May 23, 2008

Brief for Plaintiffs-Appellees, Brown v. Tennessee Dept. of Finance & Admin.

Samuel R Bagenstos

No. 07-6163

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

LAKERSKO BROWN, *et al.*,

Plaintiffs-Appellees,

v.

TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION; M. DAVID GOETZ, JR., in his official capacity as Commissioner of the Department of Finance and Administration,

Defendants-Appellants.

APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
THE HONORABLE ROBERT L. ECHOLS

FINAL BRIEF FOR THE PLAINTIFFS-APPELLEES

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STATEMENT REGARDING ORAL ARGUMENT

Because this case presents important questions concerning a state's obligations under both the Medicaid Act, 42 U.S.C. § 1396 *et seq.*, and a settlement agreement into which the state voluntarily entered, Plaintiffs-Appellees request oral argument.

DISCLOSURE OF CORPORATE AFFILIATIONS AND FINANCIAL INTEREST

Pursuant to 6th Cir. R. 26.1, Plaintiff-Appellee Disability Law & Advocacy Center of Tennessee, Inc. makes the following disclosure:

1. Is said party a subsidiary or affiliate of a publicly owned corporation? **No.**

2. Is there a publicly owned corporation, not a party to the appeal, that has a financial interest in the outcome? **No.**

/s Samuel R. Bagenstos
Counsel for Plaintiffs-Appellees

May 23, 2008
Date

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STATEMENT OF JURISDICTION

The district court had jurisdiction pursuant to 28 U.S.C. § 1331. On February 8, 2008, this Court determined that it has jurisdiction pursuant to 28 U.S.C. § 1292(a)(1) over the state's appeal from the district court's denial of the motion to vacate the agreed order. *Brown v. Tennessee*, Nos. 07-6163/6325 (Feb. 8, 2008). As we demonstrate below, however, that jurisdiction does not extend to the state's challenge to the enforcement proceedings that are still pending in the district court. See pp. 43-46, *infra* (demonstrating that there is no jurisdiction under either 28 U.S.C. § 1291 or 28 U.S.C. § 1292).

STATEMENT OF THE ISSUES

1. Whether the district court abused its discretion when it refused to vacate a consent decree where no subsequent development undermined the legal basis for that decree.

2. Whether this Court can and should intervene into still-pending district court proceedings in which plaintiffs seek enforcement of a consent decree.

STATEMENT OF THE CASE

A. Procedural History

Plaintiffs brought this action in the District Court for the Middle District of Tennessee on July 13, 2000. J.A. 1 (R. 1). In their amended complaint, filed on September 19, 2000, plaintiffs alleged that the State of Tennessee violated their rights under several provisions of the Medicaid Act by failing to enroll them in the state's Home and Community Based Waiver Program. *Id.* at 30-43 (R. 10 at 2-15). The district court certified the case as a class action under Rule 23(b)(2) of the Federal Rules of Civil Procedure, R. 41, and the court denied cross-motions for summary judgment on May 7, 2003, R. 103. On December 17, 2003, the parties executed a settlement agreement and submitted it to the district court for approval. See R. 108. After a fairness hearing, the district court approved the agreement, and entered it as an order of the court, on June 17, 2004. J.A. 98-100 (R. 116). This appeal arises from the district court's denial of the state's motion to vacate the agreed order pursuant to Rule 60(b) of the Federal Rules of Civil Procedure. R. 155. The state filed that motion on January 19, 2007, *id.*, and the district court denied the motion on September 12, 2007. J.A. 62-63 (R. 200).

B. Statement of the Facts

This case involves Tennessee's failure to enroll eligible individuals with mental retardation into its Medicaid Home and Community-Based Waiver program. See generally J.A. 29-43 (R. 10). We begin with an overview of that program before turning to the dispute in this case.

1. Overview of the Medicaid Waiver Program

Title XIX of the Social Security Act (a title that is often referred to collectively as the Medicaid Act) set up Medicaid as a cooperative state-federal program. See 42 U.S.C. § 1396 *et seq.*[1] Under that program, participating states agree to provide medical assistance to eligible individuals, see *id.* § 1396a, and the federal government agrees to reimburse a substantial percentage of the state's costs, see *id.* § 1396b. But "[a]lthough participation in the program is voluntary, participating States must comply with certain requirements imposed by the Act," once they agree to participate. *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 502 (1990).

Participating states must submit, for the approval of the federal Center for Medicare and Medicaid Services (CMS), a state plan of medical assistance. See 42 U.S.C. § 1396a. The plan, as approved, provides "a compre-

[1] For a good general overview of the Medicaid program, see KAISER COMMN. ON MEDICAID AND THE UNINSURED, MEDICAID: A PRIMER (2007), *available at* http://www.kff.org/medicaid/upload/Medicaid-A-Primer-pdf.pdf.

hensive statement concerning the nature and scope of the State's Medicaid program." *Wilder*, 496 U.S. at 502. It must set forth the standards for eligibility to participate in the program (a matter on which states have substantial, but not unlimited, discretion). See 42 U.S.C. § 1396a(a)(10). See also *Atkins v. Rivera*, 477 U.S. 154, 157-159 (1985) (noting that a state must cover all "categorically needy" individuals and that a state may elect to cover "medically needy" individuals defined according to standards it sets forth). The plan must also describe the medical services for which the program will provide reimbursement. See 42 U.S.C. § 1396a(a)(10)(A). Once the state sets forth the eligibility standards and covered medical services in its plan, the Medicaid Act requires it to provide medical assistance with "reasonable promptness" to all eligible individuals for the services the plan covers. See *id.* § 1396a(a)(8), (a)(10)(A).

The Medicaid Act permits CMS to waive various requirements of the statute in certain circumstances. See *id.* § 1396n. Of relevance here, the statute authorizes CMS in some circumstances to allow a state plan to "include as 'medical assistance'" payment for "home or community-based services" for eligible individuals who would otherwise "require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded"—a type of institutional facility referred to as an

"ICF/MR." *Id.* § 1396n(c)(1). CMS may limit "the number of individuals in the State who may receive home and community-based services under a waiver," but not to "fewer than 200." *Id.* § 1396n(c)(10).

Tennessee has operated a Home and Community-Based Waiver program since 1987. The state's waiver, as approved by CMS, authorizes assistance to individuals with mental retardation and developmental disabilities who, without home and community-based services, would require the level of care provided in an intermediate care facility for the mentally retarded (ICF/MR). See STATE OF TENNESSEE, REQUEST FOR AMENDMENT: HOME AND COMMUNITY-BASED SERVICES WAIVER 34-35 (March 30, 2006).[2] Individuals enrolled in the waiver program are entitled to payment for a variety of medical services that they receive at home or in community-based settings, including: residential habilitation; physical modifications to make their homes more accessible; respite caregiving; assistive technology; physical, occupational, and speech therapy; nursing services; and personal assistance. *Id.* at 36-38.

The state's Division of Mental Retardation Services (DMRS) operates the waiver program, *id.* at A-1, but DMRS does not provide these medical services itself. See STATE OF TENNESSEE, OVERVIEW OF THE WAIVER PRO-

[2] The state's current waiver document, which we cite in text, is available at: http://www.state.tn.us/tenncare/forms/statewiderenewalrequest.pdf.

GRAM 1.[3] Rather, DMRS contracts with "individuals or organizations that meet provider qualifications" to provide those services. *Id.* To become enrolled in the program, an individual must undergo both a financial eligibility determination and a "pre-admission evaluation" (PAE) to determine whether he or she needs ICF/MR-level services. *Id.* Once these steps are completed, the individual is enrolled in the waiver program and receives what the parties have referred to as a "slot"; at that point, the individual works with a support coordination agency (a third-party provider who contracts with DMRS) to develop a "plan of care" or "Individual Support Plan." *Id.* He or she may obtain the medical services on the plan of care from one or more of the "approximately 1300 service providers" with which DMRS contracts. TENNESSEE DIVISION OF MENTAL RETARDATION SERVICES: ANNUAL REPORT JULY 1, 2006-JUNE 30, 2007 at 10.

