

1 Medi-Cal providers and beneficiaries challenge the State of
2 California's impending 5% reduction in the reimbursement rate
3 paid to providers. Plaintiffs contend that the rate reduction
4 violates the Medicaid statute, particularly the quality of care
5 and equal access provisions, and they seek a preliminary
6 injunction preventing defendant Diana Bonta, the Director of the
7 California Department of Health Services, from implementing the
8 rate reduction when it is scheduled to go into effect on January
9 1, 2004.

10 The case presents two sorts of issues. First, the court
11 must decide whether plaintiffs have standing and whether Congress
12 has given them a cause of action under 42 U.S.C. § 1983 to
13 enforce certain provisions of the Medicaid statute. The court
14 concludes that Medi-Cal beneficiaries have both standing and a
15 cause of action and that Medi-Cal providers have third party
16 standing to assert claims on behalf of beneficiaries concerning
17 fee-for-service rates. However, the court does not find that
18 either beneficiaries or providers have a claim under § 1983 to
19 enforce the provisions in the Medicaid statute relating to
20 managed care plans. Those statutory provisions are addressed to
21 the Secretary of Health and Human Services, are designed to
22 reduce the State's costs, and do not unequivocally confer rights
23 on either providers or beneficiaries. Furthermore, because
24 managed care providers are contractually bound to provide
25 adequate services to Medi-Cal beneficiaries, beneficiaries in
26 managed care plans should not be adversely affected by the rate

1 cut. As will be explained, there are other avenues available to
2 managed care providers to protest the rate cut.

3 Second, the court must decide whether the across-the-board
4 5% rate cut, which was enacted by the California legislature,
5 violates the quality and equal access requirements of the
6 Medicaid Act. Under binding Ninth Circuit law, the Medicaid
7 statute grants a right to beneficiaries to a rate setting
8 decision by the State that is not arbitrary and that takes into
9 account provider costs, quality of service, and equal access to
10 medical services for Medi-Cal recipients. See Orthopaedic Hosp.
11 v. Belshe, 103 F.3d 1491, 1500 (9th Cir. 1997). Where the
12 administrative record reveals a considered decision by the
13 Department of Health Services that a certain rate is consistent
14 with the requirements of the Medicaid Act and the approved State
15 plan, the court will review that decision with deference. Given
16 the complexity of the Medi-Cal system, deference to the expertise
17 of the Department of Health Services is not only appropriate, it
18 is virtually a necessity. However, in this case, there is no
19 record of considered decisionmaking. There is no evidence that
20 the Director recommended the rate reduction, that the State
21 legislature ever sought the recommendation of the Director, or
22 that any responsible official in State government made a
23 determination that the pending rate reduction is consistent with
24 quality care and equal access in light of provider costs. Thus,
25 as to this rate reduction, there is no considered decisionmaking
26 process that the court may review. The decision to cut fee-for-

1 service rates across the board without analyzing the effect on
2 services to beneficiaries is arbitrary and violates federal law.
3 Accordingly, the court finds that the preliminary injunction
4 should issue as to the non-managed care, fee-for-service
5 reimbursement rates affected by the pending 5% rate reduction.

6 There are undoubtedly many ways in which the Director may
7 reduce overall Medi-Cal costs. For example, some of the medical
8 services provided by Medi-Cal are optional in the sense that they
9 are not required by the Medicaid statute. A decision to cut
10 these services from Medi-Cal would not implicate federal law even
11 though the decision could leave some beneficiaries without
12 coverage for medical care that few would consider "optional" in
13 the normal sense of the term. But when the decision involves a
14 cut to a reimbursement rate for a service that the State either
15 must or has elected to include within Medi-Cal, federal law
16 requires that the decision be based on a considered finding that
17 in light of provider costs the rate reduction will not affect the
18 quality of service afforded to beneficiaries or their equal
19 access to such medical service.

20 I. Facts and Procedural History

21 A. The Federal Medicaid Program

22 Medicaid is a federal program that distributes funds to
23 states in order to provide health care services for poor persons
24 who are aged, blind, disabled, or members of families with
25 dependent children. 42 U.S.C. §§ 1396a-1396v. The program is
26 jointly funded by the federal and state governments and is

1 administered by the states. The states determine eligibility,
2 the types of services covered, payment levels for services, and
3 other aspects of administration, within the confines of federal
4 law. See Orthopaedic Hosp., 103 F.3d at 1493. Federal law
5 requires participating states to provide a basic array of
6 services and allows states to provide certain additional optional
7 services, such as dental care, if they so choose. 42 U.S.C. §
8 1396a(a)(10); Elizabeth Blackwell Health Ctr. for Women v. Knoll,
9 61 F.3d 170, 173 (3d Cir. 1995).

10 In order to receive federal funds, a state prepares and
11 submits a state plan, which describes the standards and methods
12 to be used to set reimbursement rates for the services covered.
13 Orthopaedic Hosp., 103 F.3d at 1494. The state plan must be
14 approved by the Secretary of Health and Human Services. The
15 Medicaid Act sets out the requirements of a state plan at 42
16 U.S.C. § 1396a(a)(1)-(65). The provision central to these two
17 suits is § 1396a(a)(30)(A) ("Section 30(A)"). Section 30(A)
18 requires a state plan to:

19 provide such methods and procedures relating to the
20 utilization of, and the payment for, care and services
21 available under the plan . . . as may be necessary. . .
22 to assure that payments are consistent with efficiency,
23 economy, and quality of care and are sufficient to
24 enlist enough providers so that care and services are
25 available under the plan at least to the extent that
26 such care and services are available to the general
population in the geographic area.

These Section 30(A) standards are referred to as the "efficiency,
economy, and quality" requirement and the "equal access"
requirement.

1 The requirements of § 1396a, including Section 30(A), apply
2 to Medicaid programs that operate on the traditional fee-for-
3 service basis. Under this model, a Medicaid recipient may see
4 any enrolled service provider, who is reimbursed directly by the
5 state. 42 U.S.C. § 1395a. However, by way of a waiver from the
6 Secretary of Health and Human Services, states have the
7 alternative of contracting with managed care plans to provide
8 some or all of the covered services in exchange for payment under
9 a prepaid capitation rate or some other risk-based arrangement.
10 42 U.S.C. § 1396b(m). Under this arrangement, the managed care
11 plans receive predetermined periodic payments in return for
12 providing the required services. Under 42 U.S.C. §
13 1396b(m)(2)(A)(iii), the rates paid to the managed care plans
14 must be made on an "actuarially sound basis." Under 42 U.S.C. §
15 1396n(b)(4), the Secretary of Health and Human Services may grant
16 the necessary waivers that permit a state to require Medicaid
17 recipients to receive care through managed care programs, so long
18 as the managed care providers "meet, accept, and comply with the
19 reimbursement, quality, and utilization standards under the State
20 plan, which standards . . . are consistent with access, quality,
21 and efficient and economic provision of covered care and
22 services."

23 B. The California Medi-Cal Program

24 California's Medicaid program is known as Medi-Cal. See
25 Cal. Welf. & Inst. Code §§ 14000 et seq. It is administered by
26 the California Department of Health Services. Medi-Cal operates

1 on both a fee-for-service and managed care basis. California has
2 elected to provide 35 of the 36 available optional services.¹
3 (Menda Decl. Ex. A, p. 2.) The yearly cost of the Medi-Cal
4 program to the State is \$12 billion. The federal government
5 contributes something just over this amount to the State for the
6 operation of Medi-Cal.

7 California has an extensive regulatory framework for the
8 setting of reimbursement rates. See, e.g., Cal. Welf. & Inst.
9 Code §§ 14075, 14079, 14105. However, on the basis of the record
10 now before the court, it appears that the Department of Health
11 Services does not have any continuous study of rates and their
12 adequacy to meet the Section 30(A) requirements.² Nor is there
13 any record that the State legislature - authorized by the State
14 plan to make rate adjustments - has any ongoing study of rates
15 independent of the Department of Health Services.

16 In January 2003 and again in May 2003, the then-Governor
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19 ¹ These optional services include: dental care; podiatry;
20 optometry; physical therapy; occupational therapy; speech
21 pathology; audiology; drugs; prosthetic appliances; eyeglasses;
22 diagnostic, screening, preventive, and rehabilitative services;
23 hospice; psychology; certified midwife; medical supplies; hearing
24 aids; acupuncture; and drug addiction treatment and
rehabilitation. (Menda Decl. ¶ 4.) In addition, Medi-Cal pays
for illegal alien medical services provided by emergency rooms,
which is the most expensive way in which to provide medical
services that are not actual emergencies. (See Campbell Decl.
Ex. D, p. 3. (illegal alien coverage costs \$852 million))

25 ² According to the Legislative Analyst, the Department
26 has "no rational basis" for its rate system and has not for many
years. (Campbell Decl. Ex. D, p. 16.) The rates for various
services have been adjusted a number of times over the last 15
years, mostly on an "ad hoc" basis. (Id.)

