

U.S. Court of Appeals Docket No. 04-15532
(Decided August 2, 2005, O'Scannlain, Cowen and Bea, Circuit Judges)

IN THE
UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

CALIFORNIA MEDICAL ASSOCIATION; AMERICAN ACADEMY OF
PEDIATRICS-CALIFORNIA DISTRICT IX; AMERICAN COLLEGE OF
OBSTETRICIANS AND GYNECOLOGISTS-DISTRICT IX; CALIFORNIA
CHAPTER, AMERICAN COLLEGE OF CARDIOLOGY; CALIFORNIA
CHAPTER, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS;
CALIFORNIA DENTAL ASSOCIATION; LONG TERM CARE PHARMACY
ALLIANCE; CALIFORNIA FOUNDATION FOR INDEPENDENT LIVING
CENTERS; CALIFORNIA PHARMACISTS ASSOCIATION; AIDS
HEALTHCARE FOUNDATION; PROFESSIONAL PHARMACY ALLIANCE
OF CALIFORNIA, INC.; BRAIN INJURY POLICY INSTITUTE; LONG TERM CARE
MANAGEMENT COUNCIL; OSTEOPATHIC PHYSICIANS AND SURGEONS OF
CALIFORNIA, DISABLED RIGHTS UNION,
Plaintiffs-Appellees,

vs.

DIANA M. BONTA, DIRECTOR OF THE DEPARTMENT OF HEALTH SERVICES,
STATE OF CALIFORNIA
Defendant-Appellant.

PETITION FOR PANEL REHEARING AND REHEARING EN BANC

On Appeal From the United States District Court
For The Eastern District of California
The Honorable David F. Levi, Judge
(Court Docket No. CIV-S-03-2336 DFL PAN)

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I. INTRODUCTION

The Court issued a memorandum disposition in these cases (*Clayworth, et al. v. Bonta* (“*Clayworth*”), No. 04-15498, and *California Medical Association, et al. v. Bonta* (“*CMA*”), No. 04-15532)¹, reversing the district court’s issuance of a preliminary injunction and relying solely on the Court’s companion opinion filed the same day in *Sanchez v. Johnson*, No. 04-15228, 2005 WL 1804195 (“*Sanchez*”). Appellees seek rehearing or rehearing en banc in their own right. However, this petition focuses on *Sanchez*, which the panel here found dispositive of the issues.

Sanchez holds that Medicaid beneficiaries have no private right of action under Section 1983 of the Civil Rights Act (“Section 1983”) to enforce Medicaid’s “equal access” statute, 42 U.S.C. § 1396a(a)(30)(A) (“Section (30)(A)”). That holding strips Medicaid beneficiaries of their right to health care commensurate with the care available to the general insured population, raises issues of exceptional importance that will reverberate around the country, and represents a radical departure from decisions in this and other circuits.

If these cases are not reheard, they will almost certainly accelerate the crisis in access to healthcare in California, causing a return to a two-tiered health care

¹ Appellees in *CMA* and *Clayworth* are filing separate petitions. Appellees here attach a copy of the district court’s opinion in *Clayworth v. Bonta*, 295 F.Supp.2d 1110 (E.D.Cal. 2003).

system in which the economically less fortunate have only marginal access to necessary services. Although *Sanchez* purports to glean congressional intent as to Section (30)(A)'s enforceability by barring Medicaid beneficiaries from using the federal courts to require states to set Medicaid payment rates at federally-mandated levels, it conflicts with both Congress's directive that equal access cannot be guaranteed without adequate payment rates and the federal courts' enforcement of that guarantee over the past two decades.

Sanchez's holding that Medicaid beneficiaries (as opposed to providers²) have no private right of action to enforce Section (30)(A) under Section 1983 conflicts with every other circuit—the Third, Fourth, Fifth, Sixth, Seventh, and Eighth—that has addressed the issue. *Sanchez* reasoned that the Supreme Court's decision in *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002), determines enforceable rights and eviscerates all these circuit decisions. That reasoning is unsound, particularly because *Gonzaga* did not reverse *Wilder v. Virginia Hospital Ass'n*, 496 U.S. 498 (1990), an analytical twin of the cases here.