2. The Plaintiffs' Claims

Plaintiffs, six individuals with mental retardation, brought this action on behalf of themselves and "all current and future Tennessee residents with developmental disabilities who are eligible for Medicaid services under the ICF/MR program or the Medicaid Waiver program but have been denied entry into those programs." J.A. 33 (R. 10 ¶ 13). They contended, *inter alia*,

[3] The overview of the waiver program is available on the state's website at: http://www.state.tn.us/tenncare/forms/statewidewaiveroverview.pdf.

that the state's maintenance of a waiting list for entry into the waiver program violated the Medicaid Act's "reasonable promptness" requirement, 42 U.S.C. § 1396a(a)(8). See J.A. 42 (R. 10 ¶ 46).

These allegations centered, not on the state's failure to provide medical services directly, but on the state's failure to fund new enrollments in the program. In particular, plaintiffs alleged that "[e]ligible individuals and their parents [we]re told that there is no funding for services and that they must be placed on a waiting list." *Id.* at 37 (¶ 28). Although there were "ongoing problems with identifying the number of people" on a waiting list, *id.* (¶ 29), it was evident that "hundreds, and probably thousands of Tennesseans" remained on that list. *Id.* at 10 (¶ 31). A report prepared by the state itself declared that, as of August 1999, as many as 843 individuals were on ICF/MR or waiver waiting lists, and the number was growing. See *id.* at 38-39 (¶ 32). Nevertheless, the state projected that "there [would] be new funding for only 164 individuals" who were not yet receiving those services. *Id.* at 37 (¶ 27).

By the time plaintiffs filed their motion for summary judgment in February 2003, the state had filled only about 4,300 to 4,400 of the 5,581 waiver slots that CMS had authorized the state to fill. J.A. 192-193 (Damons Dep. 163-164). At the same time, 3,021 individuals in the com-

munity whom the state had determined to be eligible for the waiver program waited on the DMRS waiting list, *id.* at 193-196 (Damons Dep. 164-167), as did another 542 individuals in state institutions who had been recommended for community placement. See *id.* at 215-216 (Kellogg Dep. Exh. 2 at 4-5).

On May 24, 2001, less than a year after plaintiffs filed this suit, CMS imposed a moratorium on the enrollment of new individuals into Tennessee's waiver program. See *id.* at 79, 234-235 (R. 102 at 7; Tighe Dep. Exh. 4). John Tighe, a state official with a leading role in Tennessee's Medicaid program, later explained that "that the State did not, in their opinion, have an adequate system to oversee and to investigate issues, especially around patient safety or protection of personal belongings or those kinds of issues, for people in the community." *Id.* at 233 (Tighe Dep. 34). CMS also "had an issue with provider quality." *Id.* The CMS moratorium permitted the state to enroll new individuals into the waiver programs only in narrowly defined "crisis" circumstances. See *id.* at 208, 211-212 (Damons Dep. 179; Kellogg Dep. 142-143). According to a declaration filed by the state in February 2003, a total of "87 individuals ha[d] been enrolled in the Medicaid waiver under a crisis exception" since CMS imposed the moratorium nearly two years earlier. *Id.* at 71 (Kellogg Decl. ¶ 11).

3. The Settlement Agreement

At a pre-trial conference on May 2, 2003, the district court announced that it was denying the plaintiffs' motion for summary judgment (as well as the state's cross-motion for summary judgment). J.A. 182 (5/2/2003 Tr. 2).[4] Defense counsel responded that the state "would like to send this case to mediation with Steve Norris," who was at that point mediating two other cases involving challenges to Tennessee's community-based services. *Id.* at 184 (5/2/2003 Tr. 4). She proposed that the mediation seek to craft a settlement to each of the three cases:

> What the State ideally would like to do is bring all the parties together from all three lawsuits into an informal meeting with state officials, let the state officials explain our proposal where we want to see this whole community system go because they are interrelated and see if we can't work out a settlement that would resolve all three of these lawsuits in consistent manner.

Id. Any settlement agreement that resulted from the mediation, defense counsel suggested, might well go beyond the precise requirements of the law to address deeper systemic issues that contributed to the problems of which

[4] The court provided the reasons for that ruling in a memorandum issued five days later. See J.A. 73 (R. 102). Rejecting the defendants' motion for summary judgment (which was premised on the argument that plaintiffs had no right of action to enforce the Medicaid Act), the court explained that the Medicaid Act "confer[red] on Plaintiffs private rights enforceable under [42 U.S.C.] § 1983." *Id.* at 92 (R. 102 at 20). But the court also explained that "genuine issues of material fact concerning all of Plaintiffs' claims in this complicated case remain in dispute" and therefore denied plaintiffs' motion for summary judgment. *Id.* at 96-97 (R. 102 at 24-25).

the plaintiffs had complained: "It may be as drastic as completely revamp how we're delivering services in the community system." *Id.* Although plaintiffs' counsel expressed a willingness to go to trial, and a concomitant reluctance to delay matters further with a mediation, see *id.* at 185-187 (5/2/2003 Tr. 13-15), plaintiffs ultimately agreed to submit the case to Steve Norris for mediation. See *id.* at 188-189 (5/2/2003 Tr. 24-25).[5]

On December 17, 2003, the plaintiffs and the state entered into a settlement agreement. J.A. 101-122 (R. 116, Exh. A). The "goal" of the agreement, the parties stated, was "to eliminate or substantially reduce the waiting list for services for Medicaid-eligible persons with mental retardation that meet the ICF/MR level of care criteria." *Id.* at 103 (R. 116, Exh. A ¶ II). The agreement did not require the state to provide medical services under the waiver directly; as we have shown, any such requirement would have worked a fundamental change in the structure of Tennessee's Medicaid program. See pp. 5-6, *supra*. Instead, the agreement focused on increasing the number of waiver slots available to Tennessee residents and funding and enrolling eligible individuals into those slots so that they could receive services

[5] In the midst of the mediation, the state appointed Steve Norris the Deputy Commissioner in charge of the Division of Mental Retardation Services. Plaintiffs continued to negotiate a settlement agreement with the state, although the former mediator was now, in effect, the opposing party.

from the providers who contract with the state. See J.A. 105-115 (R. 116, Exh. A).

The agreement required the state to provide "improvement funding" of $12 million in each of fiscal years 2003-2004, 2004-2005, and 2005-2006 "to allow the enrollment of additional eligible individuals in the existing Home and Community Based Services Waiver." *Id.* at 107-108 (R. 116, Exh. A ¶ IV.C). And the state agreed that, "to the extent that there exists an available waiver slot and funding for that slot, eligible individuals should be enrolled in the Waiver with reasonable promptness." *Id.* at 108-109 (¶ V.A). Accordingly, the state agreed in the first two years of the agreement to "identify, notify, and enroll persons in this waiver" so that "additional eligible persons will be enrolled and receive services with . . . reasonable promptness." *Id.* at 110 (¶ V.C, D). So long as the moratorium remained in effect, the state agreed that it would "exercise best efforts to identify those who could meet the requirements for the 'crisis' category." *Id.* (¶ V.C). The state agreed to "initiate this process in a timely manner so that all eligible individuals, within the limits of funding, can be enrolled in [the] current year." *Id.* The state also agreed to "exert [its] best efforts to obtain relief from [the CMS] moratorium," including by taking steps to "address community infrastructure needs." *Id.* at 112 (¶ VI.E).

