Nos. 04-15498, 04-15532

IN THE

United States Court of Appeals for the Ninth Circuit

JAMES CLAYWORTH, R.PH., DBA CLAYWORTH HEALTHCARE PHARMACY, et al.,

Plaintiffs-Appellees,

v.

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

Defendant-Appellant.

CALIFORNIA MEDICAL ASSOCIATION, et al.,

Plaintiffs-Appellees,

v.

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

Defendant-Appellant.

On Appeal from the United States District Court
for the Eastern District of California

BRIEF FOR AMICI CURIAE THE AMERICAN ACADEMY OF PEDIATRICS AND THE AMERICAN MEDICAL ASSOCIATION SUPPORTING APPELLEES AND AFFIRMANCE

JONATHAN S. FRANKLIN
JESSICA L. ELLSWORTH
KATHERINE J. HAYES
Hogan & Hartson L.L.P.
555 Thirteenth Street, N.W.
Washington, D.C. 20004
(202) 637-5766

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Counsel for Amici Curiae

RULE 26.1 CERTIFICATION

In compliance with Rule 26.1 of the Federal Rules of Appellate procedure, amicus the American Academy of Pediatrics states that it is a nonprofit corporation organized and operating under the laws of the State of Illinois. American Academy of Pediatrics has no parent corporation and no publicly held company owns 10% or more of its stock.

Amicus the American Medical Association is a nonprofit corporation organized and operating under the laws of the State of Illinois. The American Medical Association has no parent corporation and no publicly held company owns 10% or more of its stock.

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INTEREST OF AMICI CURIAE

The American Academy of Pediatrics ("AAP") and the American Medical Association ("AMA") are both dedicated to ensuring access to quality care for all Americans.[1] The AAP is a nonprofit organization of over 60,000

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[1] Pursuant to Fed. R. App. P. 29(c)(3), amici state that the source of authority to file this brief is that all parties have consented to its filing.

primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of children. The AAP advocates for children and their right to medical care through the adoption of professional policies, educational programs, efforts to influence social and governmental policy, and, occasionally, litigation. The AAP has significant clinical and academic expertise regarding health care issues facing the over twenty million children served nationwide by Medicaid.

The AAP is particularly interested in this case because of the stakes: ensuring that low-income children have access to adequate health care as required by federal law. AAP members, who regularly treat Medicaid-eligible children, know first-hand that failure to ensure such access endangers young lives. The AAP therefore seeks health care financing mechanisms that promote continuity and coordination of quality care for all children. In particular, the AAP has long advocated for a "medical home" for children. A medical home is an approach to the delivery of quality medical care that is, among other things, accessible, continuous, comprehensive, compassionate, culturally-effective, and family-centered, where such care is overseen by a pediatrician who continuously provides

care over an extended period of time and can develop a relationship with the child and the child's family.[2]

The AMA, with approximately 250,000 members, is the nation's largest professional organization of physicians and medical students.[3] AMA members practice in all fields of medical specialization and in every state, including California. The AMA was founded in 1847 to promote the science and art of medicine and betterment of public health. The AMA seeks to become the most authoritative voice and influential advocate for patients and physicians.

The AMA believes that every United States citizen should have access to necessary medical care, regardless of ability to pay. The AMA supports the use of Medicaid to ensure access to health care for those without private insurance, and believes that Medicaid funding should be sufficient to enable recipients to secure access to an adequate number of physicians. The AMA believes the District

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[2] See AAP Medical Home Initiatives for Children With Special Needs Project Advisory Committee, The Medical Home, 110 Pediatrics 184-186 (July 2002); AAP Committee on Child Health Financing, Scope of Health Care Benefits for Newborns, Infants, Children, Adolescents, and Young Adults Through Age 21 Years, 100 Pediatrics 1040-1041 (Dec. 1997).

[3] The AMA submits this brief on its own behalf and as a representative of the Litigation Center of the American Medical Association and the State Medical Societies (the "Litigation Center"). The Litigation Center, a coalition of the AMA and 51 state medical societies (each state plus the District of Columbia), was established to present the views of the medical profession to the courts.

Court's decision in this case should be upheld in order to protect patients' access to care and patients' quality of care.

The goals of the AAP and the AMA cannot be met for all people unless state governments—as required by federal law—ensure that poorer individuals have the same access to quality comprehensive health care as their more fortunate peers. These goals are particularly important for children. Far more than adults, children rely on Medicaid for health care. Accordingly, amici have consistently sought meaningful enforcement of the "equal access" provision of Medicaid, 42 U.S.C. § 1396a(a)(30)(A), which requires states to afford Medicaid recipients access to quality medical care and services that is at least equal to that of privately-insured individuals. In particular, amici are firmly convinced that continuity of care and access to preventive care are critical foundations of quality health care and that a state's failure to provide equal access to such services harms the short- and long-term health of children enrolled in Medicaid.

Unfortunately, due in large part to the failure of states to reimburse pediatricians and other providers at rates remotely comparable to Medicare or private insurance rates, Medicaid has been failing the children whose very lives often depend on it. When below-cost reimbursement rates force physicians out of the Medicaid program, children are unable to receive timely medical care and lack the continuity of care vital to proper health.