² Although the district court in *Clayworth* held providers do not have a private right of action to enforce Section (30)(A), it also held the provider and provider association plaintiffs had third-party standing to enforce the rights of Medi-Cal beneficiaries. The state challenged this latter holding, but given the panel's conclusion that beneficiaries do not have a private right of action to enforce Section (30)(A), the panel did not reach the standing issue. Resolution of it is unnecessary to uphold the preliminary injunction, as some plaintiffs in *Clayworth* and *CMA* are Medi-Cal beneficiaries and beneficiary associations.

In addition to raising issues of exceptional importance, *Sanchez* conflicts with *Wilder* and with at least two of this Court's decisions. In *Orthopaedic Hospital v. Belshe*, 103 F.3d 1491 (9th Cir. 1997), this Court ordered enforcement of Section (30)(A)'s mandates by holding that hospital outpatient payment rates in California's Medi-Cal program did not ensure consistency with efficiency, economy and quality of care. *See also Clark v. Coye*, No. 92-15131 (unpub. affirmance reported at 967 F.2d 585 (9th Cir. 1992), 1992 WL 140278 (citable under Ninth Cir.R. 36-3(b)(iii)), *aff'g liability and remanding as to relief Clark v. Kizer*, 758 F. Supp. 572 (E.D. Cal. 1990) (holding low reimbursement rates in California's Denti-Cal program failed to guarantee Medi-Cal beneficiaries equal access to services). *Sanchez* has effectively reversed *Orthopaedic* and *Clark* based on reasoning that is inconsistent with the results in those cases.

Clayworth and *CMA* are excellent examples of the need for and amenability of Section (30)(A) to judicial enforcement. Plaintiffs in those matters—a coalition of Medi-Cal beneficiaries and health care providers—sought a preliminary injunction to prevent a five percent across-the-board reduction in Medi-Cal rates from taking effect as scheduled in January 2004. The Legislature imposed that reduction—without any studies, analysis or consideration of its impact on the quality and access to care for Medi-Cal recipients—because of the “significant state budget deficit projected for the 2003-04 fiscal year.” Cal. Welf. & Inst. Code

§14105.19(a); *Clayworth*, 295 F.Supp.2d at 1128. Plaintiffs presented evidence below showing that the threatened rate reductions would further reduce the ability of Medi-Cal beneficiaries to obtain health care services commensurate with those available to the general insured population and that the State already pays rates so low that fewer and fewer providers participate. Based on evidence that the State had failed to consider the relevant factors of “quality” and “access,” the district court enforced Section (30)(A) by preliminarily enjoining the scheduled rate reduction, thus assuring that federally-guaranteed access to services to Medi-Cal beneficiaries would not be further reduced. *Id.* at 1129.

Given the district court’s application of Section (30)(A) in *Clayworth/CMA* and the statute’s enforcement by courts around the country (*see infra*)—including *Orthopaedic* and *Clark*—the panel’s view that Section (30)(A) is “ill-suited to judicial remedy” [*Sanchez*, 2005 WL 1804195, at *6] is unsupportable.

II. THE PANEL’S DECISION CONFLICTS WITH THIS COURT’S PRECEDENTS

Sanchez interpreted *Gonzaga* in a way that is inconsistent with this Court’s previous analysis of that decision and with how this Court has addressed cases seeking enforcement of Section (30)(A). *Sanchez* acknowledged that the three-prong test articulated in *Blessing v. Freestone*, 520 U.S. 329 (1997), remains the standard for determining whether a federal statute is enforceable under Section

1983. *Sanchez*, 2005 WL 1804195, at *3, *8.³ Although *Sanchez* also indicated that *Gonzaga* resolved a possible “inconsistency” in the test’s first prong [*id.* at *3], it misapplied the test by essentially conflating the first and second prongs, blending the inquiry about whether Congress intended to establish enforceable rights with the separate inquiry about whether the statute is too vague to be easily prone to judicial enforcement.

