendants' contention that Congress intended §1396a(a)(10)(B) to be enforced only by the Secretary, and not by private individuals.

3. The Early Periodic Screening Diagnosis and Treatment (EPSDT) statutes clearly confer a private right of action on the plaintiffs that are under 21 years of age.

Defendants argue that the EPSDT statutes that plaintiffs rely on in Counts VI and VII do not confer a private right of action under section 1983. In defendants' view, neither the EPSDT outreach provisions, 42 U.S.C. § 1396a(a)(43) (Count VI), nor the provision of services sections, 42 U.S.C. §§ 1396d(a)(4)(B) and d(r)(3) (Count VII), contain "rights-creating" language. D. Mem. at 27-29. Yet the handful of cases to address EPSDT claims under section 1983 since *Gonzaga* have concluded that these statutes do indeed create private rights of action. *See Kenny A. v. Perdue*, 218 F.R.D. 277, 293-94 (N.D.Ga. 2003); *McCree*, Exh. A at 32-33; *see also S.D. v. Hood*, 2002 U.S. Dist. LEXIS 23535, *4-6 (E.D. La.); *Pediatric Specialty Care, Inc. v. Ark. Dept. of Human Svcs*, 293 F.3d 472, 477-79 (8th Cir. 2002), *appeal after remand*, 364 F.3d 925 (8th Cir. 2004). This recent case law is bolstered by earlier cases, which applied the *Blessing* test (reiterated in *Gonzaga*) to find that 42 U.S.C. §§ 1396a(4)(B), (a)(43) and 1396d(r)(3) create private enforcement rights. *See* cases cited pp. 14-15, *infra*. Federal regulations and guidance

further support plaintiffs' position. *See* 42 CFR § 441.56(a) and (c); State Medicaid Manual §§5010-5360; *see also* State Medicaid Director Letter, SMDL # 01-010 (January 18, 2001), esp. at 3 ("[i]nadequate Medicaid non-institutional provider rate structures may expose a State to serious litigation risk"), attached as **Exhibit C**. Defendants' arguments to the contrary must fail.

42 U.S.C. § 1396a(a)(43), the EPSDT outreach provision, requires that a State plan:

> must provide for informing all persons in the State who are under the age of 21 and who have been determined to be eligible for medical assistance...of the availability of early and periodic, screening, diagnostic and treatment services as described in [42 U.S.C.] 1396d(r)

42 U.S.C. §§ 1396d(a)(4))(B) defines "medical assistance" to include EPSDT services, which are defined in section 1396d(r)(3) to include:

> Dental services...which are provided...at intervals,which meet reasonable standards of dental practice...at such other intervals, indicated as medically necessary...which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health

In *Kenny A.*, the court found a private right of action under the above sections, on the grounds that "eligible children under 21, . . . are the clearly intended beneficiaries of the [EPSDT] provisions," the language of the sections is focused on the needs of individual children, and there is no "enforcement mechanism through which an aggrieved individual can obtain review." 218 F.R.D. at 293-294. Similarily, the *McCree* court, reviewing its 2001 decision in *Antrican v. Buell*, 158 F. Supp. 2d 663, after considering Gonzaga, affirmed that the EPSDT provisions conferred a private right of action on plaintiff children seeking dental care. See Ex. A, at 32-33. Even a case that defendants cite supports the plaintiffs' right to pursue their EPSDT claims. *See Bonnie L. v. Bush*, 180 F. Supp. 2d 1321, 1345-47(S.D.Fla. 2001) (plaintiff foster children have right of action under §1396a(a)(43)), *aff'd in part, vacated in part on other grounds sub nom. 31 Foster Children v. Bush*, 329 F.3d 1255 (11th Cir. 2003). Guaranteeing the

rights of EPSDT-eligible children in Massachusetts to information, screening services, and corrective treatment for dental care is well within the judicial competence. *See Bonnie L.*, 180 F Supp. 2d at 1346.

Defendants assert that, in enacting the EPSDT provisions, "Congress was concerned with providing a yardstick to measure delivery of services, not the creation of individual rights." D. Mem. at 28. The defendants further depict the EPSDT statutes as "aggregate" rules because they state requirements for the contents of a state Medicaid plan. *Id.* at 29. Once again, defendants appear to argue that deriving a private right of action is impermissible because the provisions are found in the state plan. Congress has foreclosed this argument. 42 U.S.C. § 1320a-2; *Rabin v. Wilson-Coker,* 362 F.3d 190, 201-202 (2nd Cir. 2004) (rejecting Connecticut Medicaid commissioner's argument on similar grounds). The EPSDT provisions confer enforceable rights on plaintiffs because they are written in terms of individual Medicaid beneficiaries under 21 years of age, they are not too vague or ambiguous to be enforced by a court, they are binding on participating states and they are not precluded by comprehensive remedies in the Medicaid Act. *See Kenny A.*, 218 F.R.D. at 293-94; *McCree*, Exh. A at 32-33.