1 proposed an across-the-board 15% rate cut in Medi-Cal
2 reimbursement rates as part of his proposed budget. (S. Thompson
3 Decl. ¶ 7.) When the State legislature failed to enact a budget
4 by July 1, 2003 (as required by state law), a compromise budget
5 proposal was negotiated. (Id. ¶ 9.) This proposal, which was
6 ultimately enacted into law, includes a 5% cut in the Medi-Cal
7 reimbursement rate. This rate cut applies across-the-board,
8 though certain services are excepted. The rate cut is codified
9 in Welf. & Inst. Code § 14105.19, as follows:

10 (a) Due to the significant state budget deficit
11 projected for the 2003-04 fiscal year, and in order to
12 implement changes in the level of funding for health
13 care services, the Director of Health Services shall
14 reduce provider payments as specified in this section.

(b) (1) Payments shall be reduced by 5 percent for
Medi-Cal program services for dates of service on and
after January 1, 2004.

15 The statute also requires the Department of Health Services to
16 reduce the capitation payments to managed care plans by the
17 "actuarial equivalent" of 5%. Welf. & Inst. Code §
18 14105.19(b)(3). The actuarial equivalent of the reimbursement
19 rate reduction varies depending on the characteristics of the
20 managed care plan and its members, but the typical reduction is
21 approximately 3%. (See Campbell Decl. Ex. E, pp. 1-3; Tough
22 Decl. ¶ 6.) The rate cut is anticipated to save \$245 million in
23 reimbursement costs borne by the State between January 1 and June
24 30, 2004. (Menda Decl. ¶ 9.)

25 C. The Parties

26 The plaintiffs in CIV-S-03-2110 are a pharmacist enrolled as

1 a Medi-Cal provider and two Medi-Cal recipients. The plaintiffs
2 in CIV-S-03-2336 are all membership organizations that represent
3 the interests of Medi-Cal providers and recipients. Only one of
4 these organizations, the Disabled Rights Union, has members who
5 are Medi-Cal recipients. (See Edmon Decl. ¶¶ 3-4.) Others, for
6 example, the California Chapter of the American College of
7 Cardiology, have members who are Medi-Cal providers.³ (See Watson
8 Decl. ¶ 3.) Two organizations, the Brain Injury Policy Institute
9 and the California Foundation for Independent Living, advocate on
10 behalf of Medi-Cal recipients, but have no Medi-Cal beneficiaries
11 as members. (See Vick Decl. ¶¶ 1-5; Yeager Decl. ¶ 3.)

12 Diana Bonta is the defendant in both suits. She is sued in
13 her official capacity as Director of the Department of Health
14 Services.⁴

15 II. Standing

16 The question of plaintiffs' standing is the first of a set
17 of interrelated issues relating to whether plaintiffs, or some of
18 them, may assert a claim under § 1983. Because standing affects
19 the court's jurisdiction to go any further, it must be addressed
20 first. But the standing inquiry is not independent of the two
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22 ³ At least one of these, the AIDS Healthcare Foundation, is
23 itself a Medi-Cal provider. (Stidham Decl. ¶ 4.) The Foundation
operates a Medi-Cal managed care plan. (*Id.* ¶ 5.)

24 ⁴ Plaintiffs in CIV-S-03-2110 also name the Department of
25 Health Services as a defendant. However, the Department is
immune from suit under the 11th Amendment and, therefore, must be
26 dismissed, leaving Director Bonta as the sole defendant.
Pennhurst State School & Hosp. v. Halderman, 465 U.S. 89, 100,
104 S.Ct. 900 (1984).

1 additional questions that must be addressed before reaching the
2 merits of the dispute: (1) does the Medicaid statute confer any
3 rights on either Medi-Cal providers or recipients that may be
4 enforced by a private right of action under 42 U.S.C. § 1983; and
5 (2) if there is such a right, what is the substance of that
6 right? In the sections that follow the standing analysis, the
7 court concludes that only Medi-Cal recipients have a claim under
8 § 1983, not providers, and that this claim extends only so far as
9 the equal access to quality care provisions of Section 30(A).
10 Further, in keeping with Ninth Circuit precedent, the court finds
11 that the right guaranteed by Section 30(A) has a large procedural
12 component: Medi-Cal recipients are entitled to a considered rate
13 making decisional process in which equal access to quality care
14 is evaluated in relation to provider costs and the proposed rate.
15 The standing analysis presages these conclusions by focusing on
16 beneficiary standing to advance the procedural component of the
17 Section 30(A) entitlement.

18 Standing consists of two broad levels of analysis, both of
19 which are implicated in this case. The most basic analysis
20 involves whether plaintiffs satisfy the constitutional minimum
21 requirements of injury-in-fact, causation, and redressability.
22 Courts have also crafted various prudential standing doctrines,
23 two of which, associational standing and third-party standing,
24 are at issue here. The first question is whether Medi-Cal
25 beneficiaries and providers have Article III standing to seek to
26 enjoin the 5% rate cut. The second question is whether Medi-Cal

1 providers have third-party standing to assert the rights of Medi-
2 Cal beneficiaries. The final standing issue is whether
3 beneficiary and provider organizations, who make up most of the
4 plaintiffs in these suits, have associational standing to bring
5 suit on behalf of their respective members.

6 A. Article III Standing of Medi-Cal Beneficiaries and
7 Providers

8 To comply with the requirements of Article III standing, a
9 plaintiff must satisfy three elements: injury-in-fact, causation,
10 and redressability. See Lujan v. Defenders of Wildlife, 504 U.S.
11 555, 560-61, 112 S.Ct. 2130 (1992).

12 The Article III standing analysis in this case is relatively
13 straightforward. Medi-Cal beneficiaries and providers will
14 suffer concrete injury caused by the 5% cut if it is permitted to
15 go into effect. The injury to providers is obvious. As to
16 beneficiaries, plaintiffs have presented sufficient evidence
17 showing that at least some Medi-Cal providers will cease
18 participating in the Medi-Cal program altogether or will refuse
19 to take on new Medi-Cal patients if rates are reduced by 5%.⁵

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21 ⁵ For instance, one practice group that provided primary
22 care and OB/GYN services for 1500 Medi-Cal fee-for-service
23 patients will stop providing anything but OB/GYN services to
24 those patients, and may discontinue even those services as well.
25 (Polansky Supp. Decl. ¶ 4.) Another provider is one of the only
26 dermatological practices in the Bay Area to treat Medi-Cal
patients. (Geisse Decl. ¶ 6.) Appointments for Medi-Cal
patients are already restricted to "children, emergencies, severe
debilitating dermatologic conditions, and cancer victims." (Id.)
After the rate reduction, this practice will have to stop taking
most new Medi-Cal patients. (Id. ¶ 11.) Additionally,
plaintiffs have presented statistical evidence that physician
participation in Medi-Cal was low before the rate reduction.

1 (See, e.g., Mazer Decl. ¶ 9; Kuon Decl. ¶ 10.) This reduction in
2 the number of providers in the program will adversely affect
3 beneficiaries' equal access to medical care and, quite possibly,
4 its quality.

5 Moreover, as to redressability, an injunction prohibiting
6 the rate reduction at least until a proper study of reimbursement
7 rates has been conducted would redress providers' and
8 beneficiaries' impending injury. Under the relaxed
9 redressability standards applicable in procedural standing cases,⁶
10 plaintiffs need demonstrate only that proper consideration of

12 (Bindman Decl. Ex. A, p. 2.) All of this evidence tends to
13 confirm the statements made in many declarations that
14 reimbursement rates for many services are already set below
15 providers' costs. (See, e.g., Yelamanchili Decl. ¶ 10; Coughlin
16 Decl. ¶ 7.)