To expand the available slots, the state agreed, by January 1, 2004, to seek approval from CMS "for a new Medicaid Self-Determination Waiver program." *Id.* at 105-106 (¶ IV.A). That waiver, which was designed to "emphasize individual and family control and choice," would provide funding to eligible individuals and permit them to select providers and medical services within a set budget. *Id.* The agreement required the state to "provide funding for and . . . enroll and begin the provision of services" for 600 enrollees in that waiver in the first year after it was approved, and an additional 900 enrollees in the second year. *Id.* at 106-107 (¶ IV.B). The state also agreed to "implement a targeted case management program" for individuals on the waiting list. *Id.* at 111 (¶ VI.B). That program would provide "information about the MR waiver program," and it would connect people to services in the community. *Id.* And the state agreed to "develop a program to provide consumer directed support"—*i.e.*, money to pay for medical services that the individual chooses and supervises—"to each individual who is on the waiting list in the crisis, urgent or active category but not currently receiving family support services," and to "provide $500,000 per month in state funds" to pay for "interim services" for eligible individuals on the waiting list. *Id.* at 111-112 (¶ VI.C, D).

Because the agreement provided for its most significant obligations during the first two years it would be in effect, the parties agreed to "meet and reach agreement on expansion of enrollment and provision of services for the third, fourth, and fifth years." *Id.* at 112-113 (¶ VII). The parties agreed that "[s]ervices will be expanded at a reasonable rate such that the waiting list will be eliminated or substantially reduced by the conclusion of the term of this agreement." *Id.* In case the parties did not reach agreement on the precise duties to be imposed for the third through fifth years, the settlement agreement provided that either party may request mediation by a Magistrate Judge. See *id.* Should the Magistrate Judge declare an impasse, the agreement provided that "the matter shall be set for a case management conference to set a scheduling order and enter a trial date." *Id.*

The agreement provided that it could be enforced by a process involving notice to the opposing party, mediation before the Magistrate Judge, and ultimately a motion for specific performance before the district court. See *id.* at 117-118 (¶ IX.B.4, 5). "After two years following the approval of this Agreement," the parties agreed, "defendants may defend any action for non-compliance on the grounds that defendants are in compliance with the federal laws that are the basis of the underlying action which is the subject of this Agreement." *Id.* (¶ IX.B.5.d). The parties also agreed that the district

court would retain jurisdiction over the action, and that the agreement would expire on December 31, 2009. See *id.* at 116, 121 (¶¶ IX.B.3, XII.B). After a fairness hearing, the district court approved the agreement, and entered it as an order of the court, on June 15, 2004. See *Id.* at 98-100 (R. 116).

4. The Motion to Vacate and the Ongoing Enforcement Proceedings

The parties did not reach an agreement on the duties to be imposed during years three through five. See J.A. 124 (R. 145). On December 4, 2006, the Magistrate Judge declared an impasse and recommended, pursuant to the settlement agreement, "that the case should be reopened and a trial date set." *Id.* In the meantime, the waiting list had grown substantially, from 3,165 at the time the district court approved the settlement agreement to 5,074 by December 1, 2006. See *id.* at 126 n.1 (R. 150, Exh. 2 at 2 n.1). The waiting list grew, in major part, because the state significantly decreased the number of new enrollments into the waiver program, from a peak of 145 per month during a seven-month period in the first year of the agreement (2005), to an average of 19 per month in the last half of the second year (2006). See *id.* at 129. The head of DMRS, Deputy Commissioner Norris, informed those on the waiting list that "DMRS has been limited in its ability regarding enrollment into the Medicaid waiver," in part because of a lack of "available funds." *Id.* at 139 (R. 150, Exh. 2, Exh. D). By June of 2007, ap-

proximately 800 individuals who had been determined to be in "crisis," and who had been on a waiting list for over 90 days, remained on that list. See *id.* at 132 (R. 150, Exh. 2 at 8). Accordingly, on January 18, 2007, the plaintiffs moved to modify the settlement agreement to require the state, by the beginning of July, to enroll into the waiver all individuals who had been in the crisis category for 90 days or more. See *id.* at 136 (R. 150, Exh. 2 at 12).

The very next day, on January 19, 2007, the state filed a motion to vacate the settlement agreement. R. 155. The state argued that the agreement was "based upon the legal premise that the Medicaid Act imposed on the State a duty to directly provide plaintiffs with MR services." *Id.* at 1. At the time the parties entered into the agreement, the state contended, "virtually every federal court to consider the issue had concluded that the provision of the Medicaid Act requiring the State to provide 'medical assistance' to eligible MR individuals with 'reasonable promptness' obliged the State to provide the MR services themselves." *Id.* (citation omitted). But, the state continued, this Court rejected that premise in *Westside Mothers v. Olszewski*, 454 F.3d 532, 540 (6th Cir. 2006), which the state characterized as holding that the Medicaid Act "impose[s] *no obligation* on the state to ensure the provision of actual medical services." R. 156 at 15.

Plaintiffs responded that the state's motion mischaracterized both the terms of the settlement agreement and the legal effect of *Westside Mothers*. R. 176. And because the state had failed to meet its obligations during the first two years of the agreement in a number of respects (notably, by failing to spend the funds for interim support that the settlement agreement requires), plaintiffs separately moved for specific performance on May 9, 2007. R. 183, 184. But the district court, on the state's motion, suspended briefing on that motion pending its ruling on the state's motion to vacate. *Id.* at 162 (R. 188).

On September 12, 2007, the district court denied the state's motion to vacate the settlement agreement. J.A. 45-61 (R. 199). The court explained that "Defendants were not required by the Agreement itself or now by *Westside Mothers II* to provide [medical] services themselves," and that the agreement was therefore fully consistent with that case. *Id.* at 54 (R. 199 at 10). "There are no provisions in the Agreement," the district court concluded, "obligating the Defendants to provide medical services directly or making the State a 'provider of last resort.'" *Id.* at 55 (R. 199 at 11). Accordingly, the court held that the law had not "changed to such an extent that all of the provisions of the Agreement now impose a higher burden on the state Defendants than federal law requires." *Id.*

As for the pending enforcement proceedings, the district court denied plaintiffs' motion to modify the settlement agreement to impose new obligations on the state. See *id.* at 56-60 (R. 199 at 12-16). The court did not rule on the motion for specific performance in its September 12 order; instead, it authorized plaintiffs to "file an amended or supplemented motion." *Id.* at 61 (R. 199 at 17). Plaintiffs filed such a motion on September 21, 2007. R. 209. After discovery and responsive briefing, the district court held a hearing on the motion on January 23, 2008. R. 248. The motion is still pending before the district court, as is plaintiffs' motion to set the case for trial on the merits.

SUMMARY OF ARGUMENT

I. The district court did not abuse its discretion in refusing to vacate the settlement agreement. Contrary to the state's assertion, the district court did *not* hold that the settlement agreement must remain in effect "regardless whether plaintiffs have legally enforceable rights under any federal statute." Opening Br. 15 (emphasis deleted). Rather, the district court correctly concluded that the obligations the state assumed in the settlement agreement were fully consistent with the obligations that the Medicaid Act imposes on the state under this Court's decision in *Westside Mothers v. Olszewski*, 454 F.3d 532 (6th Cir. 2006). In *Westside Mothers*, this Court held that the

Medicaid Act does not require the state to provide medical services directly. But it held that the statute imposes a significant obligation on the state to *enroll* eligible individuals in the Medicaid program promptly "to enable them to obtain the necessary medical services" from the third-party providers who participate in the program. *Id.* at 540. The essence of plaintiffs' claim was that the state was failing to comply with that obligation to enroll eligible individuals promptly. The agreement in which they settled that claim—an agreement that does not require the state to provide *any* medical services—focuses squarely on enforcing that obligation. Far from undercutting the settlement agreement, then, this Court's decision in *Westside Mothers* reinforces it.