Sanchez’s view of Section (30)(A), moreover, is at odds with *Orthopaedic*. *Sanchez* viewed the statute’s mandate that payments be “consistent with efficiency, economy, and quality of care” as a statement of “competing goals” that cannot support an enforceable standard and is “ill-suited to judicial remedy.” *Sanchez*, 2005 WL 1804195, at *6. But *Orthopaedic* held that rates must be set by considering responsible cost studies and that if rates deviate from costs, reasoned explanations are required. This is a clear and enforceable standard, as the *Clayworth* district court recognized. *Clayworth*, 295 F.Supp.2d at 1123-24 (“This formulation requires the State to consider providers’ costs in setting rates. Given this construction... the right of recipients to quality care is not so vague and ambiguous that its enforcement would strain judicial competence.”).

³ That test, originally articulated in *Wilder*, requires a showing that: (1) Congress must have intended the statute to benefit the plaintiffs; (2) the right the statute assertedly protects must not be so vague or amorphous that its enforcement would strain judicial resources; and (3) the statute that protects that right must be mandatory rather than precatory. *Blessing*, 520 U.S. at 340-41.

Even more importantly, *Sanchez* all but ignored Section (30)(A)'s "equal access" component. Added in 1989, that provision requires setting payments at levels sufficient to enlist a sufficient number of providers so health care services are available to Medicaid beneficiaries to the same extent they are available to the general population in the same area. Indeed, this Court in *Clark* recognized the judicial enforceability of the "equal access" mandate, by affirming the district court's holding that "Denti-Cal" rates were so low that a sufficient number of providers were not participating, resulting in a violation of the mandate. *Clark*, 1992 WL 140278, at *2. *Clark*'s affirmance on liability led to a magistrate judge's decision, later upheld, that ordered the setting of rates at specific levels to assure adequate access. *Clark v. Coye*, No. Civ. S-87-1700 JFM, 1992 WL 370801, at *2 (E.D.Cal. 1992), *aff'd as to injunction*, 8 F.3d 26 (9th Cir. 1993). Thus, Section (30)(A)'s mandates are specific enough to be judicially enforced. *Sanchez*'s erroneous view on that issue colored its analysis as to whether Congress intended the statute to include an enforceable right.

Sanchez is also inconsistent with this Court's recent analysis of *Gonzaga* in *Price v. City of Stockton*, 390 F.3d 1105 (9th Cir. 2004). *Price* declared that *Gonzaga* affirmed but did not displace the *Blessing* test [*id.* at 1110 n.4] and

confirmed *Wilder*'s continuing validity.⁴ *Id.* at 1111. There, the Court applied *Gonzaga*'s analytical framework to the "text and structure" of Section 104 of the Housing and Community Development Act ("HCDA") and ruled that some of its provisions created private rights of action while others did not. *Id.* at 1111-14. Accordingly, it held that 42 U.S.C. § 5304(k) clearly mandated "benefits to any person involuntarily and permanently displaced" and that such provision was "phrased with an unmistakable focus on the benefited class." *Id.* at 1111. Because 42 U.S.C. §§ 5304(d)(2)(A)(iii) and 5304(d)(2)(A)(iv) identified certain relocation benefits that grantees were required to provide to displaced individuals, when read together with 42 U.S.C. § 5304(k), they confirmed Congress's intent to confer an enforceable entitlement to such benefits on displaced persons. *Id.* at 1113. In contrast, 42 U.S.C. §§ 5304(d)(2)(A)(i) and 5304(d)(2)(A)(ii) served to ensure the

⁴ In contrast, *Sanchez* labeled *Wilder* "anomalous," and failed to recognize the striking similarity between the Medicaid provision at issue in *Wilder*, which found a private right of action, and Section (30)(A). *Wilder* found a private right of action in former 42 U.S.C. §1396a(a)(13)(A) (the Boren Amendment), which required state Medicaid Plans to reimburse at rates determined in accordance with state-developed methods and standards that the State finds reasonable and adequate to meet the costs facilities must incur and to ensure eligible individuals have reasonable access. *Wilder*, 496 U.S. at 518-519. There is no significant difference in the language of the Boren Amendment and Section (30)(A). Both require the states to set Medicaid rates according to a certain standard ("reasonable and adequate" in one statute, "sufficient" in the other) to guarantee Medicaid beneficiaries access to services. This Court has recognized the similarity between the two. *See Orthopaedic*, 103 F.3d at 1498-99. There is no legitimate basis for finding a private right of action in one but not the other.

availability of low and moderate income dwellings that “could have been, but were not occupied by anyone.” *Id.* at 1113. This Court found these latter statutes, which did not focus on individuals or entitlements, were phrased in the aggregate and therefore did not create individual rights. *Id.*

The panel here, however, erroneously found Section (30)(A) was written in the aggregate. *Sanchez*, 2005 WL 1804195, at *5. The panel focused on the language requiring States to develop “methods and procedures” for providing “care and services,” and analogized to the statutes found wanting in *Price*. *Id.* at *5-7. But a proper application of the *Price* analysis to Section (30)(A) shows the statute has an individual rather than aggregate focus.