17 ⁶ Plaintiffs seek to vindicate what is in part a procedural
18 right, the right to have the State of California consider certain
19 factors when setting Medi-Cal reimbursement rates. See
20 Orthopaedic Hosp., 103 F.3d at 1500; infra at 32-34. This is a
21 "procedural right" in the sense that it is a "procedural
22 requirement the disregard of which could impair a separate and
23 concrete interest of" plaintiffs (i.e., Medi-Cal beneficiaries'
24 interest in receiving equal access to medical care). Lujan, 504
25 U.S. at 572. In a case involving a procedural right, the
26 standards of redressability and causation applied in normal
standing cases are relaxed. See Laub v. U.S. Dep't of the
Interior, 342 F.3d 1080, 1086-87 (9th Cir. 2003); Hall v. Norton,
266 F.3d 969, 975 (9th Cir. 2001); Lujan, 504 U.S. at 572 & n.7.
Plaintiffs in a procedural standing case need not establish that,
were the government to follow the proper procedures, its ultimate
action would be different. Instead, plaintiffs in a procedural
standing case need demonstrate only that the factors the
government failed to consider could have an influence on the
ultimate outcome. Laub, 342 F.3d at 1087; Hall, 266 F.3d at 977.
Thus, in order to establish causation and redressability,
plaintiffs in this case need demonstrate only that consideration
of Medi-Cal providers' costs in relation to equal access to
quality services could influence the reimbursement rates the
State ultimately sets.

1 provider costs in setting Medi-Cal reimbursement rates could
2 influence the ultimate level at which those rates are set. See
3 Laub, 342 F.3d at 1087; Hall, 266 F.3d at 977. Plaintiffs have
4 made this demonstration. Thus, both Medi-Cal providers and
5 beneficiaries have Article III standing to pursue this case.

6 B. Third-Party Standing

7 In addition to advancing their own interests, the provider
8 organization plaintiffs seek to assert the interests of their
9 Medi-Cal beneficiary patients. To assert such third-party
10 standing, the person or entity seeking to represent another: (1)
11 must have suffered an injury-in-fact, (2) must have a close
12 relationship with the third party, and (3) there must be "some
13 hindrance" or a "genuine obstacle" to the third party's ability
14 to assert its own interests. Powers v. Ohio, 499 U.S. 400, 410-
15 411, 111 S.Ct. 1364 (1991); Singleton v. Wulff, 428 U.S. 106,
16 112-116, 96 S.Ct. 2868 (1976). All of these criteria are
17 satisfied in this case.

18 Medi-Cal providers will suffer a concrete economic injury if
19 the 5% cut in their reimbursement rate is implemented. Moreover,
20 Medi-Cal providers have a sufficiently close relationship with
21 their patients who are Medi-Cal beneficiaries to meet the second
22 factor in the third-party standing analysis. Indeed, the
23 providers are in a unique position to advance the interests of
24 Medi-Cal beneficiaries, since it is they who can predict the
25 effect of a reimbursement rate cut on the services they intend to
26 provide. See, e.g., Singleton, 428 U.S. at 117 (explaining that

1 a patient cannot secure medical services without the aid of a
2 doctor and that an impecunious patient cannot secure medical
3 services without his or her doctor's being reimbursed by the
4 government for the doctor's services).

5 Whether Medi-Cal beneficiaries face "some hindrance" or a
6 "genuine obstacle" to their ability to assert their own rights is
7 a closer question. Here, the obstacle Medi-Cal beneficiaries
8 face is a lack of information about the effect of Medi-Cal
9 reimbursement rates on providers in light of providers' costs and
10 the further effect of a rate cut on the provision of services to
11 Medi-Cal beneficiaries.⁷ Providers are the ones who know the
12 relationship of reimbursement to service and to their costs. As
13 compared to beneficiaries, they are in a far better position to
14 evaluate the State's decisional process and the data relied upon
15 by the State in determining reimbursement rates. This
16 informational hurdle is similar in kind to those found sufficient
17 in Powers and Singleton to confer third-party standing, and it

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19 ⁷ The Supreme Court has in the past recognized a lack of
20 incentive in the form of "practical barriers to suit" because of
21 "the small financial stake involved and the economic burdens of
22 litigation" as an obstacle sufficient for third-party standing
23 purposes. Powers, 499 U.S. at 414-415. Defendant points out
24 that the Ninth Circuit has held that "[a] simple lack of
25 motivation does not constitute a 'genuine obstacle' to asserting
26 an interest." Viceroy Gold Corp. v. Aubry, 75 F.3d 482, 489 (9th
Cir. 1996) (holding that an employer does not have third-party
standing to challenge a labor statute on its employees' behalf
simply because the "employees probably would not be motivated to
assert their own interests because they lack a sufficient
individual economic stake in the outcome"). There seems to be
some tension between Powers and Viceroy Gold on this point, but
it is not material to the "genuine obstacle" analysis in this
case.

1 suffices, at least at this point in the litigation, to confer
2 third-party standing on Medi-Cal providers to assert the
3 interests of their patients who are Medi-Cal beneficiaries.

4 C. Associational Standing

5 In CIV-S-03-2336, all of the plaintiffs are organizations
6 whose members are either Medi-Cal providers or Medi-Cal
7 beneficiaries. Under Hunt v. Wash. State Apple Adver. Comm'n,
8 432 U.S. 333, 343, 97 S.Ct. 2434 (1977), an organization has
9 standing to sue on behalf of its members if "(a) its members
10 would otherwise have standing to sue in their own right; (b) the
11 interests it seeks to protect are germane to the organization's
12 purpose; and (c) neither the claim asserted nor the relief
13 requested requires the participation of individual members in the
14 lawsuit."

15 1. Beneficiary Organizations

16 The only true beneficiary organization is the Disabled
17 Rights Union.⁸ It has about 400 members, the "vast majority" of
18 whom are Medi-Cal beneficiaries.⁹ (Edmon Decl. ¶ 3.) In light of
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20 ⁸ Defendant argues that there is no evidence (outside of
21 plaintiffs' affidavits) of the existence of this organization, in
22 that there is no record of its registration with the California
23 Secretary of State or the Attorney General. However, a
24 supplemental declaration from Beverly Edmon, the director of the
25 Disabled Rights Union, makes clear that the Disabled Rights Union
26 is a bona fide organization that has been registered with the
Secretary of State since 1981 as "an unincorporated nonprofit
association." (Edmon Suppl. Decl. ¶ 3.)

⁹ At the hearing on this motion, defendant also pointed out
that Ms. Edmon is not herself a Medi-Cal beneficiary. This is
irrelevant for purposes of determining whether the Disabled
Rights Union has associational standing to assert its members'

1 its membership and purpose, the first two steps of the
2 associational standing test are met: Medi-Cal beneficiaries
3 would have standing to sue in their own right, and one of the
4 purposes of the Disabled Rights Union is to help Medi-Cal
5 recipients obtain access to Medi-Cal services. (Edmon Decl. ¶¶
6 4, 6, 8.) The final requirement - whether the claim or relief
7 requires individual members to participate - is also satisfied.
8 As the Third Circuit recently pointed out in a case based on
9 similar facts, "[t]he need for some individual participation . .
10 . does not necessarily bar associational standing under this
11 third criterion." Pa. Psychiatric Soc'y v. Green Spring Health
12 Servs., Inc. ("PPS"), 280 F.3d 278, 283 (3d Cir. 2002).

13 Here, plaintiffs seek only injunctive relief such that an
14 individualized showing on damages will not be required.
15 Moreover, whatever individualized showing may be made as to
16 access and quality, a significant component of plaintiffs' claim
17 is directed at the State's failure to follow a considered
18 decisionmaking process as required by Orthopaedic Hospital.
19 Evidence about what the State considered - or failed to consider
20 - when it enacted the rate reduction will not require
21 individualized proof by beneficiary members. See PPS, 280 F.3d
22 at 286.

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interests. Ms. Edmon's declarations state that the "vast
majority" of the Disabled Rights Union's members are Medi-Cal
beneficiaries.

1 2. Provider Organizations

2 The next question is whether the provider organizations that
3 make up most of the plaintiffs in these suits have associational
4 standing to assert both the direct interests of their Medi-Cal
5 provider members and their members' third-party interest in
6 protecting the rights of their Medi-Cal patients.

7 Medi-Cal providers have standing to sue in their own right
8 to enjoin a reimbursement cut.¹⁰ Less well-established is whether
9 a provider organization may claim associational standing to
10 assert the interests of beneficiaries, where association members
11 have third-party standing on behalf of beneficiaries. In the
12 most analogous case, the Third Circuit found that associational
13 standing followed from the third party standing of association
14 members. In that case an organization of psychiatrists was
15 permitted to assert the interests of patients because its
16 members' individually had third party standing to advance their
17 patients' interests. See PPS, 280 F.3d at 291; Tacy F. Flint, A
18 New Brand of Representational Standing, 70 U.Chi.L.Rev. 1037
19 (2003) (arguing that there is no constitutional impediment to
20 combining associational and third party standing). The reasoning
21 in PPS is persuasive. As to the second Hunt factor, there is no
22 dispute that the interests of Medi-Cal providers and
23 beneficiaries are germane to the purposes of these organizations.