Even if, as the state argues, the settlement agreement imposed obligations that went beyond what *Westside Mothers* declared the Medicaid Act requires, there would be no basis for vacating that agreement. First, *Westside Mothers* did not represent the sort of significant and unanticipated change in the law that warrants relief under Fed. R. Civ. P. 60(b). Cf. *Rufo v. Inmates of the Suffolk County Jail*, 502 U.S. 367, 384 (1992). This Court's decision in *Westside Mothers* did not overrule a single Sixth Circuit case, and its holding was consistent with the only federal appellate case to have directly addressed the relevant question at the time the parties entered

into the settlement agreement. See *Bruggeman v. Blagojevich*, 324 F.3d 906, 910 (7th Cir. 2003). In addition, the state did not carry its burden to show that "applying [the agreement] prospectively is no longer equitable." Fed. R. Civ. P. 60(b)(5). The flexible, time-limited settlement agreement fully accommodates the principle that a state "depends upon successor officials, both appointed and elected, to bring new insights and solutions to problems of allocating revenues and resources." *Frew v. Hawkins*, 540 U.S. 431, 442 (2004). And it was the state's own "unilateral[] and secretive[]" conduct that prevented defendants from complying with the agreement. J.A. 50 (R. 199 at 6).

II. No question of judicial enforcement of the settlement agreement is properly before this Court. In light of the state's significant and ongoing violations of the settlement agreement and the Medicaid Act, the plaintiffs have filed in the district court a motion to enforce the agreement. That motion remains pending. This Court has no jurisdiction to intervene in pending enforcement proceedings in the district court. In any event, there would be no reason for this Court to intervene, for the state's objection to the enforcement proceedings rests on the state's erroneous reading of *Westside Mothers*.

ARGUMENT

I. The District Court Did Not Abuse its Discretion When it Refused to Vacate the Settlement Agreement

The district court incorporated the settlement agreement in an agreed order; both the parties and this Court have treated that agreement as a consent decree. See *Brown v. Tennessee*, Nos. 07-6163/6325 (Feb. 8, 2008). This Court reviews the denial of a Rule 60(b)(5) motion to vacate a consent decree for abuse of discretion. See, *e.g.*, *Lorain NAACP v. Lorain Bd. of Educ.*, 979 F.2d 1141, 1147-1148 (6th Cir. 1992), cert. denied, 509 U.S. 905 (1993).

The legal standards that apply to such a motion are well established. First, the "party seeking modification of a consent decree bears the burden of establishing that a significant change in circumstances warrants revision of the decree." *Rufo v. Inmates of the Suffolk County Jail*, 502 U.S. 367, 383 (1992). Second, because a consent decree represents a settlement, its entry is not based on *establishment* of "the claims the plaintiffs originally sought to enforce but never proved applicable through litigation," *Lorain NAACP*, 979 F.2d at 1148 (internal quotation marks and brackets omitted), and plaintiffs therefore need not prove their case on the merits to enforce the decree, see *Rufo*, 502 U.S. at 389-390. Rather than providing a remedy for a proven violation of federal law, a consent decree must merely "be directed to pro-

tecting federal interests." *Frew v. Hawkins*, 540 U.S. 431, 437 (2004).[6] Such a decree may permissibly implement the federal statute that underlies the litigation "in a highly detailed way, requiring the state officials to take some steps that the statute does not specifically require." *Id.* at 439. It may even "provide[] broader relief than the court could have awarded after a trial." *Local No. 93*, 478 U.S. at 525. Third, even if the law has changed to make legal the conduct the consent decree prohibits, the state must still prove that "applying [the decree] prospectively is no longer equitable." Fed. R. Civ. P. 60(b)(5).[7] "A proposed modification should not strive to rewrite a consent decree so that it conforms to the [statutory] floor." *Rufo*, 502 U.S. at 391.

Applying those standards, the district court acted well within its discretion in refusing to vacate the settlement agreement. First, even after this Court's decision in *Westside Mothers*, *supra*, the agreement protects the federal interests secured by the Medicaid Act. In particular, the agreement di-

[6] See also *id.* (explaining that "a federal consent decree must spring from, and serve to resolve, a dispute within the court's subject-matter jurisdiction; must come within the general scope of the pleadings; and must further the objectives of the law upon which the complaint was based") (citing *Local No. 93, Firefighters v. City of Cleveland*, 478 U.S. 501, 525 (1986)).

[7] Defendants filed their motion while the previous version of the Federal Rules of Civil Procedure was in effect. Nonetheless, in this brief we cite the current language of Rule 60(b), because it is identical in substance to the former version, and the Court ought accordingly to apply the current language pursuant to Fed. R. Civ. P. 86(a)(2).

rectly implements the state's obligation to make "a prompt determination of eligibility and a prompt payment to eligible individuals to enable them to obtain the necessary medical services." *Westside Mothers*, 454 F.3d at 540. Second, *Westside Mothers* hardly reflected the kind of "significant change" in the law required for modification; at most, it was the sort of "clarification in the law" that does not "automatically open[] the door for relitigation of the merits of every consent decree." *Rufo*, 502 U.S. at 389. Finally, it would not be equitable to vacate the settlement agreement in any event, both because the state's conduct indicates that—even before *Westside Mothers*—it never intended to comply and because the narrowly framed agreement by its terms operates for only a short period of time and is sufficiently flexible to permit "successor officials, both appointed and elected, to bring new insights and solutions to problems of allocating revenues and resources." *Frew*, 540 U.S. at 442.

A. The Settlement Agreement Was Not Premised on a Mistaken Understanding of the Medicaid Act

The state contends that the settlement agreement rested on an understanding of the Medicaid Act that this Court subsequently rejected in *Westside Mothers*, *supra*. That is incorrect. The state mischaracterizes this Court's holding in *Westside Mothers*, the legal theory that underlay the settlement agreement in this case, and the district court's basis for refusing to

vacate it. Contrary to the state's argument, the district court did *not* conclude that the settlement agreement was inconsistent with *Westside Mothers* but must continue to be enforced "regardless whether plaintiffs have legally enforceable rights under any federal statute." Opening Br. 15 (emphasis deleted). Rather, the district court specifically held that, *consistent* with this Court's holding in *Westside Mothers*, "[t]here are no provisions in the Agreement obligating the Defendants to provide medical services directly or making the State a 'provider of last resort.'" J.A. 54-55 (R. 199 at 10-11). That determination was entirely correct, and the district court accordingly did not abuse its discretion in refusing to vacate the settlement agreement.

1. Westside Mothers *Requires the State Promptly to Enroll Eligible Individuals to Enable Them to Obtain Medical Services*

The state contends that, after *Westside Mothers*, its "only duty is to furnish reimbursement to those eligible individuals who do, in fact, procure providers." Opening Br. 3. The state misreads that case. *Westside Mothers* held that the state's obligation under the Medicaid Act, like that of a private insurer under an insurance contract, is to provide *payment* for medical services that may be performed by others; the state need not "provide medical services directly." *Westside Mothers*, 454 F.3d at 540. But the Court made clear, contrary to the state's argument here, that the state has a significant obligation *before* an eligible individual procures a provider. The Court held

that the Medicaid Act requires the state to make "a prompt determination of eligibility and a prompt payment to eligible individuals *to enable them to obtain the necessary medical services*." *Id.* (emphasis added). See also *id.* (agreeing with courts that have held that "a State must merely provide financial assistance to eligible individuals *to enable them to obtain covered services*") (emphasis added).[8]

In so holding, this Court read the Medicaid Act's "reasonable promptness" language, 42 U.S.C. § 1396a(a)(8), in accord with its meaning in the context in which it originated—the "reasonable promptness" provision that governed the earlier Aid to Families with Dependent Children program. See *Jefferson v. Hackney*, 406 U.S. 535, 545 (1972) (provision was a response to placement of eligible individuals "on waiting lists, because of the shortage of state funds" and "was intended to prevent the States from denying benefits even temporarily" in such situations). This Court also read the provision in accord with the basic purpose of the statute, which is that eligible indi-

[8] Although *Westside Mothers* spoke of payment "to eligible individuals," the Court could not have intended to suggest that the state's obligation is to pay money directly to the individuals who are enrolled in the Medicaid program. As this Court explained in *Schott v. Olszewski*, 401 F.3d 682, 687 (6th Cir. 2005), Medicaid is "a vendor-payment system" under which payment goes to the providers of medical services; states may pay individual beneficiaries directly "only in limited circumstances." In any event, this case does not present the question whether the state must write checks to the individuals enrolled in the Medicaid program or, instead, to providers.

viduals actually receive medical services. See, *e.g.*, *Alexander v. Choate*, 469 U.S. 287, 304 (1985) (aim of Medicaid Act is that "care and services are provided in 'the best interests of the recipients'") (quoting 42 U.S.C. § 1396a(a)(19)).