The question in this case is whether affected parties will have any effective mechanism to ensure state compliance with the federal mandate to provide Medicaid beneficiaries with equal access to quality health care. Amici submit this brief to highlight the importance of retaining such a remedy. Unless affected parties can ensure that federal law is obeyed, the costs of such non-compliance will fall disproportionately on one of the most defenseless segments of society. The millions of poor children relying on Medicaid for basic health care require an effective mechanism to enforce the requirements of federal law.

ARGUMENT

I. LOW-INCOME CHILDREN DEPEND ON THE MEDICAID ACT TO ENSURE THEIR ACCESS TO THE SAME QUALITY MEDICAL CARE AS THEIR MORE FORTUNATE PEERS.

Medicaid is a joint federal-state program providing medical assistance to low-income individuals and families. States receive federal funds in return for administering health insurance programs that meet mandatory requirements established by federal law. See West Virginia Univ. Hosps., Inc. v. Casey, 885 F.2d 11, 15 (3d Cir. 1989). Today, all fifty states and the District of Columbia participate in Medicaid, and it is the largest source of funding for medical and health-related services for low-income Americans. See HHS, Center for Medicare and Medicaid Services ("CMS"), Medicaid: A Brief Summary (available at http://www.cms.hhs.gov/publications/overview-medicare-medicaid/default4.asp).

The Nation's children disproportionately depend on Medicaid to meet their health care needs. Nationwide, over 51% of Medicaid beneficiaries are children.[4] A significant portion of all children in the United States are enrolled in Medicaid. During fiscal year 2000, 48% of all infants and 39% of all children ages 1-5 were enrolled in Medicaid.[5] The absolute numbers are staggering. More than 24.3 million children were enrolled in Medicaid during fiscal year 2002, with 18.9 million enrolled for the entire year.[6] Likewise, 25.2 million children were expected to be enrolled in Medicaid during fiscal year 2003, with 19.6 million enrolled for the entire year. Id. For 2004 and 2005, the Medicaid budget is based on 19.7 million and 20.2 million needy children enrollees.[7] In California, children

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4 See HHS, CMS, MSIS Statistical Reports for Federal Fiscal Year 2000, Table 2 (available at http://www.cms.hhs.gov/medicaid/msis/msis99sr.asp?).

5 See AAP State Reports—FY 2000 (available at http://www.aap.org/research/pdf00/FY2000FullReport.pdf).

6 See CMS 2002 Data Compendium, Medicaid Enrollment and Beneficiaries Selected Fiscal Years (Sept. 2002) (available at http://www.cms.hhs.gov/researchers/pubs/datacompendium/2002/02pg34.pdf).

7 See HHS, FY 2005 Budget in Brief, CMS Medicaid (available at http://www.hhs.gov/budget/05budget/centersformed.html#Medicaid).

are insured through Medi-Cal. Medi-Cal is the largest state Medicaid program in the country, serving more than 6.5 million Californians.[8]

Medicaid's central purpose is to ensure that poor individuals are not denied the necessary medical services that others take for granted. Thus, federal law mandates that state Medicaid plans "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. § 1396a(a)(30)(A). The question in this case is whether this requirement is an empty promise, or whether—as the District Court held—courts will be able to require states to comply with their federal obligation to ensure that low-income individuals have access to quality medical care comparable to that received by their more fortunate peers.

A. States Have Engaged In Widespread Violations Of The Federal Equal Access And Quality Care Requirements.

Research confirms the need for children, in particular, to have an effective means of enforcing the federal equal access and quality of care requirements. In 2001, the federal official overseeing Medicaid expressly

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8 See Martha Gold, et al., Access to Physicians in California's Public Insurance Programs at 10 (May 2004) (available at http://www.chcf.org/documents/policy/AccessToPhysiciansInCAPublicProgramsIB.pdf).

recognized that children served by Medicaid do not receive the same access to care as other children. See Letter from Director, Center for Medicaid and State Operations at HHS (Jan. 19, 2001) (available at http://www.healthlaw.org/pubs/200112.hhsmemo.pdf). As he recognized, inadequate reimbursement rates discourage sufficient numbers of providers from participating in Medicaid, resulting in limited access to care and longer wait times for appointments—contrary to the mandate of Section 1396a(a)(30)(A). Id. at 2. In particular, the official noted that children on Medicaid were not receiving adequate screening for lead poisoning or dental care. Id. at 1-2.

The states and the Federal government, however, have done little, if anything, on their own to ensure the equal access to quality care mandated by federal law. Indeed, the General Accounting Office ("GAO") has found that most states do not set goals for, or even analyze, the availability of participating primary care physicians in Medicaid fee-for-service plans, even though such programs serve more than half of all children in Medicaid. See GAO, Medicaid and SCHIP: States Use Varying Approaches to Monitor Children's Access to Care at 33-34 (Jan. 2003) (available at http://www.gao.gov/new.items/d03222.pdf).

Across the United States, an average of only 54.6% of private office-based primary care pediatricians accept all Medicaid patients who request care. See Steve Berman, et al., Factors That Influence the Willingness of Private

Primary Care Pediatricians to Accept More Medicaid Patients, 110 Pediatrics 239, 242 (Aug. 2002). Tennessee had the lowest rate of participation, at 19.6%. And importantly for this case, California had the third lowest rate, at only 33.1%. Id. at 241. Overall, primary care pediatricians in 40 states and the District of Columbia reported that they were less open to Medicaid patients than to privately-insured patients. Id. at 242. Even adjusting for practices that cannot accept new patients of any type, pediatric practices are significantly more likely to accept a new non-Medicaid patient than a new Medicaid patient. Id. at 241.