24
25 ¹⁰ Defendant argues that Medi-Cal providers lack standing
26 because they do not have a right to enforce 42 U.S.C. §
1396a(a)(30)(A) under 42 U.S.C. § 1983. (Def.'s Opp'n at 7-8.)
This is not an argument about standing but about the merits of
the providers' legal theory.

1 Finally, for the same reasons discussed above in the context of
2 beneficiary organizations, individual participation by members is
3 not necessary. Thus, the provider organizations here have
4 standing to assert the interests of providers and beneficiaries
5 alike.

6 III. Existence of an Enforceable Right Under 42 U.S.C. § 1983

7 The plaintiffs bring suit under 42 U.S.C. § 1983, which
8 provides a remedy for persons who are deprived of "any rights,
9 privileges, or immunities secured by the Constitution and laws."

10 The Supreme Court has held that the phrase "and laws" permits
11 persons to sue for the violation of rights secured to them by
12 federal statute. See Maine v. Thiboutot, 448 U.S. 1, 4-8, 100
13 S.Ct. 2502 (1980). However, not all federal statutes create

14 individual rights that can be enforced through § 1983. See
15 Blessing v. Freestone, 520 U.S. 329, 340, 117 S.Ct. 1353 (1997).

16 The Court has developed a three factor test to determine whether
17 a federal statutory provision creates an enforceable right: (1)
18 Congress must have intended that the provision benefit the
19 plaintiff; (2) the right must not be so "vague and amorphous"
20 that its enforcement would strain judicial competence; and (3)
21 the statute must unambiguously impose a binding obligation on the
22 states. Id. at 340-41.

23 The Court recently clarified this test in Gonzaga University
24 v. Doe, 536 U.S. 273, 283, 122 S.Ct. 2268 (2002). The plaintiff
25 in Gonzaga brought suit under § 1983 to enforce a provision in
26 the Family Educational Rights and Privacy Act (FERPA), which

1 limits the release of a student's educational records without
2 permission. The Court found that FERPA does not confer an
3 enforceable right because the language of the statute does not
4 focus on the protected student, but rather on the Secretary and
5 the educational institution, and is couched in terms of a "policy
6 and practice" rather than any one individual's entitlement.
7 Moreover, the Court found that the structure of the statute also
8 suggests that Congress did not intend to create a right under §
9 1983 because the statute provides for an administrative remedy.
10 In reaching its holding, the Court rejected the view that it is
11 enough for a plaintiff to show membership in a group generally
12 benefitted by a statute; rather, "[f]or a statute to create such
13 private rights, its text must be 'phrased in terms of the persons
14 benefitted,'" not the person regulated or any aggregate group.
15 Id. at 284. Thus, Gonzaga requires close attention to the
16 wording and structure of a statute to determine whether Congress
17 has created an individual entitlement that may give rise to a
18 claim under section 1983.

19 There is an additional complication in applying the Gonzaga
20 test to § 1396a of the Medicaid statute. In two identical
21 statutes, Congress spoke directly, if opaquely, to the approach
22 courts should use in determining whether Congress intended to
23 create an enforceable right in different portions of the Social
24 Security Act, including its Medicaid provisions. See 42 U.S.C.
25 §§ 1320a-2 & 1320a-10. These statutes are identically worded,
26 and the fact that there are two such statutes is probably a

1 mistake.¹¹ The statutes provide as follows:

2 In an action brought to enforce a provision of this
3 chapter, such provision is not to be deemed
4 unenforceable because of its inclusion in a section of
5 this chapter requiring a State plan or specifying the
6 required contents of a State plan. This section is not
7 intended to limit or expand the grounds for determining
8 the availability of private actions to enforce State
9 plan requirements other than by overturning any such
10 grounds applied in Suter v. Artist M., 112 S.Ct. 1360
11 (1992), but not applied in prior Supreme Court
12 decisions respecting such enforceability; provided,
13 however, that this section is not intended to alter the
14 holding in Suter v. Artist M. that section 671(a)(15)
15 of this title is not enforceable in a private right of
16 action. 42 U.S.C. § 1320a-2.

17 The two statutes were enacted in 1994 after the Court's decision
18 in Suter v. Artist M., 503 U.S. 347, 112 S.Ct. 1360 (1992).¹² The
19 intended effect of the statutory language is at best uncertain
20 because the reference to "any such grounds applied in [Suter],
21 but not applied in prior Supreme Court decisions" is open to
22 interpretation. However, "the fairest reading of Section 1320a-2
23 [and 1320a-10] is that Congress was concerned . . . that a court
24 should not eviscerate an otherwise enforceable right merely
25 because it appears in a statute mandating that participating
26 states include a particular provision in their state plans."
Messier v. Southbury Training School, 916 F.Supp. 133, 144-45
(D.Conn. 1996); see also Harris v. James, 127 F.3d 993, 1002-03
(11th Cir. 1997). But see LaShawn A. v. Barry, 69 F.3d 556, 568-

24 ¹¹ See Pub. L. 103-382 (42 U.S.C. § 1320a-2); Pub. L. 103-
25 432 (42 U.S.C. § 1320a-10).

26 ¹² The Supreme Court did not consider the effect of this
statute in Blessing, which dealt with Title IV-D of the Social
Security Act. Blessing, 520 U.S. at 332.

1 70 (D.C. Cir. 1995), vacated by 87 F.3d 303 (1996) (holding that,
2 because Suter did not use an approach different from past cases,
3 §§ 1320a-2 & 1320a-10 are without any effect). In light of
4 sections 1320a-2 and 1320a-10, when applying Gonzaga to the
5 particular sections of the Medicaid Act at issue here, the court
6 will not consider that an individual entitlement is absent simply
7 because the wording of the statute is directed to the required
8 contents of a state plan as opposed to the rights of a
9 beneficiary or provider under a plan. Thus, provisions that
10 require certain contents in state plans can create rights
11 enforceable under § 1983, so long as they otherwise meet the test
12 employed by the Court in Suter, Blessing and Gonzaga.¹³

13 A. Section 30(A)

14 Plaintiffs contend that Section 30(A) creates an individual
15 right for both Medicaid providers and beneficiaries. They rely
16 primarily on the Ninth Circuit's decision in Orthopaedic Hospital
17 v. Belshe, 103 F.3d 1491 (9th Cir. 1997), and the Supreme Court's
18 decision in Wilder v. Virginia Hospital Association, 496 U.S.
19 498, 110 S.Ct. 2510 (1990). In Orthopaedic Hospital, the Ninth
20 Circuit held that a Medi-Cal rate reduction violated Section
21 30(A). 103 F.3d at 1496. The case was brought under § 1983 by a
22

23 ¹³ The court respectfully notes that Congress would give
24 greater assistance to the courts, and retain its proper authority
25 over an important policy and political question - when and by
26 whom suit may be brought - by directly stating which provisions
give rise to a claim under section 1983, and for whom, rather
than commenting, in vague language, on particular approaches
adopted by the Supreme Court to divine Congress' unexpressed
intent.

1 provider hospital, and the district court had held that Section
2 30(A) creates an enforceable right for Medicaid providers.¹⁴
3 (Bookman Decl. Ex. A, p. 7.) However, this question was not
4 addressed by the Ninth Circuit and apparently was not put in
5 issue on appeal. Since the question was not actually decided by
6 the court, but only assumed, Orthopaedic is not binding on
7 whether providers have an enforceable right under Section 30(A)
8 and § 1983. See Sorenson v. Mink, 239 F.3d 1140, 1149 (9th Cir.
9 2001) ("unstated assumptions on non-litigated issues are not
10 precedential holdings"); Estate of Magnin v. Comm'r, 184 F.3d
11 1074, 1077 (9th Cir. 1999).