As we show in the next section, the settlement agreement in this case is not premised on any supposed obligation of the state to provide medical services directly. Instead, the agreement requires the state to *enroll* eligible individuals in the waiver program—under which the state itself provides no medical services—so that they can use their enrollment in the program (and the concomitant promise of reimbursement) to obtain medical services from the third-party providers who have contracted with the state. Far from contradicting *Westside Mothers*, then, the settlement agreement enforces precisely the obligation that case imposes on the state.

Nor is the settlement agreement in conflict with the Tenth Circuit's decision in *Mandy R. v. Owens*, 464 F.3d 1139 (10th Cir. 2006), cert. denied, 127 S. Ct. 1905 (2007), on which the state heavily relies. That case described the state's obligation under the Medicaid Act in virtually identical language to that employed by *Westside Mothers*: "'[W]hat is required 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 . . . .'" *Mandy R.*, 464 F.3d at 1146 (quoting *Bruggeman v. Blagojevich*, 324 F.3d 906, 910 (7th Cir. 2003)).

As the state notes, the *Mandy R.* court followed *Westside Mothers* in concluding "that the Medicaid statute does not require states to be service-providers of last resort." *Id.* But unlike here, that proposition doomed the plaintiffs' claim in *Mandy R.*: The plaintiffs in that case did not did not seek merely to be enrolled in the Medicaid program so that they could obtain covered medical services from willing providers. Instead, they challenged the lack of available providers to perform the covered medical services. The *Mandy R.* plaintiffs were individuals on a waiting list for services in an ICF/MR facility, but only 3 such facilities, with about 86 total beds, existed in the state. See *id.* at 1141-1142, 1145-1146. As a result, the state did not have the facilities to house the 21 people on the waiting list for ICF/MR services. *Id.*

If the Tenth Circuit had held that the state violated the Medicaid Act in *Mandy R.*, where the lack of service providers was the *sole* reason individuals were left on a waiting list, its holding would have been tantamount to requiring the state to be the "service-provider[] of last resort." *Id.* at

1146.[9] But, as we show below, nothing in the settlement agreement here requires the state to be a service provider of last resort. To the contrary, the settlement agreement requires the state merely to *enroll* eligible individuals in the waiver program and give them the financial assistance (a promise of reimbursement) that will enable them to obtain from third-party providers the medical services the program covers. That is precisely what *Mandy R.* itself says the Medicaid Act requires.[10]

2. The Settlement Agreement Requires the State Promptly to Enroll Eligible Individuals to Enable Them to Obtain Medical Services

As the statement of facts demonstrates, see pp. 10-14, *supra*, the settlement agreement in this case is not premised on any supposed state obliga-

[9] As both *Mandy R.* and *Westside Mothers* make clear, where the lack of available service providers results from the state's "inadequate payments [that] effectively deny the right to 'medical assistance,'" the state will be liable for a violation of the Medicaid Act. *Westside Mothers*, 454 F.3d at 541. See also *Mandy R.*, 464 F.3d at 1145 (noting that the state "conceded that it may not escape paying for . . . services by setting rates so low that no one can provide them").

[10] That is also what the other court of appeals to have directly addressed the question—the Seventh Circuit in *Bruggeman*, *supra*—said the Medicaid Act requires. See *Bruggeman*, 324 F.3d at 910 (using virtually identical language as this Court in *Westside Mothers*). For further discussion of *Bruggeman*, which preceded the settlement in this case, see pp. 38-39, *infra*. The two district court cases on which the state relies (Opening Br. 23 n.9) are to the same effect. See *Equal Access for El Paso, Inc. v. Hawkins*, 428 F. Supp.2d 585, 622 (W.D. Tex. 2006) (quoting the same language from *Bruggeman*), rev'd on other grounds, 509 F.3d 697 (5th Cir. 2007), pet. for cert. filed, 76 USLW 3499 (Mar. 10, 2008); *Clark v. Richman*, 339 F. Supp.2d 631, 642 (M.D. Pa. 2004) (quoting the same language from *Bruggeman*).

tion to provide medical services directly. Under Tennessee's waiver program, the state does not provide medical services directly, and plaintiffs have never challenged that aspect of the system. Once the state enrolls an eligible individual in the waiver program, that individual must then go to a third-party provider to obtain the medical services financed by the program. Enrollment in the waiver does nothing more than enable the individual to go to those providers with a guarantee that the state will provide reimbursement for medical services covered by the waiver.

And it was the state's failure to *enroll* eligible individuals in the waiver—enrollment that would enable those individuals to obtain medical services from third-party providers—that was the plaintiffs' target in this case from the very beginning. Thus, the complaint sought certification of a class of individuals "who are eligible for Medicaid services under the ICF/MR program or the Medicaid Waiver program, but *have been denied entry into those programs*." J.A. 33 (R. 10 ¶ 13) (emphasis added). And the complaint described the essential problem with the state's conduct *not* as a failure to provide medical services but instead as a failure to provide *funding* for eligible individuals who were waiting to be enrolled. See *id.* at 36-37 (¶ 27) ("According to the state's projections, during Fiscal Year 2000-2001, there will be new funding for only 164 individuals who are not now receiv-

ing ICF/MR or Waiver services."); *id.* at 37 (¶ 28) ("Eligible individuals and their parents are told that there is no funding for services and that they must be placed on a waiting list.").

The settlement agreement, which does not require the state to provide *any* medical services, continues this focus on enrollment and funding. The agreement's "reasonable promptness" provisions—the focus of the state's motion to vacate—are quite explicit that *enrollment* in the program, and not direct provision of medical services, is all they require of the state: "The parties also agree that, within the limits of federally approved waivers, to the extent that there exists an available waiver slot and funding for that slot, eligible individuals should be *enrolled in the Waiver* with reasonable promptness." J.A. 109 (R. 116, Exh. A ¶ V.A.) (emphasis added). In the paragraphs that follow that sentence, the agreement consistently speaks in terms of "enroll[ing]" eligible individuals in the waiver. See *id.* at 9-10 (¶¶ V.B.-V.D.) (using the "enroll" language eight times in the three paragraphs that follow that sentence).[11] To ensure that the state's waiver slots would be

[11] In a few instances, the agreement speaks of the state's obligation to "enroll and begin the provision of services" J.A. 106-107 (R. 116, Exh. A ¶ IV.B.), or of the requirement that additional eligible individuals "be enrolled and receive services," *id.* at 109 (¶ V.B.). But these phrases do not require the state to provide medical services—otherwise, the language in Paragraph IV.B. would provide that the state must "enroll and provide" services, and the language in Paragraph V.B. would focus on the state and its obligation to

funded and available for eligible individuals to enroll in them, the agreement required the state to appropriate $12 million in "improvement funding" for each of the 2003-2004, 2004-2005, and 2005-2006 fiscal years. *Id.* at 107 (¶ IV.C.). The agreement directed that the additional funding would be used "to allow the enrollment of additional eligible individuals in the existing Home and Community Based Services Waiver." *Id.*

A review of the settlement agreement therefore demonstrates that it does *not* require the state to provide medical services—whether as a matter of first or of last resort. Rather, the agreement implements the obligation this Court affirmed in *Westside Mothers*: The state must enroll eligible individuals with reasonable promptness to enable them to obtain medical services from willing (third-party) providers.