Other research confirms that equal access to quality care and services for Medicaid-insured and privately-insured individuals in California is a myth. Children enrolled in Medi-Cal do not have even close to comparable access to primary care physicians, medical specialists, or surgical specialists as the general population. The simple fact is that "[t]he supply of physicians available to Medi-Cal patients is significantly less than that available to the general population." Andrew B. Bindman, et al., Medi-Cal Policy Institute, Report: Physician Participation in Medi-Cal, 2001 at 2 (May 2003) (available at http://www.chcf.org/documents/policy/MediCalPhysParticipation2001.pdf). On average, Medi-Cal beneficiaries have access to less than two-thirds of the state's primary care

physicians, less than one-half of the state's medical specialists, and less than one-third of the state's surgical specialists. Id. at 7.[9]

Nearly half of all physicians in California's urban counties are unwilling to accept new Medi-Cal patients into their practice. Specifically, only 55% of primary care physicians, 48% of medical specialists, and 43% of surgical specialists who accept new patients are willing to accept new Medi-Cal patients. Id. at 1. Between 1998 and 2001, the number of specialized physicians who had Medi-Cal patients in their practices decreased as well. Id. at 15. Consistent with these statistics, over half of Medi-Cal beneficiaries report difficulty finding doctors who are willing to treat them. Id. at 4.

Children enrolled in Medicaid also have unequal access to dental care as compared to privately-insured children. A July 2000 survey found that Medicaid children in 42 of 44 states had trouble accessing dental care, and that the most commonly cited reason was the low reimbursement rate. See American Public Human Service Association, Dental Care for Medicaid Enrolled Children at 2 (July 2000) (available at http://www.nasmd.org/pubs/DentalCare.PDF).

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[9] Only 46 primary care physicians are available per 100,000 Medi-Cal patients, compared to 70 for the population as a whole. Only four medical specialists are available per 100,000 Medi-Cal patients, compared to 10 for the entire population. And only five surgical specialists are available per 100,000 Medi-Cal beneficiaries, compared to 15 for the entire population. Id. at 20-21.

It is no mystery why children and other Medicaid beneficiaries cannot obtain needed services: low reimbursement rates that do not even cover physicians' basic costs. Not surprisingly, studies have found a definite correlation between state Medicaid payment levels and pediatrician participation. See Berman, supra, at 243; Joel W. Cohen and Peter J. Cunningham, Medicaid Physician Fee Levels and Children's Access to Care, 14 Health Affairs 255 (Spring 1995); see also The Lewin Group, Analysis of Medicaid Reimbursement in Oregon at 3, 6 (Feb. 26, 2003) (available at http://www.oahhs.org/news/lewin/lewin_study_final.pdf). In a national survey of AAP pediatricians, the low level of reimbursement was the reason most commonly rated "very important" for limiting participation in Medicaid. See AAP Pediatrician Participation in Medicaid/SCHIP, Survey of Fellows of the American Academy of Pediatrics, U.S. Report: Private Office-based Primary Care Pediatricians in Direct Patient Care at 2 (2000) (available at http://www.aap.org/statelegislation/med-schip/pcp/US.pdf).

The GAO has found that "[n]ationally, low Medicaid physician fees and physician participation have been long-standing areas of concern." See GAO, Medicaid and SCHIP, State's Enrollment and Payment Policies Can Affect Children's Access to Care at 29 (Sept. 2001) (available at http://www.gao.gov/new.items/d01883.pdf). Because physicians decide whether to participate in Medicaid at least partly on the basis of payment rates, lower Medicaid payments

relative to other payers result in fewer physicians accepting Medicaid. Id. at 33.[10] Even compared to the Medicare population, payments to providers for Medicaid services are as low as 32% of Medicare payment rates in some states and less than half of Medicare rates in California. See GAO, Medicaid and SCHIP: States Use Varying Approaches to Monitor Children's Access to Care at 59.

Inadequate reimbursement is the most common reason given by California physicians for not participating in Medi-Cal. Bindman, supra, at 25. The low reimbursement levels particularly affect the care available for special needs children—including children with asthma, attention deficit disorder, or cerebral palsy—who require more medical services and specialty care than others. See California HealthCare Foundation, The California Medical Home Project at 2 (Dec. 2003) (available at http://www.chcf.org/documents/chronicdisease/CAMedicalHomeFactSheet.pdf); Gold, supra, at 8, 12.

One reason participation rates are inadequate to ensure equal access to quality care is that Medicaid reimbursement rates in many states do not even cover physicians' overhead costs. See, e.g., David L. Skaggs, et al., Access to Orthopedic Care for Children with Medicaid Versus Private Insurance in California, 107 Pediatrics 1405, 1406 (June 2001); Ohio Coalition of Primary Care

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[10] Indeed, plaintiffs provided evidence to the District Court that providers would cease participating if the challenged rate cut occurred. Clayworth v. Bonta, 295 F. Supp. 2d 1110, 1116 (E.D. Cal. 2003).