Section (30)(A) ensures that the state plan “provide such methods and procedures relating to the utilization of, and payment for, *care and services*... to assure that payments... are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” *Id.* (emph. added). The statute’s call for the development of “methods and procedures” rather than for the provision of services does not mean it lacks an individual focus. Like the provisions in *Price*, Section (30)(A) “does not speak ‘only in terms of institutional policy and practice’ [*Gonzaga*, 536 U.S. at 288], but rather requires that benefits be provided to particular persons.... This language evinces a clear

intent to create a federal right.” *Price*, 390 F.3d at 1111. The Medicaid Act defines Section (30)(A)’s “care and services” phrase as medical assistance to “individuals” who are eligible for coverage. 42 U.S.C. § 1396a(a)(10)(A)(i). That phrase “under the plan,” therefore, plainly refers to the medical assistance to which *individuals* (i.e., eligible Medicaid beneficiaries) must have access under a Medicaid plan. In short, the statute confers a benefit on a defined class of “individuals,” as *Gonzaga* requires. *See also Rio Grande Comm’y Health Center, Inc. v. Rullan*, 397 F.3d 56, 74 (1st Cir. 2005) (“mere fact that all the Medicaid laws are embedded within the requirements for a state plan does not, by itself, make all of the Medicaid provisions into ones stating a mere institutional policy or practice rather than creating an individual right”).

Sanchez also strayed from the analysis in *Price* by failing to consider the legislative history that explains Congress’s intent—a proper focus, given *Price*’s focus on both the Housing Act’s legislative history and its text. *Price*, 390 F.3d at 1111-13. Here, the Medicaid Act’s legislative history leaves little doubt that Congress intended its provisions to be enforceable by beneficiaries.

In 1989, Congress amended Section (30)(A) to add the “equal access” requirements. Contrary to *Sanchez*’s dismissive view of the importance of provider participation, Congress correctly perceived the unavoidable reality that the Medicaid eligibility and benefit expansions in the Act “will not have their

intended effect if physicians are not willing to treat Medicaid patients.” H.R. Rep. No. 101-247 (1989), at 390, *reprinted in* 1989 U.S.C.C.A.N. 2060, 2116. *Sanchez* did not mention the 1989 amendments, which added the requirement that payment to providers be “sufficient to enlist enough providers so that the care and services are available under the plan at least to the extent such services are available to the general population in the geographic area.” Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6402(a) (codified at 42 U.S.C. § 1396a(a)(30)(A)). Congress explained that, “without adequate payment levels, it is simply unrealistic to expect physicians to participate in the program....” H.R. Rep. No. 101-247, at 389-390, *reprinted in* 1989 U.S.C.C.A.N. at 2115-16. Congress was forced to act in 1989 based on concerns that physician participation in the Medicaid programs was approaching alarmingly inadequate levels because states had not maintained adequate provider reimbursement levels. *Id.*⁵ By requiring provider payments be sufficient to insure Medicaid beneficiaries access to “care and services” on a par with the general population, Congress was “concerned with whether the needs of... particular persons have been satisfied” [*Gonzaga*, 536 U.S. at 288]—namely those persons who meet at least one eligibility category the Act enumerates in 42 U.S.C.

⁵ *See also* Jane Perkins, *Increasing Provider Participation in the Medicaid Program*, 26 Soc. Sec. Rep. Serv. 846, 851 (1989) (as of 1988, half of California’s 58 counties had so few Medi-Cal participating ob/gyns so as to render such services unavailable for more than 175,000 Medi-Cal-eligible women of childbearing age).