12 The plaintiffs' reliance upon the Supreme Court's decision
13 in Wilder is similarly unavailing. Wilder did not deal with
14

15 ¹⁴ Plaintiffs contend that this holding of the district
16 court precludes the defendant from arguing that Section 30(A)
17 does not create an enforceable right. (CMA's Mot. at 19-21.)
18 The court, however, declines to find preclusion. First, the
19 district court's June 28, 1991 decision in Orthopaedic Hospital
20 came before the Supreme Court's decisions in Suter, Blessing, and
21 Gonzaga, which refined the enforceable rights analysis. See
22 Steen v. John Hancock Mut. Life Ins. Co., 106 F.3d 904, 914 (9th
23 Cir. 1997) (holding that collateral estoppel does not apply when
24 there is a "significant change in the legal climate"). Second,
25 because of the unique position of the government in litigation, a
26 state should not ordinarily be subjected to nonmutual offensive
issue preclusion. See United States v. Mendoza, 464 U.S. 154,
162-63, 104 S.Ct. 568 (1984) (holding that nonmutual offensive
issue preclusion does not apply against federal government);
Hercules Carriers, Inc. v. Claimant Fla., 768 F.2d 1558,
1577-1582 (11th Cir. 1985) (holding that nonmutual offensive
issue preclusion is not available against the state government);
Chambers v. Ohio Dep't of Human Servs., 145 F.3d 793, 801 n.14
(6th Cir. 1998) (holding that nonmutual issue preclusion should
not apply against the state government); Helene Curtis, Inc. v.
Assessment Appeals Bd., 76 Cal.App.4th 124, 133, 90 Cal.Rptr.2d
31 (1999) (holding that, as a matter of state law, nonmutual
offensive issue preclusion does not apply against the state).

1 Section 30(A) but with another provision of the Medicaid Act, 42
2 U.S.C. § 1396a(a)(13)(A), the Boren Amendment, which subsequently
3 has been repealed. 496 U.S. at 501. The Court in Wilder held
4 that the Boren Amendment created an enforceable right for
5 Medicaid providers. Id. The Boren Amendment required states to
6 pay certain providers rates that "the State finds, and makes
7 assurances satisfactory to the Secretary, are reasonable and
8 adequate to meet the costs which must be incurred by efficiently
9 and economically operated facilities in order to provide care and
10 services in conformity with applicable State and Federal laws."
11 Id. at 503. Plaintiffs argue that the language of Section 30(A)
12 is indistinguishable from the Boren Amendment.

13 Even assuming the continued vitality of Wilder after
14 Gonzaga, the language of Section 30(A) is not the same as that of
15 the Boren Amendment. Both the Fifth and the Third Circuits have
16 so held. See Pa. Pharmacists Ass'n v. Houstoun, 283 F.3d 531,
17 538 (3d Cir. 2002) (en banc) ("The language of Section 30(A)
18 contrasts sharply with that of the Boren Amendment. . . .");
19 Evergreen Presbyterian Ministries, Inc. v. Hood, 235 F.3d 908,
20 926-28 (5th Cir. 2000) ("However, in contrast to the Boren
21 Amendment, section 30(A) does not create an individual
22 entitlement in favor of any provider."). Gonzaga makes clear
23 that a court must examine the specific statutory provision at
24 issue in determining whether it creates an enforceable right.
25 Thus, the question here is whether Section 30(A), not the
26 repealed Boren Amendment, creates an enforceable right under the

1 standards announced in Gonzaga, as modified by 42 U.S.C. §§
2 1320a-2 and 1320a-10.

3 1. Congressional Intent to Confer a Right

4 The first step under Gonzaga is to determine whether
5 Congress unambiguously intended to create an enforceable right.
6 Gonzaga, 536 U.S. at 280. The focus is on the text and structure
7 of the statute. Id. at 284-86. As the Third Circuit has found,
8 the efficiency and economy requirements of Section 30(A) are
9 aimed at benefitting the State and preserving Medi-Cal/Medicaid
10 funds. Pa. Pharmacists, 283 F.3d at 537. Neither requirement
11 assists either providers or beneficiaries. Moreover, as both the
12 Third and Fifth Circuits further found, quality and access do not
13 benefit providers, but do directly benefit beneficiaries. Id.;
14 Evergreen Presbyterian Ministries, 235 F.3d at 928-29. Further
15 in favor of a claim by beneficiaries, the two requirements are
16 not phrased in aggregate or indirect terms - such as requiring a
17 general policy or requiring substantial compliance - that might
18 suggest that no single beneficiary is entitled to quality care or
19 equal access. Thus, the statutory language suggests that
20 providers do not have an enforceable right under § 1983, but that
21 beneficiaries do.

22 Admittedly, as to beneficiaries, the language of Section
23 30(A) is not the paragon of rights-creating language, like Title
24 VI of the Civil Rights Act. However, the structure of §
25 1396a(a), as a list of requirements that a state plan must meet,
26 largely prevented Congress from using the sort of "no person

1 shall" language cited by the Gonzaga Court. And it is precisely
2 this structure -- a provision's inclusion as a requirement of a
3 state plan -- that Congress, in §§ 1320a-2 and 1320a-10, directed
4 the courts to ignore when determining whether the provision
5 creates an enforceable right under § 1983. Moreover, it has been
6 generally understood, even after Suter and Blessing, that Section
7 30(A) creates an enforceable right for recipients. See Pa.
8 Pharmacists, 283 F.3d at 544 ("Medicaid recipients plainly
9 satisfy the intended-to-benefit requirement and are thus
10 potential private plaintiffs."); Evergreen Presbyterian
11 Ministries, 235 F.3d at 928 ("[T]he recipient plaintiffs have an
12 individual entitlement to the equal access guarantee of section
13 30(A)."). Finally, unlike the statute in Gonzaga, a Medi-Cal
14 beneficiary can resort to no administrative procedure to seek
15 quality care or equal access.

16 Such legislative history as there is also supports the
17 conclusion that Congress intended a private enforcement action
18 under section 1983 for beneficiaries but not for providers.
19 When the Boren Amendment was repealed, the legislative history
20 indicates a congressional intent to end provider suits. See H.R.
21 Rep. No. 105-149, at 590 (1997) ("It is the Committee's intention
22 that, following enactment of this Act, neither this nor any other
23 provision of [42 U.S.C. § 1396a] will be interpreted as
24 establishing a cause of action for hospitals and nursing
25 facilities relative to the adequacy of the rates they receive.").
26 Indeed, this was Congress' "dominant objective." Pa.

1 Pharmacists, 283 F.3d at 540 n.15. On the other hand, in passing
2 certain 1981 amendments to section 30(A), Congress noted that "in
3 instances where the States or the Secretary fail to observe these
4 statutory requirements, the courts would be expected to take
5 appropriate remedial action." H.R. Rep. No. 97-158, at 301
6 (1981). As the Third Circuit noted, this statement suggests
7 that Congress intended that some class of plaintiffs, such as
8 beneficiaries, would be able to enforce the terms of section
9 30(A) by private suit under § 1983.

10 The court holds that in Section 30(A) Congress created
11 rights to quality care and equal access that may be enforced by
12 Medicaid recipients under § 1983. However, the language of the
13 statute does not unambiguously create such rights in Medicaid
14 providers, given that economy, efficiency, quality, and equal
15 access do not evince an intent to benefit providers. The focus
16 of Section 30(A), and the Medicaid Act generally, is upon
17 Medicaid recipients. Providers are benefitted only incidentally,
18 not directly, and Gonzaga clarifies that simply receiving a
19 benefit is not enough to demonstrate the intentional creation of
20 an enforceable right. The two circuit courts to have considered
21 the enforceability of Section 30(A) most recently both decided
22 that Congress intended to create a right for Medicaid recipients
23 but not providers. Pa. Pharmacists, 283 F.3d at 544; Evergreen
24 Presbyterian Ministries, 235 F.3d at 928-29. The court follows
25 these holdings and the reasoning of these decisions.
26

1 2. Vague and Ambiguous

2 The second factor in the enforceable rights analysis is
3 whether the right at issue is too vague and ambiguous for
4 judicial enforcement. As previously discussed, Section 30(A) is
5 intended to create a right to both quality care and equal access.
6 Equal access - access equivalent to privately insured persons in
7 the same geographic area - is sufficiently definite for
8 enforcement by courts. See, e.g., Evergreen Presbyterian
9 Ministries, 235 F.3d at 930 (agreeing with "the many other courts
10 that have addressed the equal access provision that it is not too
11 vague and amorphous to be beyond the competence of the judiciary
12 to enforce").

13 The term "quality of care" is less definite. Unlike the
14 access language, there is no point of reference - for example,
15 equal in quality to that received by the general population in
16 the geographic area. However, the Ninth Circuit has already
17 construed the term "quality of care" as meaning that rates must
18 "bear a reasonable relationship to efficient and economical
19 [providers'] costs." Orthopaedic Hosp., 103 F.3d at 1496. This
20 formulation requires the State to consider providers' costs in
21 setting rates. Given this construction, further discussed below,
22 the right of recipients to quality care is not so vague and
23 ambiguous that its enforcement would strain judicial competence.¹⁵

25 ¹⁵ The court expresses no opinion as to whether a claim to
26 quality services would be judicially manageable where the issue
were other than whether rates have been set in consideration of
cost of service.