Physicians and the Ohio State Medical Association, Ohio Physician Medicaid Survey, Key Findings at 11 (Apr. 28, 1998). In California, for example, 60% of pediatricians reported that Medicaid reimbursements do not cover overhead costs, while only 9.3% reported that they do. See AAP Pediatrician Participation in Medicaid/SCHIP, Survey of Fellows of the American Academy of Pediatrics, 2000, California: All Primary Care Pediatricians in Private Office-based Settings at 2 (available at http://www.aap.org/statelegislation/med-schip/pcp/ca.pdf).[11]

Over time, reimbursement rates have not increased with the cost of providing medical care. For instance, when adjusted for inflation, Medi-Cal reimbursement rates have actually decreased by 54% since 1985. See Skaggs, supra, at 1406. Likewise, an independent analysis of Oregon's Medicaid program found that the gap between the Medicaid payment rates and actual hospital costs grew from 4.5% in 1996 to 20% in 2002. See The Lewin Group, supra, at 15.

Thus, states are plainly failing to comply with the federal access mandate, which requires that individuals enrolled in state Medicaid programs have access to the same quality care and services as their insured peers. As next shown, this failure has seriously compromised the health of low-income children and others who depend on Medicaid to meet their basic health care needs.

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11 The remaining 30.7% did not know whether Medicaid payments covered overhead costs. Id.

B. Non-Compliance With Section 1396a(a)(30)(A) Has Compromised The Health Of Children Served By Medicaid.

The lack of equal access can be catastrophic for the health of Medicaid children in California and elsewhere. In general, "poor kids are sicker than other kids." Colleen A. Foley, Comment, The Doctor Will See You Now: Medicaid Managed Care and Indigent Children, 21 Seton Hall Legis. J. 93, 108 (1997); see also Barbara Wolfe, Poverty, Children's Health, and Health Care Utilization, FRBNY Economic Policy Review at 9-10 (Sept. 1999). Low-income children are more likely than other children to struggle with low birth weight, lead poisoning, rheumatic fever, and asthma, as well as vision, dental, speech, and behavioral problems. See Foley, supra, at 108. The stresses of low wages, substandard housing, violence, and inadequate nutrition also contribute to higher rates of physical and mental illness for poorer children. See Sidney D. Watson, Commercialization of Medicaid, 45 St. Louis U. L. J. 53, 56-57 (2001); see also National Center for Children in Poverty, Early Childhood Poverty, A Statistical Profile (Mar. 2002) (poor children face increased risk of impaired development because of inadequate nutrition and exposure to environmental toxins) (available at http://www.nccp.org/media/ecp02-text.pdf).

Inadequate reimbursement rates and other unequal access harm the health of children and other Medicaid beneficiaries for two basic reasons. First, the lack of physicians willing to accept Medicaid leads to unacceptable waiting

times for outpatient care. As researchers in California discovered, there are vast differences between the medical care available to children on Medi-Cal and that available to similarly-situated children with private insurance. See Skaggs, supra, at 1405. The researchers found that when contacted about a hypothetical child with a broken arm, only 2% of randomly selected orthopedic surgeons in Los Angeles would schedule an appointment within a week for a Medi-Cal insured child, whereas 100% would schedule an appointment within a week for a privately-insured child. Id. In other words, 98% of the orthopedic surgeons offering to see a privately-insured child refused to see the same child if insured by Medi-Cal. Of the orthopedic offices that would not see the Medi-Cal child, 87% could not even recommend another orthopedic office that would accept Medi-Cal. Id. Given the importance of seeing injured children quickly, it is obvious that the lack of access for Medicaid-eligible children negatively impacts their overall health. Indeed, if a fracture is not properly aligned in the first few weeks, a permanent deformity may result. Id. Moreover, delay in care inherently means a prolongation of pain regardless of the ultimate medical outcome.

Second, by increasing turnover in the Medicaid program among physicians and their staffs, below-cost reimbursement rates have prevented Medicaid-enrolled children from receiving the continuity of care—most importantly, preventive care—that is essential for maintaining proper health.

Effective primary pediatric care requires a regular physician who can follow the child, thereby providing continuous, coordinated, and comprehensive care. Research demonstrates that having a continuous relationship with a health care provider improves the quality of care. See Leighton Ku and Donna Cohen Ross, Staying Covered: The Importance of Retaining Health Insurance For Low Income Families at 7 (Dec. 2002); Dimitri A. Christakis, et al., Continuity of Care Is Associated with High-Quality Care by Parental Report, 109 Pediatrics 54 (Apr. 2002). Continuity of pediatric care provides health advantages in childhood and beyond in part because having a regular source of care is the most important factor associated with receiving preventive care services. See Barbara Starfield and Leiyu Shi, The Medical Home, Access to Care, and Insurance: A Review of Evidence, 113 Pediatrics 1493, 1495 (May 2004).

Preventive care, such as periodic well-child visits, greatly increases the health of Medicaid-insured children and decreases avoidable hospitalizations for them.[12] Coordination of care and continuity of care are especially critical for children with special needs and disabilities, who require early intervention as well

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[12] See Rosemarie B. Hakim and Barry V. Bye, Effectiveness of Compliance With Pediatric Preventive Care Guidelines Among Medicaid Beneficiaries, 108 Pediatrics 90, 94 (July 2001); see also Dimitri A. Christakis, et al., Association of Lower Continuity of Care with Greater Risk of Emergency Department Use and Hospitalization in Children, 107 Pediatrics 524-529 (Mar. 2001); Lindsey Grossman, et al., Decreasing Nonurgent Emergency Department Utilization By Medicaid Children, 102 Pediatrics 20 (July 1998).

as treatment plans that must be regularly reviewed and revised. See AAP Committee on Children With Disabilities, Role of the Pediatrician in Family-Centered Early Intervention Services, 107 Pediatrics 1155 (May 2001) (available at http://aappolicy.aappublications.org/cgi/content/full/pediatrics;107/5/1155).