Defendants would have this Court ignore pre-*Gonzaga* decisions holding that the EPSDT provisions confer private rights under section 1983. D. Mem. at 29, n. 15. Defendants' wholesale dismissal of these cases overstates the impact of *Gonzaga.* The reasoning of these cases, which apply the *Blessing* principles affirmed and clarified by *Gonzaga*, remains viable. *See Westside Mothers v. Haveman*, 289 F. 3d 852, 863 (6th Cir. 2002), *cert. denied*, 123 S.Ct. 618 (2002); *Okla. Chap.of Am. Acad. of Pediatrics v. Fogarty,* 205 F. Supp. 2d 1265, 1271-72 (N.D. Okla. 2002); *DajourB. v. City of New York*, 2001 WL 830674, *7-10, 2001 U.S. Dist. LEXIS 10251 (S.D.N.Y.).

4. *Long Term Care Pharmacy Alliance* did not eliminate the right of Medicaid beneficiaries to enforce 42 U.S.C. §1396a(a)(30) through private action

In Count V, plaintiffs assert a cause of action pursuant to 42 U.S.C. §1396a(a)(30), often referred to as the "equal access" provision. This statute confers a private right of action on plaintiffs, as Medicaid beneficiaries, which is enforceable under 42 U.S.C. §1983. The provision requires that participating states:

> 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 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 question raised by defendants is whether Congress, in enacting §1396a(a)(30), intended to unambiguously confer rights on Medicaid recipients. *See Gonzaga*, 586 U.S. at 283. The defendants argue that *Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50 (1st Cir. 2004) effectively decided this question in the negative. However, that case found that Medicaid *providers* have no private right of action under this provision. The court issued no opinion concerning the rights of Medicaid recipients, nor was the issue briefed by the parties. 362 F.3d at 59. Moreover, neither the parties nor the court addressed the *Suter* amendment, 42 U.S.C. §1320a-2. Therefore, defendants' reliance on *Long Term Care Pharmacy Alliance* is misplaced. *See Clayworth v. Bonta*, 295 F. Supp. 2d 1110, 1121(E.D.Cal. 2003) (citations omitted) ("[u]nstated assumptions on non-litigated issues are not precedential holdings"). When analyzed under *Gonzaga*, with due consideration of subsequent and prior cases, 42 U.S.C. §1396a(a)(30) should be read to create an enforceable right for Medicaid recipients.[10]

[10] There is ongoing litigation concerning private enforcement of the "equal access" provision. *Compare Sanchez v. Johnson*, 301 F. Supp. 2d 1060 (N.D. Cal. 2004) and *Clayworth v. Bonta*, 295 F. Supp. 2d 1110 (E.D.Cal. 2003).

The First Circuit did not provide a detailed analysis of (a)(30)(A)'s subparts.

> Because this language is—to put it mildly—complex, it is helpful to break it down…a state must provide 'methods and procedures'. These . . . must assure that payments to providers produce four outcomes: (1) 'efficiency'; (2) 'economy'; (3) 'quality of care'; and (4) adequate access to providers by Medicaid recipients."

Penn. Pharmacists Assoc. v. Houstoun, 283 F.3d 531, 537 (3d Cir. 2002). The quality of care and adequate access subparts of the provision have an "an unmistakable focus on Medicaid beneficiaries." *Id.* at 538; *accord Clayworth*, 295 F. Supp. at 1122.

Plaintiffs' essential claim is that defendants have failed to fulfill the adequate access requirement of §1396a(a)(30). See Complaint, ¶ 107. This provision is phrased in terms benefiting recipients (requires "care and services… [to be] available") and ensuring their right to access medical providers. *See Evergreen*, 235 F.3d at 908, 928; *Ark. Med. Soc'y, Inc.*, 6 F.3d at 526; *Penn. Pharmacists*, 283 F.3d at 543-44; *see also In re NYAHSA Litigation*, 2004 WL 1126348, *9 (N.D.N.Y.) (adopting position of First Circuit in *Long Term Care Pharmacy Alliance* that equal access provision was intended to benefit Medicaid recipients).