1 3. Binding Obligation

2 The final factor in the enforceable rights analysis is
3 whether the statutory provision imposes a binding obligation on
4 the states. Gonzaga, 536 U.S. at 282. The provision must be
5 phrased in "mandatory, rather than precatory, terms." Id.
6 (quoting Blessing, 520 U.S. at 340-41.). Although Medicaid is an
7 optional program, once a state elects to participate, the
8 contents of the state plan specified in § 1396a(a) are required,
9 not optional. Section 30(A) uses only mandatory language. It
10 imposes a binding obligation on any state that participates in
11 the Medicaid program.

12 In sum, the quality and access provisions of Section 30(A)
13 meet the Supreme Court's three factor test, as clarified in
14 Gonzaga, for finding a statutory right enforceable through §
15 1983. However, this right extends only to recipients and not to
16 providers.

17 B. Managed Care Provisions

18 There are two Medi-Cal managed care provisions that the
19 plaintiffs claim create rights enforceable under § 1983: 42
20 U.S.C. §§ 1396b(m)(2)(A)(iii) and 1396n(b)(4). Section
21 1396b(m)(2)(A)(iii) requires states to pay "actuarially sound"
22 rates to Medicaid managed care plans. Nothing in this provision
23 benefits, or creates rights for, Medicaid recipients. By
24 contracting with the State, the managed care plan must guarantee
25 to provide services to recipients. (Pierson Decl. ¶ 3.) The
26 actuarial soundness provision does not add anything that directly

1 benefits the recipients, such as requirements of quality care or
2 equal access. Moreover, it is at least unclear that the
3 actuarial soundness provision is intended to create a right for
4 providers to a certain reimbursement rate. It is equally
5 plausible that the section is intended to protect the State plan
6 from overpayment.

7 The plaintiffs argue that the applicable regulation suggests
8 that the term "actuarially sound" is intended to benefit
9 providers. (CMA's Reply at 33.) However, even assuming that it
10 is permissible to base a § 1983 right on a regulation,¹⁶ the
11 applicable regulation is itself far from clear:

12 Actuarially sound capitation rates means capitation
13 rates that--

14 (A) Have been developed in accordance with
15 generally accepted actuarial principles and
16 practices;

17 (B) Are appropriate for the populations to be
18 covered, and the services to be furnished
19 under the contract; and

20 (C) Have been certified, as meeting the
21 requirements of this paragraph (c), by
22 actuaries who meet the qualification
23 standards established by the American Academy
24 of Actuaries and follow the practice
25 standards established by the Actuarial
26 Standards Board. 42 C.F.R. § 438.6(c) (1) (I).

Plaintiffs argue that the requirement that the rates be

¹⁶ Whether federal regulations can create rights enforceable under § 1983 is not at all clear. However, there are good reasons to think that they cannot. See Wright v. City of Roanoke Redev. & Hous. Auth., 479 U.S. 418, 437-38, 107 S.Ct. 766 (1987) (O'Connor, J., dissenting) (noting concerns with allowing regulations to create enforceable rights); S. Camden Citizens in Action v. N.J. Dep't of Env'tl. Prot., 274 F.3d 771, 790 (3d Cir. 2001) (holding that regulations do not create enforceable rights when they are too far removed from congressional intent).

1 "appropriate for the populations to be covered, and the services
2 to be furnished under the contract" is intended to create a right
3 to a minimum payment level for providers. (CMA's Reply at 33.)
4 But plaintiffs read too much into the word "appropriate." The
5 plain meaning of this regulation is that to be "actuarially
6 sound" a rate must be based on the demographics of the area to be
7 served and the services provided there. Nothing in this concept
8 requires any particular level of reimbursement or consideration
9 of provider costs. In light of Gonzaga, this language is too
10 oblique to create an enforceable right under § 1983 for
11 providers.

12 The second managed care provision at issue, § 1396n(b)(4),
13 states that:

14 The Secretary, to the extent he finds it to be
15 cost-effective and efficient and not inconsistent with
16 the purposes of this subchapter, may waive such
17 requirements of section 1396a of this title . . . as
18 may be necessary for a State- . . . (4) to restrict the
19 provider from (or through) whom an individual (eligible
20 for medical assistance under this subchapter) can
21 obtain services (other than in emergency circumstances)
22 to providers or practitioners who undertake to provide
23 such services and who meet, accept, and comply with the
24 reimbursement, quality, and utilization standards under
25 the State plan, which standards shall be consistent
26 with the requirements of section 1396r-4 of this title
and are consistent with access, quality, and efficient
and economic provision of covered care and services, if
such restriction does not discriminate among classes of
providers on grounds unrelated to their demonstrated
effectiveness and efficiency in providing those
services and if providers under such restriction are
paid on a timely basis in the same manner as health
care practitioners must be paid under section
1396a(a)(37)(A) of this title. 42 U.S.C. §
1396n(b)(4).

The convoluted grammar of this section defeats authoritative

1 interpretation. But unlike Section 30(A), § 1396n(b)(4) does not
2 directly confer a right to equal access to quality care upon
3 Medi-Cal beneficiaries. Rather, the section permits the
4 following sequence:

5 1. The Secretary in his guided discretion ("to the extent
6 he finds it to be cost-effective and efficient and not
7 inconsistent with the purposes" of Medicaid);

8 2. May waive other requirements of § 1396a and grant
9 permission to a state to create managed care programs that
10 restrict beneficiaries to certain managed care providers;

11 3. If the providers agree to comply with the state plan,
12 including the requirements of "access, quality, and efficient and
13 economic provision" of services.

14 The apparent intention of this provision is not to benefit
15 Medi-Cal recipients, who would otherwise have a greater degree of
16 choice of providers under the fee-for-service system, but to
17 benefit the state plan by providing a possibly more cost-
18 effective way to provide medical services.

19 Furthermore, this provision, and managed care in general,
20 inserts the managed care plan as an intermediary between the
21 patient-recipient and the practitioner-providers. In the fee-
22 for-service context, it is the State itself that is obligated to
23 provide access to quality services to Medi-Cal beneficiaries. In
24 the managed care system, it is the managed care plan that
25 assumes, by its contract with the State, the obligation of
26 providing access and quality services to beneficiaries. The two

1 examples of plan contracts in the record contain quite detailed
2 provisions relating to the quality of services and the managed
3 care plan's duty to provide access to those services.¹⁷ (See
4 Pierson Decl. Exs. 1 & 2.) If the managed care plan fails to
5 provide required services, then there are internal grievance
6 procedures for plan members, and the State may also take action
7 against the provider for failing to adhere to its contract. (Id.
8 Ex. 1, pp. 8-34, 8-36.) Under the contract, whatever the
9 capitation rates paid to the managed care provider, the duties
10 owed by the provider do not vary. For example, the managed care
11 plans are specifically bound by contract to "maintain adequate
12 numbers and types of specialists within the network." (Id., p.
13 7-4.) If a plan causes too many of its specialists to stop
14 seeing Medi-Cal patients, by passing along the full capitation
15 rate reduction to its doctors, then the plan will be in breach of
16 its contract with the State. If a beneficiary plan member is
17 denied needed medical treatment because the plan has failed to
18 enroll specialists, then the beneficiary may initiate an
19 administrative proceeding. If the managed care plan defaults
20 because of the capitation rate, then Medi-Cal beneficiaries will
21 be eligible for regular fee-for-service coverage. In sum, §
22 1396n(b)(4) is directed toward the relationship between the State
23 and the managed care plan, has little direct effect upon the

24
25 ¹⁷ For example, the Health Net of California plan contract
26 requires Health Net to maintain a network of primary care
physicians, who are located within thirty minutes or ten miles of
beneficiaries' residences. (Pierson Decl. Ex. 2, Exhibit A,
Attachment 6.8.)

1 services made available to beneficiaries, and does not provide a
2 standard by which capitation rates can be evaluated. Under
3 Gonzaga, beneficiaries are too indirectly benefitted, if at all,
4 by § 1396n(b)(4) to assert a right enforceable under § 1983.