In support of its suggestion that the settlement agreement was premised on its supposed obligation to provide medical services directly, the state

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provide medical services instead of on the individual and his or her receipt (from an unidentified provider) of services. They merely emphasize that the purpose of the "reasonable promptness" provision is that eligible individuals will be enrolled so that they can receive services from available providers in a timely fashion. In any event, the district court did not read this "services" language to impose on the state the obligation to provide medical services directly. To the contrary, the court concluded that "[t]here are no provisions in the Agreement obligating the Defendants to provide medical services directly or making the State a 'provider of last resort.'" J.A. 55 (R. 199 at 11). The interpretation of the district judge who presided over the negotiation and approval of the settlement agreement is entitled to great deference.

can do nothing more than point to a few references, in the complaint and in the district court's memorandum denying summary judgment, to the state's obligation to provide "services" or "waiver services" promptly. Opening Br. 7, 18, 20 (citing J.A. 38-39, 78-79, 94 (R. 10. ¶¶ 31-32, R. 102 at 6-7, 22)). These scattered words and phrases could not undermine the plain terms of the settlement agreement, which, as we have shown, do *not* impose on the state any obligation to provide medical services directly.

In any event, scattered references in the record to "services" and "waiver services" do not demonstrate that the settlement agreement is premised on a state's supposed obligation to provide medical services directly.[12] As we have shown, see pp. 10-14, *supra*, the whole purpose of the Medicaid Act is that eligible individuals actually receive medical services. Although it need not provide those services directly, the state has an obligation to enroll eligible individuals in its Medicaid program and thereby "to enable them to obtain covered services" from willing providers by guaranteeing reimbursement. *Westside Mothers*, 454 F.3d at 540. A state breaches that obligation when eligible individuals are unable, on account of the state's failure to en-

[12] Although it is a more minor point, we note that the language the state quotes does not refer specifically to "medical services." But it is "medical services" that a state, like a private insurer, has no obligation to provide directly. See pp. 23-27, *supra*. The state, of course, must provide the sorts of "services" that an insurer must provide, such as those involved in determining eligibility and paying for treatment.

roll them in the program, to receive from third parties the medical services Medicaid guarantees. As we have shown, the plaintiffs have contended from the start of this case that they have been unable to obtain covered services from the third parties who provide those services under the Tennessee waiver program because the state has failed to enroll them in that program in a timely way. Nothing in *Westside Mothers* or *Mandy R.* undercuts the plaintiffs' argument.

3. The Rule 60(b) Cases on Which the State Relies are Inapposite

As we have shown, the district court correctly recognized that the settlement agreement is entirely consistent with *Westside Mothers*. J.A. 54-55 (R. 199 at 10-11). Accordingly, this case is decisively unlike the cases on which the state relies to support relief under Rule 60(b). In each of those cases, a change in the law after the entry of a consent decree authoritatively rejected any plausible federal claim the plaintiffs might have sought to vindicate.

In *Sweeton v. Brown*, 27 F.3d 1162 (6th Cir. 1994) (*en banc*), cert. denied, 513 U.S. 1158 (1995), the parties had entered into a consent decree that rested on the premise that "a state statute or regulation creating a purely procedural limitation concerning parole may also create a federal due process liberty interest." *Id.* at 1164. But after the district court entered that de-

cree, both this Court and the Supreme Court held that "procedural statues and regulations governing parole do not create federal due process rights." *Id.* Because the consent decree rested on a premise that subsequent cases had authoritatively rejected, this Court held that Rule 60(b) relief was appropriate: "The foundation upon which the claim for injunctive relief was built has crumbled." *Id.* at 1166. Here, however, subsequent cases did *not* reject the premise on which the settlement agreement rested; *Sweeton* is inapposite.[13]

The Seventh Circuit's decision in *Evans v. City of Chicago*, 10 F.3d 474 (7th Cir. 1993) (*en banc*), cert. denied, 511 U.S. 1082 (1994), is even more inapposite. There, private plaintiffs challenged the city's method of paying interest on judgments against it; after a decision of the Seventh Circuit indicated that the city's method violated the Equal Protection Clause,

[13] The Supreme Court's decision in *System Federation No. 91 v. Wright*, 364 U.S. 642 (1961), is to the same effect. There, the Court held that an injunction forbidding union shop agreements should have been modified after Congress amended the Railway Labor Act to make clear that such agreements are "a legislatively approved contract term." *Id.* at 648. See also *id.* ("When the decree in this case was originally made, union shop agreements were prohibited by the Railway Labor Act and thus constituted in themselves a form of statutorily forbidden discrimination. Congress has since, in the clearest terms, legislated that bargaining for and the existence of a union shop contract, satisfying the conditions provided in § 2 Eleventh of the Railway Labor Act, are not forbidden discriminations by union or employer."). Because no change in the Medicaid Act undermines the settlement agreement in this case, *System Federation* is inapposite.

the parties entered into a consent decree to change that method prospectively. *See id.* at 475 (plurality opinion). But the plaintiffs continued to pursue their retrospective damages claims against the city, and, in a subsequent ruling on those claims, the Seventh Circuit reversed course and held that the city's prior method of calculating interest was constitutional. *See id.* at 475-476. Because the later decision authoritatively rejected the legal basis on which the consent decree had been entered—indeed, rejected it in a separate appeal involving the identical issues and parties—the court held that Rule 60(b) relief was appropriate. *See id.* at 480-481 (plurality opinion); *id.* at 483 (Ripple, J., concurring in the judgment).

But that is a far cry from this case. In *Evans*, the consent decree covered only the question of relief; the decree rested on the premise that the Seventh Circuit's earlier decision in that case "resolved the merits, leaving for decision only issues about relief." *Id.* at 477 (plurality opinion). See also *id*. at 476-477 (stating that "Chicago did not settle *any* aspect of the merits" but rather "litigated the merits to the nines and settled only the details of relief" based on what the Seventh Circuit's first decision "implied that it must do"). When the Seventh Circuit changed its mind about the merits, the entire basis for relief collapsed. But this is not a case in which the Court first found the defendants liable and then changed its mind. Rather,

this is a case in which the parties settled both the merits and relief, and nothing in this Court's cases undermines the plaintiff's claim.

The Supreme Court's decision in *Pasadena Bd. of Educ. v. Spangler*, 427 U.S. 424 (1976), is also quite far from this case. There, the district court refused to vacate a provision of an agreed school desegregation order, which provision the court had interpreted to require the school district *each year* to ensure that no school had a majority of members of a minority group. As the Supreme Court noted, neither the plaintiffs nor the defendants had read the provision that way, see *id.* at 432-433, and the Court had "expressly disapproved" any "'substantive constitutional right [to a] particular degree of racial balance or mixing'" in a decision issued the year after the agreed order had been entered. *Id.* at 433-434 (quoting *Swann v. Charlotte-Mecklenburg Bd. of Educ.*, 402 U.S. 1, 24 (1971)). It was the combination of the direct inconsistency with *Swann* and "the fact that the parties to the decree interpreted it in a manner contrary to the interpretation ultimately placed upon it by the District Court" that led the Court to hold that "modification should have been ordered by the District Court." *Id.* at 437-438. Here, the district court did *not* interpret the settlement agreement in a manner contrary to the parties, and the agreement is *not* in conflict with any subsequent, authoritative case.

In sum, because *Westside Mothers* and *Mandy R.* did not reject the premise on which the settlement agreement rests—and they indeed fully support that premise—this is not a case like *Sweeton*, *System Federation*, *Evans*, or *Spangler* in which changes in the law have undercut the premises of a decree. Rather, the relevant precedent is *Polites v. United States*, 364 U.S. 426, 433 (1960), where the Court held that the petitioner was not entitled to Rule 60(b) relief because "the later decisions of this Court upon which his motion to vacate relied did not in fact work the controlling change in the governing law which he asserted." The same is true here, and the district court accordingly did not abuse its discretion in denying Rule 60(b) relief.