Since *Gonzaga*, several courts have found that the equal access requirement is actionable by Medicaid beneficiaries. *Clayworth*, 295 F. Supp. at 1122-24 (beneficiaries have section 1983 private right of action although providers do not); *McCree*, Exhibit A, at 30-32. Moreover, the analysis of this provision in many pre-*Gonzaga* cases continues to be persuasive. *See especially Penn. Pharmacists,* 283 F.3d at 534-44 (closely mirroring reasoning of *Gonzaga*); *Evergreen Presbyterian Ministries, Inc. v. Hood*, 235 F.3d 908, 924-928 (5th Cir. 2000) (similar); *see also Ark. Med. Soc'y, Inc. v. Reynolds*, 6 F.3d 519, 523-28 (8th Cir 1993).

Should the court allow Count V to be tried without ruling on defendants' motion, the court may benefit from further judicial guidance after trial.

The equal rights provision is sufficiently clear to confer a private right upon Medicaid recipients. *See Clayworth*, 295 F. Supp. at 1122-23; *McCree*, Exh. A at 32. The statute is not phrased in "aggregate" terms, such as those recognized by the *Gonzaga* court to negate a private right of action. 536 U.S. at 287-88. The fact that the statute addresses a state plan requirement does not rule out individual enforcement rights. *See Clayworth*, 295 F. Supp. 2d at 1122 (citing *Suter* amendment). The language is sufficient to confer an individual entitlement to equal access to care, which is enforceable under §1983.[11] This court should follow the Third and Fifth Circuits, and find that § 1396(a)(30) confers a private right of action on MassHealth recipients.

C. Defendants' "alternative" arguments are without merit.

Defendants pose "alternative" arguments as to why Counts II and III fail to state a claim. These counts assert causes of action under 42 U.S.C. § 1396a(a)(8) (reasonable promptness) and (a)(10)(B) (comparability), respectively. Defendants' arguments are without merit.

42 U.S.C. § 1396a(a)(8) requires in pertinent part that "[medical] assistance shall be furnished with reasonable promptness to all eligible individuals." The defendants argue that this provision requires only that the state *pay for,* not that it actually *furnish*, medical services with reasonable promptness. *See* Def. Mem. at 24-25(citing *Bruggeman v. Blagojevich*, 324 F.3d 906, 910 (7th Cir. 2003)). Under the Medicaid scheme, payments for medical services are made not to individuals, but to providers, *after* the eligible individual receives a covered service. Defendants' reading of § 1396a(a)(8) diminishes this provision to benefit primarily Medicaid providers. This reading is inconsistent with the statute's clear focus on "eligible individuals." Virtually every court that has considered the question has read 1396a(a)(8) to require that Medicaid-covered

[11] Defendants cite *Sanchez v. Johnson*, 301 F.Supp.2d 1060 (N.D. Cal. 2004) (Wilken, J.), to support their call for dismissal of Count V; however, like *Betit*, *see* pp. 8-9, *supra*, this decision has been undermined by the Third Circuit's reversal of the lower court decision in *Sabree*.

services be furnished with reasonable promptness. *See, e.g., Boulet*, 107 F.Supp. 2d at 79; *Sobke*, 855 F.Supp. 1123; *Antrican v. Buell*, 158 F.Supp. 2d at 670-71; *Clark*, 758 F.Supp. at 580. Many other courts have implicitly rejected defendants' approach in finding that unreasonable delay in the provision of specific Medicaid-covered services violates 42 U.S.C. §1396a(a)(8). *See, e.g., Doe v. Chiles*, 136 F.3d 709 (11th Cir. 1998); *Kirk v. Houstoun*, 2000 WL 830731 (E.D. Pa. 2000); *Linton v. Carney*, 779 F. Supp. 925, 936 (M.D. Tenn. 1990); *see also Bryson v. Shumway*, 308 F.3d at 89; *Rolland v. Cellucci*, 52 F. Supp. 2d at 240. In the face of such overwhelming precedent, defendants' reliance on one Seventh Circuit case is not a basis for the court to reject this well-supported claim.[12]