§ 1396a(a)(10)(A)(i). Congress had the *rights of individuals* in mind when it elevated the “equal access” requirement from a regulatory to a statutory mandate. H.R. Rep. No. 101-247, at 590, *reprinted in* 1989 U.S.C.C.A.N. at 2116. Yet *Sanchez* did not consider this when it held Section (30)(A) failed to set forth such a right.⁶

While professing a desire to discern congressional intent, the panel’s decision ignores this legislative history. Its failure to follow *Price*’s analysis warrants rehearing.

III. *SANCHEZ* CONFLICTS WITH OTHER CIRCUIT OPINIONS AND NUMEROUS DISTRICT COURT DECISIONS BY OVERSTATING *GONZAGA*’S IMPACT

Sanchez is the first circuit opinion in the country to hold that Medicaid beneficiaries lack a private right of action to enforce Section (30)(A). Previously, Circuit after Circuit examined this issue and reached a contrary conclusion. And several courts have analyzed this issue post-*Gonzaga* and have reached the same

⁶ In addition to the 1989 amendments, Congress expressed its concern when it clarified its intent in 1994 in response to *Suter v. Artist M.*, 503 U.S. 347 (1992). *See* 42 U.S.C. § 1320a-2. *Suter* stated that a Social Security Act provision did not create enforceable rights for private individuals if it was contained in a statute listing mandatory elements of state plans submitted to receive federal funds. *Id.* at 358. Congress’s reaction was swift and clear that the Act, including Section (30)(A), was to remain enforceable by individual beneficiaries: *See* 139 Cong. Rec. S173, S3, 189 (1993) (“[When] Congress places requirements in a statute, we intend for the States to follow them. If they fail in this, the Federal courts *can order them to comply with the congressional mandate.*” (emph. added)).

conclusion. *Sanchez* therefore represents a significant departure. Adding that fact to the significant impact it will have on the rights of Medicaid beneficiaries and the weight it will be given by courts elsewhere shows why rehearing or en banc review is warranted.

The overwhelming weight of authority supports the enforceability of Section (30)(A). *See Pediatric Specialty Care, Inc. v. Arkansas Dept. of Human Services*, 364 F.3d 925, 930 (8th Cir. 2004) (§ (30)(A) is a “clearly established right” enforceable by recipients and providers); *Westside Mothers v. Havemann*, 289 F.3d 852, 864 (6th Cir. 2002) (§ (30)(A) enforceable by providers); *Methodist Hosps., Inc. v. Sullivan*, 91 F.3d 1026, 1029 (7th Cir. 1996) (same); *Pennsylvania Pharmacists Ass’n v. Houstoun*, 283 F.3d 531, 535-544 (3d Cir. 2002) (*en banc*) (§ (30)(A) enforceable by recipients but not providers); *Evergreen Presbyterian Ministries Inc. v. Hood*, 235 F.3d 908, 927-28 (5th Cir. 2000) (§ (30)(A) enforceable by recipients); *Arkansas Med. Soc’y, Inc. v. Reynolds*, 6 F.3d 519, 528 (8th Cir. 1993) (§ (30)(A) is “a right that is unambiguously conferred”); *Visiting Nurse Ass’n v. Bullen*, 93 F.3d 997, 1005 (1st Cir. 1996) (§ (30)(A) enforceable by providers); *but see Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50 (1st Cir. 2004) (§ (30)(A) unenforceable by pharmacy providers)⁷; *see also*

⁷ *Long Term Pharmacy* is “readily distinguishable.” *S.D. v. Hood*, 391 F.3d 581, 605 n. 31 (5th Cir. 2004). It involved long-term care pharmacy plaintiffs (footnote continued)

Antrican v. Odom, 290 F.3d 178, 191 (4th Cir. 2002) (Medicaid Act, including § (30)(A), sufficiently mandatory to enforce).

While most of these cases predate *Gonzaga*, *Sanchez* erred in finding *Gonzaga* so modified the controlling analysis to demand a different result. For example, in *Evergreen*, decided in 2000, the Fifth Circuit found that *Suter* and *Blessing* require that “Congress must unambiguously confer through Section 30(A) an ‘individual entitlement’ upon *each* of the plaintiffs in the case.” *Evergreen*, 235 F.3d at 926-27 (emph. in orig.). Applying that analysis, *Evergreen* held that Section (30)(A) “directly focuses on [recipients’] access to medical care” and that “the recipient plaintiffs have an ‘individual entitlement’ to the equal access guarantee of section 30(A).” *Id.* at 927-28. This is consistent with *Gonzaga*’s requirement that there must be an “unambiguously conferred right” [536 U.S. at 283] to support a Section 1983 claim.