Children insured by Medicaid, however, are not receiving the necessary continuity of care, including preventive care, due to below-cost reimbursement rates. Although primary care pediatricians generally acknowledge that children with special health needs require coordination of care from a variety of health care professionals and organizations, such coordination requires adequate reimbursement for efforts. See AAP Committee on Children With Disabilities, Care Coordination: Integrating Health and Related Systems of Care for Children With Special Health Care Needs, 104 Pediatrics 978 (Oct. 1999). Thus, for example, even though the Federal government recognizes that low-income children have a high risk of lead poisoning, and even though 77% of children with elevated blood levels are enrolled in federal health programs, less than 20% of children served by Medicaid are ever screened for lead poisoning. See GAO, Lead Poisoning: Federal Health Care Programs Are Not Effectively Reaching At-Risk Children at 5, 23 (1999) (available at http://www.gao.gov/archive/1999/he99018.pdf); CDC, Recommendations for Blood Lead Screening of Young Children Enrolled in Medicaid: Targeting a Group at High Risk (Feb. 2000) (available at

http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4914a1.htm). In sum, while it is widely recognized that Medicaid-eligible children need such preventive care, they remain unlikely to receive it.

The equal access and quality of care mandated by the federal Medicaid Act are of the utmost importance to children enrolled in Medicaid, as these children tend to have increased and exacerbated health problems. The states, however, have demonstrated that they are not willing to comply with the requirement on their own. Accordingly, as shown below, Medicaid beneficiaries and their providers must—as Congress intended—have an adequate remedy to require the states to comply with their obligations under federal law.

II. PLAINTIFFS HAVE A CAUSE OF ACTION TO ENFORCE THE REQUIREMENTS OF SECTION 1396a(a)(30)(A).

Federal statutes that confer individual rights are enforceable under 42 U.S.C. § 1983. See Golden State Transit Corp. v. City of Los Angeles, 493 U.S. 103, 106 (1989). Federal funding provisions are enforceable under Section 1983 if they manifest an unambiguous intent to confer individual rights. Gonzaga Univ. v. Doe, 536 U.S. 273, 283 (2002). The Supreme Court considers three factors in determining whether a particular statutory provision gives rise to such a right: (1) whether Congress intended that the provision benefit the plaintiff; (2) whether the right is so "vague" and "amorphous" that its enforcement would strain judicial competence; and (3) whether the statute imposes a mandatory, binding obligation

on the state, rather than merely expressing Congressional preferences. Blessing v. Freestone, 520 U.S. 329, 340-341 (1997).

In Gonzaga, 536 U.S. at 283-284, the Supreme Court analyzed the first factor, whether Congress intended to create a federal right. A court should examine the text and structure of the statute for an indication that Congress intended to create new individual rights by (1) including "rights-creating" language and (2) expressing an individual, rather than aggregate, focus. Id. at 286-288. Applying that analysis to the non-disclosure provisions in the Family Educational Rights and Privacy Act ("FERPA") at issue in that case, the Gonzaga Court found the statute did not confer enforceable rights under Section 1983 because it did not contain rights-creating language and had an aggregate focus couched in terms of "policy and practice." Id. at 290.

In contrast, however, the Supreme Court and numerous Circuit courts have held that the Medicaid Act does confer at least some individually enforceable rights. See, e.g., Wilder v. Virginia Hosp. Ass'n. 496 U.S. 498, 522-523 (1990); Sabree v. Richman, 367 F.3d 180, 182 (3d Cir. 2004); Rabin v. Wilson-Coker, 362 F.3d 190, 201-202 (2d Cir. 2004); Rolland v. Romney, 318 F.3d 42, 56 (1st Cir. 2003); Gean v. Hattaway, 330 F.3d 758, 772 (6th Cir. 2003); Bryson v. Shumway, 308 F.3d 79 (1st Cir. 2002). The principal question now before the Court is whether the quality of care and equal access requirement of Section

1396a(a)(30)(A) is among the Medicaid provisions through which Congress intended to confer enforceable rights.

Section 1396a(a)(30)(A) is one of the many procedural and substantive protections that states choosing to participate in Medicaid must provide to enrollees. It states that:

> A State plan for medical assistance must . . . provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary . . . to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

42 U.S.C. § 1396a(a)(30)(A).

Application of the three Blessing factors, as clarified by Gonzaga, shows that plaintiffs can enforce the individual rights conferred upon them in Section 1396a(a)(30)(A). Medicaid is an individual entitlement program, and this provision imposes a specific, mandatory, and binding duty on states to provide low-income individuals with access to quality care and services equivalent to that received by their more fortunate peers. If affected parties cannot ensure that the states carry out these mandatory obligations, Congress's important promise to needy Americans will be an empty one.