B. The Holding in Westside Mothers *Did Not Work a Significant, Unanticipated Change in the Law Warranting Rule 60(b) Relief*

There is a second, independent reason why the district court did not abuse its discretion in denying Rule 60(b) relief. As *Rufo* makes clear, not every change in law warrants such relief; only "significant" changes that were not "anticipated at the time [the parties] entered into a decree" can do so. *Rufo*, 502 U.S. at 384. Even if the holding in *Westside Mothers* was an innovation in this Circuit, it was hardly unanticipated at the time the parties entered into the settlement agreement here. To the contrary, *Westside Mothers* did not overrule a single Sixth Circuit case, and its holding was consis-

tent with the only federal appellate case to have directly addressed the question at the time the parties entered into the settlement agreement.

The state asserts that, when plaintiffs filed their complaint and "persist[ing] through the time when the Settlement Agreement was executed," the "federal courts had uniformly accepted [the] premise" that the Medicaid Act requires states to provide medical services directly. Opening Br. 18-19. Tellingly, however, the state cannot point to a single case in which *this Court* had held (or even stated in *dicta*) that the Medicaid Act imposes such an obligation on states. The state relies principally on an "oft-cited district court" in California (Opening Br. 18), an Eleventh Circuit decision that quoted that district court's ruling in a footnote, and the rulings of several district courts (none from this Circuit) and the First Circuit that the state asserts to have followed that district court's ruling. Opening Br. 18-20.

Upon closer examination, neither of the appellate decisions the state cites—the First Circuit's decision in *Bryson v. Shumway*, 308 F.3d 79 (1st Cir. 2002), and the Eleventh Circuit's decision in *Doe v. Chiles*, 136 F.3d 709 (11th Cir. 1998)—actually confronted the question whether the Medicaid Act requires states to provide medical services directly. As Judge McConnell explained in his opinion for the Tenth Circuit in the *Mandy R.* case, *Bryson* and *Doe* "appear to have treated the statute as requiring the

provision of actual [medical] services," but they did not "expressly address[] the issue." *Mandy R.*, 464 F.3d at 1143 n.2. The First Circuit's decision in *Bryson*, which allowed the plaintiffs to proceed with a claim that the state violated the Medicaid Act by "fail[ing] to fill" open "waiver slots," did not address whether the state was required merely to provide financial assistance to individuals placed in those slots or instead to provide medical services directly. *Bryson*, 308 F.3d at 88. And the Eleventh Circuit's decision in *Doe*, in the portion quoted by the state (Opening Br. 18-19), was merely holding that "[t]he plain language of the provision's reasonable promptness clause is clearly intended to benefit Medicaid-'eligible individuals'" and that "'providers of services'" are therefore not the only "intended beneficiaries of the reasonable promptness clause." *Doe*, 136 F.3d at 715 & n.13. That holding says nothing about whether the state must provide medical services directly; if anything, it suggests that the court understood that services would be delivered through third-party providers.

Indeed, at the time the parties entered into the settlement agreement, only one appellate case had expressly addressed the question whether the Medicaid Act requires states to provide medical services directly—and that case had answered the question in the negative. In *Bruggeman*, *supra*, the Seventh Circuit described the state's responsibilities under the Medicaid Act

in precisely the way this Court would later describe them in *Westside Mothers*:

> Medicaid is a payment scheme, not a scheme for state-provided medical assistance, as through state-owned hospitals. The regulations that implement the provision indicate that what is required 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; a requirement of prompt treatment would amount to a direct regulation of medical services.

Bruggeman, 324 F.3d at 910.

Against this backdrop, the state could hardly have entered into the settlement agreement based on the "misunderstanding" that the "governing law" required states to provide medical services directly. Cf. *Rufo*, 502 U.S. at 390 (holding that "a decision that clarifies the law will not, in and of itself, provide a basis for modifying the decree" but that modification may be appropriate only where "the parties had based their agreement on a misunderstanding of the governing law"). Indeed, the state agreed to the settlement only *after* the district court denied plaintiffs' motion for summary judgment in an opinion that specifically cited *Bruggeman* as "calling *Doe v. Chiles* into doubt." J.A. 95 (R. 102 at 23). *Doe*, of course, is the Eleventh Circuit case that the state cites as having established the principle that the Medicaid Act requires states to provide medical services directly. See Opening Br. 18-19.

Given the district court's discussion of *Bruggeman*, the state was "undoubtedly aware . . . when [it] signed the decree," *Rufo*, 502 U.S. at 388, that the Medicaid Act had been recently read as requiring only a prompt determination of eligibility and a prompt provision of funds to enable eligible individuals to obtain covered medical services from available providers. When this Court endorsed the *Bruggeman* analysis in *Westside Mothers*, it did not overrule any prior Sixth Circuit case; at most, *Westside Mothers* clarified this Court's position on what had been an open question within the circuit. Such a mere "clarification in the law" does not warrant Rule 60(b) relief, *Rufo*, 502 U.S. at 389, and the district court was well within its discretion in denying the state's motion.

C. *The State Has Not Shown That it Would be Inequitable to Apply the Settlement Agreement Prospectively*

There is a third, independent reason why the district court acted well within its discretion in refusing to vacate the settlement agreement: the state has not shown that "applying [the agreement] prospectively is no longer equitable." Fed. R. Civ. P. 60(b)(5). To the contrary, the agreement is fully consistent with the equitable principles that apply to decrees against units of state government. And it was the *state*, acting before this Court decided *Westside Mothers*, that took actions that set up obstacles to the achievement

of the decree's purposes. Equity weighs strongly in favor of keeping the settlement agreement in force until the conclusion of its five-year term.

As the state notes (Opening Br. 28-29), the Supreme Court has directed that a "federal court must exercise its equitable powers to ensure that when the objects of the decree have been obtained, responsibility for discharging the State's obligations is returned promptly to the State and its officials." *Frew*, 540 U.S. at 442. Because a state "depends upon successor officials, both appointed and elected, to bring new insights and solutions to problems of allocating revenues and resources," *id.*, equity does not permit a public official to make a commitment—even in a consent decree—that gratuitously "ties the hands of his successor." *Evans*, 10 F.3d at 478.

But the settlement agreement here fully accommodates that principle. Far from binding "successor officials," the parties entered into the settlement agreement during Governor Bredesen's first term, and, barring any extension (which would itself be reviewable by this Court), the agreement will expire before Governor Bredesen's second term is out. By its terms, the agreement will be in force for slightly more than five years—from June 15, 2004, the date it was adopted by order of the district court, to December 31, 2009. See J.A. 100, 121 (R. 116 at 3, R. 116, Exh. A ¶ XII.B.). Notably, the agreement does not include any specific funding or enrollment targets for the third,

fourth, and fifth years; the parties explicitly left those terms for further negotiation, see *id.* at 112-113 (R. 116, Exh. A ¶ VII.). And the agreement states that, for conduct after the second year, "defendants may defend any action for non-compliance on the grounds that defendants are in compliance with the federal laws that are the basis of the underlying action which is the subject of this Agreement." *Id.* at 117-118 (¶ IX.B.5.d.).