Numerous district courts in addition to the *Clayworth* district court have analyzed Section (30)(A) in light of *Gonzaga* and have—with the exception of the *Sanchez* district court—concluded courts may enforce the statute on behalf of recipients under Section 1983. See *Oklahoma Chapter of the American Academy of Pediatrics v. Fogarty*, 366 F.Supp.2d 1050, 1102-03 (N.D. Okla. 2005); *Clark v.*

suing on their own behalf; the plaintiffs were two-steps removed from the Medicaid patients and thus were only “indirectly” affected.

Richman, 339 F.Supp.2d 631, 638-39 (M.D.Pa. 2004); *Memisovski ex rel. Memisovski v. Maram*, 2004 WL 1878332, at *5-8 (N.D.Ill. 2004); *Assoc. of Residential Resources in Minnesota v. Minnesota Comm’r of Human Servs.*, 2003 WL 22037719, at *7-8 (D. Minn. 2003); *Antrican v. Buell*, 158 F.Supp.2d 663, 669-670 (E.D.N.C. 2001), *aff’d* by 290 F.3d 178 (4th Cir. 2002), and *reconsidered* in unpublished decision in light of *Gonzaga* in Joint Appellees' Supplemental Excerpts of Record ("SER") at 569-70.

The Third and Fifth Circuits' recent post-*Gonzaga* analyses in *Sabree v. Richman*, 367 F.3d 180 (3d Cir. 2004), and *S.D.*, 391 F.3d 581, respectively, are also instructive. The *Sabree* plaintiffs relied on provisions of the Medicaid Act that entitle beneficiaries to medical assistance “furnished with reasonable promptness” [42 U.S.C. § 1396a(a)(8)] and that requires medical assistance be available to all eligible individuals [*id.*, § 1396a(a)(10)]. *Sabree* reviewed Supreme Court jurisprudence on Section 1983 private rights of action to find that the Medicaid Act “clear[ly] and unambiguous[ly]” conferred the rights the plaintiffs claimed. *Sabree*, 367 F.3d at 189. *Sabree* compared the text and structure of the Medicaid Act with the text of the Civil Rights Amendments of 1964 and the Education Amendments of 1972, which the Supreme Court stated are phrased “with an unmistakable focus on the benefited class” [*Cannon v. Univ. of Chicago*, 441 U.S. 677, 691 (1979)], and which it had characterized as exemplars

of right-creating language. *See Gonzaga*, 536 U.S. at 287. *Sabree* concluded it was impossible, “as a linguistic matter, to distinguish the import of the relevant [Medicaid Act] language—‘A State plan must provide’—from the ‘No person shall’ language of [the Civil Rights and Education Acts].” *Sabree*, 367 F3d. at 190. The court continued:

Further, the “individual focus” of Sections 1396a(a)(10), 1396d(a)(15), and 1396a(a)(8) is unmistakable. [Citing *Gonzaga*]. The relevant Title XIX provisions enumerate the entitlements available to “all eligible individuals.” *See, e.g.*, 42 U.S.C. § 1396a(a)(8). The provisions do not focus on “the [entity]... regulated rather than the individuals protected.” *Alexander v. Sandoval*, 532 U.S. [275,]... 289, 121 S. Ct. 1511.

Id.

S.D. v. Hood, another post-*Gonzaga* decision, also upheld private enforcement of provisions of the Medicaid Act under Section 1983. In doing so, the Fifth Circuit noted with approval its pre-*Gonzaga* decision in *Evergreen* in which it followed the lead of “many other circuits” in holding the “equal access” mandate of Section (30)(A) was “not too vague to be enforceable,” thus satisfying the *Blessing* formulation for enforceability. *S.D.*, 391 F.3d at 605.