A. Section 1396a(a)(30)(A) Confers Individual Rights.

The text of Section 1396a(a)(30)(A) and the overall structure of Section 1396a demonstrate Congress's unambiguous intent to confer individual rights. The language of the statute unmistakably mandates that whatever payment system the state chooses must ensure that enrollees receive quality care and equivalent access to care as insured individuals enjoy.[13] The statute explicitly states, in mandatory terms, that the state plan "must provide" for such care. Thus, as the Third Circuit has recently held, it is "difficult, if not impossible, as a linguistic matter, to distinguish the import of the relevant Title XIX language—'A State plan must provide'—from the 'No person shall' language of Titles VI and IX" that the Supreme Court cited in Gonzaga as an exemplar of rights-creating language. Sabree, 367 F.3d at 190.

There is no meaningful difference between the rights conferred by Section 1396a(a)(30)(A) and other provisions of the Medicaid Act that courts, both before and after Gonzaga, have held are enforceable under Section 1983. For example, courts have held that Section 1396a(a)(10) confers an enforceable right to coverage for individuals within certain defined eligibility categories. Sabree, 367 F.3d at 192; Pediatric Specialty Care, Inc. v. Arkansas Dep't of Human Servs., 293

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13 The "general population" referred to in 42 U.S.C. § 1396a(a)(30)(A) is the insured population. See, e.g., Clark v. Coye, 60 F.3d 600, 602 (9th Cir. 1995); Arkansas Med. Soc., Inc. v. Reynolds, 6 F.3d 519, 527 (8th Cir. 1993).

F.3d 472, 478-479 (8th Cir. 2002); Westside Mothers v. Haveman, 289 F.3d 852, 862-863 (6th Cir.), cert. denied, 537 U.S. 1045 (2002). Similarly, courts have held that Section 1396a(a)(8) confers the enforceable right to medical care that is furnished with "reasonable promptness." See Sabree, 367 F.3d at 192; Bryson, 308 F.3d at 88. Individuals also have an enforceable right to transitional medical assistance under Section 1396r-6. See Rabin, 362 F.3d at 201-202. Far from evincing a different Congressional intent, the rights afforded by Section 1396a(a)(30)(A) give meaning to these other enforceable rights. The enforceable rights to coverage mandated by these other provisions would have little effect if there were no way to require states to comply with the requirement that Medicaid beneficiaries actually be able to access quality care. An enforceable right to coverage is meaningless if states can set reimbursement rates so low that no provider is available to provide timely services to a covered individual.

Nor is there any focus in Section 1396a(a)(30)(A) on aggregate, as opposed to individual, rights. Unlike the provision at issue in Gonzaga, which addressed only "institutional policy and practice," 536 U.S. at 288, the equal access and quality of care requirements of Section 1396a(a)(30)(A) are plainly directed at ensuring a specific level of care for individual beneficiaries. The statute does not simply require states to provide some abstract, aggregate level of service that could excuse their failure to provide specific beneficiaries with services

equivalent to those received by their non-Medicaid peers. Rather, consistent with the overall structure of Medicaid as an individual entitlement program, Section 1396a(a)(30)(A) requires that payments to providers be sufficient to ensure that for individual enrollees, "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." 42 U.S.C. § 1396a(a)(30)(A) (emphasis added). Under the Medicaid Act, the "care and services" available under a state plan are specifically defined as medical assistance to "individuals," id. § 1396a(a)(10)(A)(i), not some aggregate or average level of service to beneficiaries as a group.

Contrary to appellants' argument here, the provisions of the Medicaid Act addressing enforcement by the Federal government strongly support that Congress intended specific provisions be enforceable by affected parties under Section 1983. In Gonzaga, the Court relied heavily on the fact that Congress had required the Secretary of Education to establish administrative procedures for investigating and remedying individual complaints under FERPA. The availability of such procedures "squarely distinguish[ed]" Gonzaga from Wright v. Roanoke Redev. & Hous. Auth., 479 U.S. 418 (1987), and Wilder, supra, both of which involved statutes without any federal review mechanism for an aggrieved individual. Gonzaga, 536 U.S. at 289-290. Indeed, Wilder, like this case, involved the Medicaid Act, where the only Federal enforcement mechanism is to stop

payment of Medicaid funds if a state fails to "substantially" comply with the Act, see 42 U.S.C. § 1396c—a draconian step amici understand has never been taken in the history of the statute.

Thus, unlike the statute at issue in Gonzaga, the Medicaid Act provides no direct mechanism for enforcement of individual rights, further confirming Congress's intent that the pre-existing remedy of Section 1983 be available to enforce those rights. Cf. Wilder, 496 U.S. at 521 (lack of mechanism for private enforcement under the Medicaid Act shows that Congress did not intend to supplant Section 1983 remedy). As shown above, states are not complying with the statute on their own. And because the Federal government lacks any individualized enforcement mechanism and is highly unlikely ever to cut off funding in response to a claimed violation, the statute is effectively unenforceable without the individual remedy provided by Section 1983. The Court should not hold that this important right is meaningless. Just as the Supreme Court held with respect to the Medicaid Act provision at issue in Wilder, this Court should "decline to adopt an interpretation of the [statute] that would render it a dead letter." Id. at 514.