5 Section 1396n(b)(4) also fails to create any right for the
6 managed care plans themselves. The quality and access language
7 does not benefit the plan. Moreover, the managed care plan's
8 relationship with the State is contractual. If the State has
9 breached its contract by lowering the payment to the plan, then
10 the plan's remedy is a breach of contract action in state court.
11 If the contract allows the State to reduce rates in this manner,
12 then that is a risk assumed by the plan. Section 1396n(b)(4)
13 affords no rights to managed care providers in their dealings
14 with the State.

15 IV. The Scope of Plaintiffs' Rights

16 Having decided that the beneficiary plaintiffs who are not
17 in managed care plans have rights to equal access and quality
18 care enforceable under § 1983, the court must determine the scope
19 of those rights. In doing so, the court is guided by the Ninth
20 Circuit's decision in Orthopaedic Hospital. In Orthopaedic
21 Hospital, plaintiff challenged adjustments to reimbursement rates
22 for several procedures and services. Orthopaedic Hosp., 103 F.3d
23 at 1494. The court held that Section 30(A) requires the State
24 "to consider the costs of providing. . . services" and that
25 reimbursement rates "should bear a reasonable relationship to an
26 efficient and economical [provider's] costs of providing quality

1 care." Id. at 1500. The court reviewed the State's rate setting
2 under an arbitrary and capricious standard.¹⁸

3 The Orthopaedic Hospital rule is mostly procedural - the
4 state agency must consider the proper factors in developing a
5 reimbursement rate. Because costs were not considered by the
6 State, the court did not reach the further question of whether
7 the resulting rate was appropriate under Section 30(A).

8 The Ninth Circuit's approach has substantial practical
9 benefits. The Medicaid Act is clearly intended to give states
10 discretion and flexibility in setting reimbursement rates, within
11 the limits of federal law. See Evergreen Presbyterian
12 Ministries, 235 F.3d at 361 n.12; Children's Hosp. and Health
13 Ctr. v. Belshe, 188 F.3d 1090, 1103 (9th Cir. 1999). The
14 arbitrary and capricious standard limits the court's review of
15 the State's rate setting and permits the court to defer to the
16

17
18 ¹⁸ The arbitrary and capricious standard is normally used
19 to review federal administrative action under the Administrative
20 Procedure Act, but that act does not address review of state
21 actions. Dep't of Transp. & Dev. of La. v. Beaird-Poulan, Inc.,
22 449 U.S. 971, 973, 101 S.Ct. 383 (1980) ("the APA is of course
23 not applicable to state agencies"). However, most courts have
24 used this standard to review state agency rate setting under
25 Medicaid. See Ark. Med. Soc'y, Inc. v. Reynolds, 6 F.3d 519,
26 529-30 (8th Cir. 1993) (reviewing compliance with Section 30(A)
under arbitrary and capricious standard); Concourse Rehab. &
Nursing Ctr. Inc. v. Whalen, 249 F.3d 136, 145 (2d Cir. 2001)
(reviewing compliance with Boren Amendment under arbitrary and
capricious standard); Lett v. Magnant, 965 F.2d 251, 257 (7th
Cir. 1992) (Boren Amendment); AMISUB (PSL), Inc. v. Colo. Dep't
of Soc. Servs., 879 F.2d 789, 799-800 (10th Cir. 1989) (Boren
Amendment); see Wilder, 496 U.S. at 520 n.18 (noting that "the
Courts of Appeals generally agree that . . . a federal court
employs a deferential standard of review" in reviewing state
Medicaid rate setting).

1 judgment of specialists in a complex regulatory field. Envntl.
2 Def. Ctr., Inc. v. U.S. EPA, 344 F.3d 832, 858 n.36 (9th Cir.
3 2003). Furthermore, it is fair to assume that a rate that is set
4 arbitrarily, without reference to the Section 30(A) requirements,
5 is unlikely to meet the equal access and quality requirements.
6 Thus, a beneficiary plaintiff may insist that the State, at a
7 minimum, consider the effect of a rate reduction on equal access
8 to quality services in light of provider costs.¹⁹ Orthopaedic
9 Hosp., 103 F.3d at 1500.

10 V. Preliminary Injunction Standard

11 The traditional factors for granting a preliminary
12 injunction are: (1) a strong likelihood of success on the merits;
13 (2) irreparable injury; (3) a balance of hardships in the
14 movant's favor; and (4) the public interest (in cases affecting
15 it). See L.A. Mem'l Coliseum Comm'n v. Nat'l Football League,
16 634 F.2d 1197, 1200 (9th Cir. 1980). The moving party can meet
17 its burden by making "a clear showing of either (1) a combination
18 of probable success on the merits and a possibility of
19 irreparable injury, or (2) that its claims raise serious

20
21 ¹⁹ In general, the Director's approach to Orthopaedic
22 Hospital in this litigation has been puzzling. The defendant has
23 argued extensively in briefs and at argument that Orthopaedic was
24 wrongly decided, even stating at one point that its "holding must
25 be overturned." (Def.'s Supp. Brief at 2.) The defendant has
26 attempted to convince the court that it simply cannot comply with
Orthopaedic Hospital's requirement of conducting cost studies,
declaring that "Orthopaedic is an example of the impractical and
unreasonable requirement of relying upon cost studies as a basis
for rate setting." (Opp'n to CMA's Mot. at 27.) If the
defendant wishes to argue the impracticality or invalidity of
Orthopaedic Hospital, she must do so before the Ninth Circuit.

1 questions as to the merits and that the balance of hardships tips
2 in its favor." Conn. Gen. Life Ins. Co. v. New Images of Beverly
3 Hills, 321 F.3d 878, 881 (9th Cir. 2003). "These two
4 formulations represent two points on a sliding scale in which the
5 required degree of irreparable harm increases as the probability
6 of success decreases." Taylor By and Through Taylor v. Honig,
7 910 F.2d 627, 631 (9th Cir. 1990).

8 A. Irreparable Injury

9 An irreparable injury is one that cannot be adequately
10 redressed by a legal or equitable remedy following trial.
11 Campbell Soup Co. v. ConAgra, Inc., 977 F.2d 86, 91 (3d Cir.
12 1992). Plaintiffs come forward with adequate evidence that the
13 rate reduction has a likelihood of reducing the recipient
14 plaintiffs' access to medical services, including services by
15 pharmacists.²⁰ (See supra note 5.) Medi-Cal recipients who must
16 wait until after trial to receive appropriate services may well
17 sustain irreparable injury, whether in pain suffered or
18 irremediable worsening of a condition. A future permanent
19 injunction after a full trial is not an adequate remedy for
20 someone who has been denied necessary medical care in the
21 interim.

22
23
24 ²⁰ Both plaintiffs and defendant make evidentiary
25 objections to each others' submissions. The objections either
26 lack merit or do not affect the court's overall assessment of the
record. See also Flynt Distrib. Co., Inc. v. Harvey, 734 F.2d
1389, 1394 (9th Cir. 1984) (holding that court can consider
inadmissible evidence in the context of a motion for preliminary
injunction).

1 Defendant argues that there is too much uncertainty
2 surrounding the impact of the 5% rate reduction to support
3 plaintiffs' claim of irreparable injury. (Opp'n to CMA's Mot. at
4 28.) But plaintiffs have produced evidence of serious access
5 problems even under the current rates. (See, e.g., Anaya, Sr.
6 Decl. ¶¶ 4-6; Anaya, Jr. Decl. ¶¶ 4-6; Geisse Decl. ¶¶ 5-6, 11;
7 Low Decl. ¶¶ 7-8.) Plaintiffs have also produced evidence of
8 providers who will stop taking new Medi-Cal patients or stop
9 serving Medi-Cal patients altogether if the rate reduction is
10 implemented. (See, e.g., Polansky Decl. ¶¶ 4-6; Germano Decl. ¶¶
11 3-6; Geisse Decl. ¶ 11.) Given plaintiffs' high likelihood of
12 success on the merits, discussed below, this evidence of
13 irreparable injury is sufficient to support a preliminary
14 injunction.

15 B. Likelihood of Success on the Merits

16 Section 30(A) requires the State to consider quality and
17 access when setting Medi-Cal reimbursement rates. In order to
18 properly consider quality and access, the State must consider
19 what it costs providers to perform the various services and
20 procedures. Orthopaedic Hosp., 103 F.3d at 1500.