IV. *SANCHEZ* RAISES ISSUES OF EXCEPTIONAL SIGNIFICANCE FOR THE FUTURE OF MEDICAID SINCE IT EFFECTIVELY RENDERS A CORNERSTONE OF THE PROGRAM--EQUAL ACCESS TO CARE FOR MEDICAID RECIPIENTS—A DEAD LETTER, THUS AFFECTING A RULE OF NATIONAL APPLICATION IN WHICH THERE IS AN OVERRIDING NEED FOR UNIFORMITY

Sanchez is of exceptional importance because it holds Congress did not intend to allow Medicaid beneficiaries to enforce the Act's guarantee of "equal access to care." *Sanchez*, 2005 WL 1804195, at *8. Breaking with precedent almost as old as the Medicaid Act itself, the panel limited enforcement of this bedrock component of the Act to enforcement by the HHS Secretary through the threat of withdrawal of federal funds under 42 U.S.C. § 1396c. This alternative mechanism "is a virtual death sentence for a state's program." *Withrow v. Concannon*, 942 F.2d 1385, 1387 (9th Cir. 1991). If not reconsidered, the decision will render this important guarantee to millions of Medicaid recipients "a dead letter." *Wilder*, 496 U.S. at 514.

Sanchez's holding that the Medicaid Act does not create enforceable rights for Medicaid recipients has ominous consequences for California residents simply because of the size and importance of California's Medi-Cal program. One in five Californians—6.8 million individuals—is enrolled in Medi-Cal. That program funds approximately 50 percent of all births and two-thirds of all skilled nursing facility days. The district court below issued a preliminary injunction based on

overwhelming evidence of serious access problems under even current Medi-Cal rates as well as concerns that providers would abandon the program in even greater numbers if the State implemented the threatened Medi-Cal rate reductions. *Clayworth*, 295 F.Supp.2d at 1128. The court noted that, even without the reductions, California's reimbursement rates are among the ten lowest in the nation. *Id.* Appellees also showed that the participation rate for Medi-Cal providers was low in California prior to the rate reduction (*id.* at 1116 n.5), roughly half the rate as in most states. Appellant's Excerpts of Record at 200-01, 210. The uncontradicted evidence showed that, compared to medical personnel who provide services to the general population, the number of available primary care physicians per capita for Medi-Cal beneficiaries is one-third less, the number of medical specialists more than one-half less, and the number of surgical specialists an astounding two-thirds less. *Id.* The evidence below painted a bleak picture of access to care for Medi-Cal beneficiaries, with patients already having to travel hundreds of miles to receive needed medical care. SER at 310-311. In some cases, Medi-Cal patients have risked limb amputations because of inadequate access. *See, e.g., id.*

Sanchez substantially affects a rule of national application under which Congress has taken special pains to achieve a national standard of accessibility to health care for Medicaid beneficiaries equivalent to the level the general

population enjoys. If not reconsidered, *Sanchez* and the decision here will negate Congress's efforts, with Section (30)(A)'s amendment, to improve provider participation in the Medicaid program, and will turn the clock back four decades by frustrating Congress's attempt to eliminate a two-tiered medical system in which the economically less fortunate have limited access to basic health care services.

V. CONCLUSION

The panel should rehear this and the companion decision in *Sanchez*. In the event it declines to do so, the Court should rehear these matters en banc.

DATED: August 23, 2005

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**CERTIFICATE OF COMPLIANCE PURSUANT TO CIRCUIT RULES 35-4
AND 40-1**

Case No. 04-15532

1. This brief complies with the type-volume limitation of Circuit Rules 35-4 and 40-1 because:

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DATED: August 23, 2005

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STATEMENT OF RELATED CASES

The following cases are related to *California Medical Assoc., et al. v. Bonta*,

No. 04-15532:

- 1.** ***Clayworth, et al. v. Bonta, No. 04-15498***: This case is related because it concerns the same underlying issue whether 42 U.S.C. § 1396a(a)(30)(A) creates a private right of action for Medicaid beneficiaries.
- 2.** ***Sanchez v. Johnson, No. 04-15228***: This case is related because it concerns the same underlying issue whether 42 U.S.C. § 1396a(a)(30)(A) creates a private right of action for Medicaid beneficiaries.
- 3.** ***Ball v. Rogers, No. 04-16963***: This case is related because it concerns the same underlying issue whether 42 U.S.C. § 1396a(a)(30)(A) creates a private right of action for Medicaid beneficiaries.