The only aspect of Section 1396a(a)(30)(A) that even arguably cuts the other way is that the equal access and quality care requirements are state plan requirements rather than freestanding rights. But Congress has expressly provided

that the inclusion of a right as a state plan requirement does not render the right unenforceable under Section 1983. In 1994 Congress enacted two identical statutes providing that "[i]n an action brought to enforce a provision of this chapter [i.e., the Social Security Act], such provision is not to be deemed unenforceable because of its inclusion in a section of this chapter requiring a State plan or specifying the required contents of a State plan." 42 U.S.C. §§ 1320a-2, 1320a-10. As the court below found, these statutes make clear that courts "will not consider that an individual entitlement is absent simply because the wording of the statute is directed to the required contents of a state plan as opposed to the rights of a beneficiary or provider under a plan." Clayworth v. Bonta, 295 F. Supp. 2d 1110, 1121 (E.D. Cal. 2003); see also Rabin, 362 F.3d at 201-202 (relying on Section 1320a-2 to find that Section 1396r-6 creates enforceable rights).[14]

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[14] These statutes were a response to the Supreme Court's decision in Suter v. Artist M., 503 U.S. 347 (1992), which held that a different provision of the Social Security Act was not enforceable under Section 1983. The statutes thus contain additional language overturning any grounds applied by the Supreme Court in Suter but not in prior cases. See 42 U.S.C. §§ 1320a-2, 1320a-10. But Congress was also independently concerned that Suter might be construed as holding that federal programs administered through a state plan were no longer enforceable under Section 1983. See Subcomm. on Social Security & Family Policy of the Senate Comm. on Finance, Hearing on Application of Supreme Court Decision in Suter v. Artist M., 102nd Cong. at 23 (Sept. 17, 1992). To alleviate this concern, the statutes provide that the inclusion of a right under the Social Security Act as a state plan provision does not render the right unenforceable under Section 1983.

The legislative history also shows Congress's intent that plaintiffs be able to enforce state Medicaid plan requirements under Section 1983. In 1981, the House Committee Report on amendments to the Medicaid Act emphasized that "States must continue to operate their programs in conformity with approved State plans" and "in instances where the States or the Secretary fail to observe these statutory requirements, the courts would be expected to take appropriate remedial action." H.R. Rep. No. 97-158, vol. II, at 301 (1981); see also Pennsylvania Pharmacists Ass'n. v. Houstoun, 283 F.3d 531, 541 (3d Cir.), cert. denied, 537 U.S. 821 (2002). In 1996, when a bill was introduced that proposed eliminating the federal requirements for Medicaid and providing Medicaid funding to states as a block grant, a main concern was that the bill would remove the right of an individual to bring a Section 1983 suit to enforce provisions of the Medicaid Act. See H.R. Rep. No. 104-651, at 2019 (1996). The bill failed, thereby demonstrating Congress's continued understanding that Medicaid rights remain enforceable.

B. The Requirements Of Section 1396a(a)(30)(A) Are Not So Vague Or Amorphous As To Be Unenforceable.

The second Blessing factor asks whether the right at issue is too vague or amorphous for judicial enforcement. This Court has already recognized that the rights to both quality care and equal access are sufficiently definite for judicial enforcement. See Orthopaedic Hosp. v. Belshe, 103 F.3d 1491, 1496 (9th Cir. 1997) (interpreting and enforcing the quality and access provisions of Section

1396a(a)(30)(A)); see also Clark v. Kizer, 758 F. Supp. 572, 575-577 (E.D. Cal. 1990) (finding equal access provision judicially enforceable), affirmed in relevant part sub nom., Clark v. Coye, 967 F.2d 585, 1992 WL 140278, at *2 (9th Cir. 1992); Evergreen Presbyterian Ministries, Inc. v. Hood, 235 F.3d 908, 930-931 (5th Cir. 2000) (the "equal access mandate of section 30(A) is sufficiently definite to enforce").

In Wilder, the Supreme Court held that it was "well within the competence of the Judiciary" to enforce Medicaid rights mandating "reasonable access (taking into account geographic location and reasonable travel time)" to services of "adequate quality." 496 U.S at 507, 519-520. Likewise, no part of the right to equal access or quality care is too vague and amorphous for judicial enforcement. Indeed, the equal access right in Section 1396a(a)(30)(A) is actually easier to enforce than the reasonable access right at issue in Wilder. See Evergreen Presbyterian Ministries, 235 F.3d at 930. Equal access provisions are commonly enforced by courts in other contexts. See, e.g., Oregon Paralyzed Veterans of Am. v. Regal Cinemas, Inc., 339 F.3d 1126 (9th Cir. 2003) (Americans with Disabilities Act); Prince v. Jacoby, 303 F.3d 1074 (9th Cir. 2002) (Equal Access Act). In addition, the terms "general population" and "geographic area" are not so vague as to be unenforceable. General population means the insured population. Clark, 758 F. Supp. at 575-576; see Arkansas Med. Soc'y, Inc. v. Reynolds, 6 F.3d 519, 527

(8th Cir. 1993) (holding "general population" definite enough to enforce). The term "geographic area" requires analysis similar to that for analyzing a geographic market in antitrust law. Methodist Hosps., Inc. v. Sullivan, 91 F.3d 1026, 1029 (7th Cir. 1996). See also H.R. Rep. No. 101-247, at 390 (1989) ("geographic area" language added because "Medicaid reimbursement rates have not kept pace with average community rates"). Finally, this Court has already held that the concept of quality care is sufficiently definite to be judicially enforced. Orthopaedic Hosp., 103 F.3d at 1496-97.