Like their "alternative" argument on §1396a(a)(8), defendants' attempt to shrink the scope of §1396a(a)(10)(B) must be rejected. *See* D. Mem. at 26-27. Defendants assert that plaintiffs misread the "comparability" statute to require uniform *access* to covered services. Defendants construe "medical assistance" to mean coverage (i.e., a package of benefits), not actual services. Defendants cite two cases in support of this argument, *Rodriguez v. City of New York*, 197 F.3d 611, 616 (2d Cir. 1999), and *Bruggeman*, 324 F.3d 906. Neither case supports the conclusion that defendants urge upon this court. In *Rodriguez*, the court rejected plaintiffs' contention that §1396a(a)(10)(B) required New York to provide a non-covered service on the grounds that it was "comparable" to a service covered by the state plan. In *Bruggeman*, the court rejected what it read as plaintiffs' claim that §1396a(a)(10)(B) entitled them to live "equidistant" from every facility that rendered the desired services.

[12] Only one decision, *Sanders v. Kan. Dep't of Social Rehab. Services*, 2004 WL 1089212, *13 (D. Kan.), has followed *Bruggeman*.

In contrast, plaintiffs here seek access to a service *covered* in the state Medicaid plan. Moreover, contrary to defendants' characterization, *see* D. Mem. at 27, plaintiffs do not seek "uniform" access to dental care, but rather comparable access as required by law.

Defendants misconstrue the comparability provision. Many courts have found a violation of this statute when medical services are provided in a manner that is less in amount, duration or scope than what is furnished to another recipient. *See, e.g., Clark,* 758 F.Supp. at 580; *Rolland,* 52 F. Supp. 2d at 239; *Sobke*, 855 F.Supp. at 1139. If "medical assistance" meant only a list of benefits for which the state would pay *if* the beneficiary could find a provider, Medicaid would be an empty entitlement indeed.

C. Where plaintiffs have shown that a majority of their claims are clearly enforceable, the Court should reject defendants' motion in its entirety

Plaintiffs claims should be decided at trial because defendants' have not met their substantial burden on this motion. The need for trial on any of plaintiffs' claims is sufficient to end the court's inquiry. Where the majority of plaintiffs causes of action survive this motion, the court should exercise its discretion to turn down defendants' motion in its entirety and allow plaintiffs' claims to proceed to trial.

> A court, in its discretion in shaping the case for trial, may deny summary judgment as to portions of the case that are ripe therefor, for the purpose of achieving a more orderly or expeditious handling of the entire litigation. This discretion may be exercised where a part of the matter which is ripe for summary judgment is intertwined with additional claims that must be decided at trial.

Toyoshima Corp. v. *General Footwear, Inc.*, 88 F.R.D. 559 (S.D.N.Y. 1980); *see also Anderson* v. *Liberty Lobby, Inc.*, 477 U.S. 202 (1986) (trial court may deny summary judgment even when entire case is technically ripe for summary judgment). A court may refuse to enter partial summary judgment based on principles of practicality and sound judicial administration. *See,*

e.g., FDIC v. Elefant, 4. Fed. R. Serv. 3d 1268 (7th Cir. 1986); *Bruschini* v. *Bd. of Educ. of Arlington Sch. Dist.,* 911 F. Supp. 104, 105 (S.D.N.Y. 1995) (partial disposition of claims must be conducive to conservation of judicial resources and of benefit to parties). Where defendants' motion cannot dispose of the case entirely, the court should let this matter proceed to trial. *Veilleux* v. *Nat'l Broadcasting Co., Inc.,* 8 F. Supp. 2d 23(D. Me. 1998); *Bruschini,* 911 F. Supp. at 105 (partial disposition disfavored because orders are unappealable until after judgment).

These principles apply with full force to this case. The court should deny defendants' motion because: 1) the trial will not be shortened if only some Counts are struck down at this point, as plaintiffs' claims rely essentially on the same facts; 2) partial disposition of the case creates the possibility of reversal and remand after trial, and thus does not conserve the court's resources; and 3) defendants are fully able to renew their arguments at the close of trial. Finally, and most importantly to plaintiffs, who have waited four years for a trial, the time necessary to consider and rule on partial summary judgment will likely postpone the trial. Further delay will harm the thousands of children and disabled adults on MassHealth waiting for dental care.

D. Conclusion

For the reasons set forth herein, plaintiffs respectfully request that this Court deny defendants' motion in its entirety and set this matter for trial in October 2004.

Respectfully submitted,

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DATED: July 1, 2004

CERTIFICATE OF SERVICE

I hereby certify that on this day a true copy of the above document was served upon the attorney of record for each party by mail/~~by hand~~.

Dated: 7/1/04

Clare D. McGorriar