It is hard to envision a consent decree that would more fully accommodate the interest in leaving policy judgments to successor officials than does the settlement agreement here. It is hardly inequitable to continue that agreement in force. To the contrary, the state's conduct under that agreement demonstrates that it would be inequitable to *vacate* that agreement. Under established principles of equity, "[a] suitor's conduct in relation to the matter at hand may disentitle him to the relief he seeks." *U.S. Bancorp Mortgage Co. v. Bonner Mall Partnership*, 513 U.S. 18, 25 (1994) (internal quotation marks omitted). More than three months *before* this Court decided *Westside Mothers*, the state requested that CMS *reduce* the number of slots in its waiver programs "by nearly 1,200." J.A. 50 (R. 199 at 6). CMS granted that request, which the state made without notifying either the plaintiffs or the district court. As a result, the state, by its own actions, rendered itself unable to meet the settlement agreement's goal "to eliminate or sub-

stantially reduce the waiting list." *Id.* at 103 (R. 116, Exh. A ¶ II.). As the district court observed, the "unilateral[] and secretive[]" steps to reduce the number of slots is perhaps the "most troubling" aspect of the state's lack of compliance with the decree. *Id.* at 50 (R. 199 at 6). Under these circumstances, the district court's refusal to vacate the settlement agreement was hardly an abuse of discretion.

II. Because the District Court Did Not Decide Any Motion to Enforce the Settlement Agreement, No Question of Enforcement is Properly Before This Court

The state posits, as "a second, independent ground for reversal," that the district court "disregarded the explicit terms of the very agreement it purported to be enforcing." Opening Br. 30. Because the settlement agreement provides that, after two years, the state "may defend any action for non-compliance on the grounds that defendants are in compliance with the federal laws that are the basis of the underlying action which is the subject of this Agreement," J.A. 117-118 (R. 116, Exh. A ¶ IX.B.5.d.), and the state asserts that it is currently "in compliance with the Medicaid statute," Opening Br. 30, the state argues that the district court's judgment must be reversed.

This argument is fundamentally flawed. Although the plaintiffs filed in the district court a motion to enforce the settlement agreement based on

the state's conduct during years one and two, the district court has not yet decided it. In the very order from which the state appeals, the district court made clear that it had "held in abeyance" the plaintiffs' enforcement motion, and that it would now permit the plaintiffs to "file an amended or supplemental motion," set a discovery and briefing schedule, and "hold a hearing before resolving the motion." J.A. 61 (R. 199 at 17). The plaintiffs subsequently filed an amended motion, the parties completed briefing and discovery on it, and the district court held a hearing on the motion on January 23, 2008. R. 248. As the state itself admits, "the matter is currently pending before the court below." Opening Br. 13 n.3. Moreover, because the parties have reached an impasse in negotiating the state's duties for the third through fifth years of the agreement, the plaintiffs have moved (as the settlement agreement provides) to set the case for trial on the merits in the district court. See R. 214.

Because the motion for enforcement remains pending in the district court, and might well be rendered academic by a trial on the merits in any event, this Court lacks jurisdiction to consider the state's arguments about enforcement of the agreement. This Court's jurisdiction over this appeal rests on its power, under 28 U.S.C. § 1292(a)(1), to review orders refusing to vacate injunctions. As this Court ruled in its February 8, 2008, jurisdictional

order, the district court's denial of the state's Rule 60(b) motion was "an order refusing to vacate an injunction under" Section 1292(a)(1). *Brown v. Tennessee*, Nos. 07-6163/6325, Order at 2. But the analytically distinct question of whether and how to *enforce* the injunction against the state's derelictions during the first two years it was in effect—a question that is still pending in the district court—can in no way "be construed as granting, modifying, or denying an injunction." *Sherri A.D. v. Kirby*, 975 F.2d 193, 204-205 (5th Cir. 1992). Accordingly, this Court lacks jurisdiction under Section 1292 to consider it. See, *e.g.*, *id.*; *EEOC v. Recruit U.S.A., Inc.*, 939 F.2d 746, 757 (9th Cir. 1991) (although Section 1292 gave court of appeals jurisdiction over appeal from preliminary injunction, court lacked jurisdiction over sanctions motion on which "the district court ha[d] yet to rule").

Nor are the pending enforcement proceedings immediately appealable under the "collateral order" doctrine of 28 U.S.C. § 1291. That section grants jurisdiction over "final" orders only. *Id.* Accordingly, it does not authorize this Court to intervene and decide a motion that is pending in the district court. See *In re Post-Newsweek Stations, Michigan, Inc.*, 722 F.2d 325, 329 (6th Cir. 1983) ("'Appeal gives the [court of appeals] a power of review, not one of intervention. So long as the matter remains open, unfinished or

inconclusive, there may be no intrusion by appeal.'") (quoting *Cohen v. Beneficial Indus. Loan Corp.*, 337 U.S. 541, 546 (1949)).[14]

Even if this Court had *jurisdiction* over the enforcement question, there would be no basis for reversing the district court. The state is simply wrong to assert that "defendants *are* in compliance with the Medicaid statute as interpreted by this Court in *Westside Mothers*." Opening Br. 30. That assertion rests on the misreading of *Westside Mothers* that we identified in Part I, *supra*. As we have shown, *Westside Mothers* requires the state promptly to enroll eligible individuals in the Medicaid program so that they can obtain medical services from the third-party providers who contract with the state. But far from promptly enrolling eligible individuals into the waiver program, the state has *decreased* the number of new enrollments significantly, and the waiting list has accordingly exploded in population. See J.A. 126 n.1 (R.

[14] Nor is this issue a proper subject of pendent appellate jurisdiction. Such jurisdiction exists only when this Court's ruling on an issue over which it has jurisdiction "necessarily and unavoidably decides" a separate issue over which the Court would otherwise lack jurisdiction. *Brennan v. Township of Northville*, 78 F.3d 1152, 1158 (6th Cir. 1996). If we are correct about the principal issue on this appeal, and the district court did not abuse its discretion in refusing to vacate the settlement agreement, a decision by this Court to that effect will not decide *anything* about the enforcement motions still pending in the district court. Even if we are wrong, and the district court should have vacated the agreement, a decision by this Court to that effect will not "necessarily and unavoidably" decide whether the district court should respond to the state's violation of the decree *while it was concededly in effect* with additional remedies. Cf. *Frew*, 540 U.S. at 440 ("Once entered, a consent decree may be enforced.").

150, Exh. 2 at 2 n.1, 5). See generally pp. 14-15, *supra*. In any event, the pending proceedings in the district court—including the enforcement proceedings and the plaintiffs' motion to set a trial date on the merits—will give the state a full opportunity to argue that it is in compliance with the consent decree and the Medicaid Act, and it will give the plaintiffs a full opportunity to rebut those arguments. This Court ought not pretermit those proceedings.

CONCLUSION

The judgment of the district court should be affirmed.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 32(a)(7), I hereby certify that the foregoing brief uses a 14-point, proportionally spaced font, and contains 11,190 words. In generating this word count, I relied on the word-count function of Microsoft Office Word 2003, the program that was used to prepare the brief.

/s Samuel R. Bagenstos
Samuel R. Bagenstos

ADDENDUM

Pursuant to Sixth Circuit Rules 28(d) and 30(b), Plaintiffs-Appellees hereby designate the following portions of the record for inclusion in the Joint Appendix. Designations refer to the entire document or exhibit unless specific page ranges are set forth:

Docket Number	Date	Description
77	2/26/2003	11/14/2002 Deposition of Joanna Damons, pp. 163-179
81	2/26/2003	Deposition of Richard Kellogg, pp. 142-143 and Exh. 2
85	2/26/2003	Deposition of John Tighe, p. 34 and Exh. 4
70	2/18/2003	Declaration of Richard Kellogg (attachment to Memorandum in Support of Motion for Summary Judgment)
104	5/16/2003	Transcript of Proceedings on 5/2/2003, pp. 2-4, 13-15, 24-25
145	12/4/2006	Order
150, Exh. 2	1/18/2007	Memorandum (include full text of Memorandum, plus Exhibit D (June 5, 2006 letter) to that Memorandum)
188	6/11/2007	Order

CERTIFICATE OF SERVICE

I hereby certify that on May 23, 2008, I served two copies of the foregoing Final Brief for the Plaintiffs-Appellees via Federal Express overnight delivery on the following counsel:

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