21 The State's purpose in enacting the rate reduction was to
22 reduce the budget deficit. The statute declares on its face that
23 the rate reduction is "[d]ue to the significant state budget
24 deficit projected for the 2003-04 fiscal year." Cal. Welf. &
25 Inst. Code § 14105.19(a). While the State certainly is entitled
26 to conserve funds, the defendant has produced no evidence that

1 the State legislature based the rate reduction on evidence that
2 the reduction could be sustained by providers, in light of their
3 costs, without a loss of quality or equal access for Medi-Cal
4 recipients. Indeed, what little evidence there was before the
5 State legislature suggested that a rate reduction might be
6 inconsistent with quality and access. For example, the
7 Legislative Analyst's report on the original proposed 15% rate
8 reduction states that California's reimbursement rates, when
9 adjusted for cost-of-living, are among the ten lowest in the
10 country. (Campbell Decl. Ex. D, p. 16.) The report warns that a
11 rate reduction could negatively affect access to services. (*Id.*,
12 pp. 14-16.) Finally, the report declares that California has "no
13 rational basis for [its] rate system" which can lead to
14 "overpayments for some medical procedures and underpayments for
15 others."²¹ (*Id.*, p. 16.)

16 The defendant argues that the State legislature's initial
17 rejection of the 15% rate cut shows that it did consider the
18 relevant factors in enacting the lower cut. (Opp'n to CMA's Mot.
19 at 22-24.) The defendant cites an Assembly subcommittee agenda
20 that directed certain inquiries to the Department of Health

21
22 ²¹ In 2001, the Legislative Analyst produced a report
23 entitled A More Rational Approach to Setting Medi-Cal Physician
24 Rates. Elizabeth Hill, A More Rational Approach to Setting Medi-
25 Cal Physician Rates, available at
26 http://www.lao.ca.gov/2001/020101_medi-cal_rates.pdf. The report
is critical of the Department of Health Services for not
conducting regular, periodic rate reviews to ensure the
consistency of rates with access to quality medical care. It
also argues that the rate adjustments the Department has made
over the years have not been based upon any assessment of
recipients' access. *Id.* at 1-4.

1 Services. (Campbell Decl., Ex. C.) The agenda does show that
2 the Assembly was concerned about "the impact of such a
3 significant rate reduction on the availability of providers."
4 (Id., p. 5.) However, there is no evidence of any response from
5 the Department to the committee's inquiries that could now
6 support a 5% cut.

7 In CIV-S-03-2110, which is focused solely on pharmacy
8 services, the defendant argues that the State has met the
9 Orthopaedic Hospital standard because the rates it pays are based
10 on a pharmacy's acquisition costs. (Def.'s Suppl. Brief After
11 Hearing at 5-6.) The evidence does show that reimbursement rates
12 for prescription drugs are based upon a formula that includes the
13 acquisition costs of drugs. (Hillbloom Decl. ¶¶ 5-8.) However,
14 there is no evidence that the State legislature had any evidence
15 about the consistency of the rate cut with access to quality
16 pharmacy services.²²

17 Under the standard of Orthopaedic Hospital, the plaintiffs
18 demonstrate a high likelihood of success on the merits. There is
19 no evidence that the State considered the relevant factors when
20 it enacted the rate reduction. Budget constraints are not alone
21 a valid justification for rate setting. See Ark. Med. Soc'y,
22 Inc., 6 F.3d at 531 ("Abundant persuasive precedent supports the
23

24 ²² The defendant has produced some evidence to show that
25 pharmacies' costs will continue to be met after the 5% rate
26 reduction. (Def.'s Suppl. Brief at 6-7.) If so, the record
suggest that this outcome is by luck, not design. Nonetheless,
there is no evidence that the State considered the possible
effect on beneficiaries' access to pharmacist services.

1 proposition that budgetary considerations cannot be the
2 conclusive factor in decisions regarding Medicaid."); Orthopaedic
3 Hosp., 103 F.3d at 1499 n.3; AMISUB, 879 F.2d at 800-01.

4 C. Public Interest and the Balance of Hardships

5 In deciding to grant an injunction, a court must consider
6 the balance of hardships and, in a case such as this, the public
7 interest. The defendant argues that the court should refrain
8 from issuing a preliminary injunction because of the State's
9 "unprecedented budget deficit." (Opp'n to CMA's Mot. at 43.)

10 The defendant maintains that the State was faced with very
11 difficult choices and made the best decision that it could.

12 (Id.) For example, the defendant points out that instead of
13 reducing rates across the board, "the state could have chosen to
14 eliminate certain optional benefits such as prescription drugs
15 for adults," but that this would be a harsh result (Id.)

16 The court is mindful of the difficult position facing
17 California. However, the terms of the State's participation in
18 Medicaid do not permit it to continue to receive federal monies
19 while violating the requirements of the statute, even for a good
20 purpose, such as maintaining optional benefits. As long as the
21 State wishes to be a part of the Medicaid program, it must meet
22 the requirements of the Medicaid Act.

23 The court also notes that this injunction does not leave the
24 State without options for reducing its Medicaid expenditures.
25 First, after proper study and consideration of the relevant
26 factors, the defendant may be able to show that a reduced

1 reimbursement rate in some medical services is not arbitrary but
2 in fact is consistent with quality care and equal access.
3 Second, there are other ways the State can save money within the
4 Medi-Cal program. The Legislative Analyst has recommended
5 several alternatives to an across-the-board rate reduction
6 including expanding the medical case management program,
7 increasing copayments for non-essential services, increasing
8 competition for the State's managed care contracts, and expanding
9 managed care enrollment among the elderly and disabled.
10 (Campbell Decl. Ex. D, pp. 18, 20, 24, 25.) The State also
11 chooses to provide Medi-Cal recipients with a number of services
12 not required by federal law. An earlier proposal called for
13 eliminating 18 of the 34 offered optional benefits, which would
14 have saved the State approximately \$360 million. (Id. Ex. C, p.
15 6.) While all of these "optional" services are obviously
16 important to the recipients, the State does have the authority to
17 drop optional services to reduce costs. What the State cannot do
18 under the statutory terms of its participation in Medicaid is to
19 elect to provide a service but then fail to fund it such that
20 Medi-Cal recipients receive less than equal access to quality
21 care for that service.

22 Given that the State has other options available to it and
23 that plaintiffs are likely to succeed on the merits of their
24 claim, the court finds that the public interest does not weigh
25 against issuance of a preliminary injunction.
26

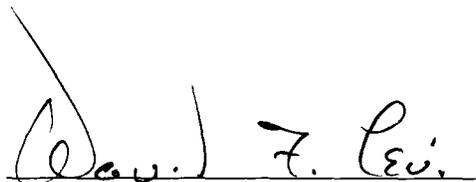
1 VI. Conclusion

2 Because the State failed to consider the effect of a rate
3 reduction on beneficiaries' equal access to quality medical
4 services, in view of provider costs, the pending rate reduction
5 is arbitrary and cannot stand. Defendant Bonta is enjoined from
6 implementing the 5% reimbursement rate reduction required by
7 Welfare and Institutions Code § 14105.19 pending further
8 proceedings in this court. This injunction does not apply to §
9 14105.19(b)(3), which reduces capitation rates paid to managed
10 care plans by the actuarial equivalent of 5%. The injunction
11 also does not apply to § 14105.19(b)(2), which reduces payments
12 made in certain non-Medi-Cal programs.

13 The Department of Health Services is dismissed from CIV-S-
14 03-2110 on the basis of 11th Amendment immunity.

15 IT IS SO ORDERED.

16 Dated: 23 December 2003.

17
18 

19 DAVID F. LEVI
20 United States District Judge
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25
26

United States District Court
for the
Eastern District of California
December 23, 2003

* * CERTIFICATE OF SERVICE * *

2:03-cv-02110
2:03-cv-02336

Clayworth

v.

Bonta

I, the undersigned, hereby certify that I am an employee in the Office of the Clerk, U.S. District Court, Eastern District of California.

That on December 23, 2003, I SERVED a true and correct copy(ies) of the attached, by placing said copy(ies) in a postage paid envelope addressed to the person(s) hereinafter listed, by depositing said envelope in the U.S. Mail, by placing said copy(ies) into an inter-office delivery receptacle located in the Clerk's office, or, pursuant to prior authorization by counsel, via facsimile.

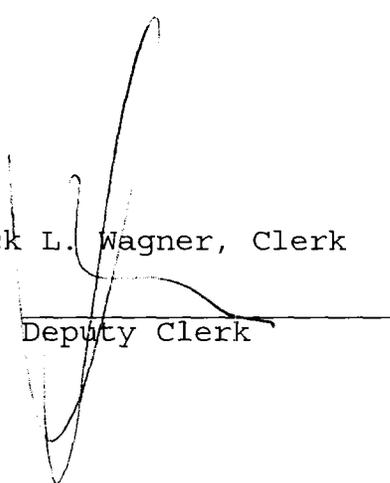
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