C. Section 1396a Imposes A Binding Obligation On States.

The final Blessing factor considers whether the obligation imposed on the states is a binding one or is merely an expression of Congressional preference. For states that opt to participate in the program, the requirements of the Medicaid Act are mandatory. See Antrican v. Odom, 290 F.3d 178, 188 (4th Cir. 2002). As already noted, under Section 1396a(a)(30)(A) states "must" provide whatever payment level is "necessary" to ensure that plan participants have equal access and quality care. There is, therefore, no question that the statute imposes a mandatory duty rather than merely reflecting Congressional preference.

III. PROVIDER ORGANIZATIONS HAVE STANDING TO ENFORCE THE RIGHTS OF THEIR MEMBERS' PATIENTS.

As the District Court held, physicians and their organizations have standing to enforce the rights of Medi-Cal patients. Physicians have third-party

standing to assert their patients' rights, and physician organizations have associational standing to litigate on behalf of their members. In such circumstances, third-party standing and associational standing are appropriately applied together to allow provider organization plaintiffs to assert the rights of Medicaid patients. See Pennsylvania Psychiatric Soc'y v. Green Springs Health Serv., Inc., 280 F.3d 278 (3d Cir. 2002); Fraternal Order of Police v. United States, 152 F.3d 998, 1002 (D.C. Cir. 1998), rehearing, 173 F.3d 898, 901 (D.C. Cir. 1999) (analysis of standing "unchanged from our prior opinion"); Ohio Ass'n. of Indep. Sch. v. Goff, 92 F.3d 419, 421-422 (6th Cir. 1996).

1. Under third-party standing principles, physicians have standing to sue on behalf of their Medicaid-insured patients because physicians have a concrete interest in the outcome, they share a close relationship with their patients, and patients face obstacles in bringing suit on their own. See Powers v. Ohio, 499 U.S. 400, 411 (1991) (outlining three requirements); Wauchope v. U.S. Dep't. of State, 985 F.2d 1407, 1411 (9th Cir. 1993) (same). Appellants contest only the last prong of third-party standing—whether there is a sufficient obstacle to Medicaid recipients bringing a challenge themselves. See Appellants' Br. at 35-36.

Importantly, the obstacle facing Medicaid recipients need not be "insurmountable" or make it "impossible" for them to sue, but must simply present "some hindrance." Powers, 499 U.S. at 411; Singleton v. Wulff, 428 U.S. 106,

116-117 (1976). As the District Court noted, Medicaid recipients are hindered from bringing suit because they lack information about the effect of reimbursement rates or rate cuts on provider participation. Another obstacle is that an individual Medicaid recipient's has a transitory need for access to quality medical care in a given instance, whereas physicians have long-term interests in securing the rights of their many patients. See Singleton, 428 U.S. at 117. Finally, Medicaid recipients' lack of economic means presents yet another hurdle. See Tesmer v. Granholm, 333 F.3d 683, 691-692 (6th Cir. 2003) (lawyers had third-party standing to sue on behalf of indigent criminal defendants based in part on defendants' lack of economic means). These obstacles are especially pronounced for poor children, who have the least access to the information and resources necessary to vindicate their rights, and the least ability to assert those rights on their own.

2. Physician organizations have associational standing to sue on behalf of their members because their members would have standing on their own, the interests the organizations seek to protect are germane to their purpose, and neither the claim asserted nor the relief requested requires the participation of individual members. See Hunt v. Washington State Apple Adver. Comm'n, 432 U.S. 333, 343 (1977); Harris v. Board of Supervisors of Los Angeles County, 366 F.3d 754, 761-764 (9th Cir. 2004) (organization had standing to assert Medicaid rights of indigent members). Appellants do not dispute that provider organizations seek

here to protect interests germane to their purpose, or that the claim asserted and the relief requested do not require the participation of individual members. Appellants solely dispute whether members of the provider organizations have standing in their own right, specifically whether granting associational standing comports with the constitutional requirement of an injury-in-fact. See Appellants' Br. at 38-39.

But if members of the organizations meet the third-party standing requirements, they inherently satisfy the injury-in-fact requirement. The "concrete interest" criterion of the third-party standing analysis asks "whether the litigant has suffered some injury-in-fact, adequate to satisfy Article III's case-or-controversy requirement." Voigt v. Savell, 70 F.3d 1552, 1564 (9th Cir. 1995). The injury-in-fact must be particularized, actual and imminent, and fairly traceable to the challenged action of the defendant. Lujan v. Defenders of Wildlife, 504 U.S. 555, 560 (1992). Here, appellants do not dispute that physicians satisfy the concrete interest requirement through their financial interest in preventing a 5% rate cut in Medi-Cal reimbursements. As in Singleton, there is no doubt that Medicaid providers will "suffer concrete injury from the operation of the challenged statute," and that if the providers prevail, they will benefit through the payment received for their services. 428 U.S. at 112-113. Thus, physicians have a concrete interest in the outcome of the dispute. See Voigt, 70 F.3d at 1564 (financial interest suffices to meet concrete injury requirement). As such, physicians necessarily satisfy the

injury-in-fact requirement, and physician organizations therefore have associational standing to litigate on behalf of their members.

CONCLUSION

For the foregoing reasons, the judgment below should be affirmed.

Respectfully submitted,

Jonathan S. Franklin
Jessica L. Ellsworth
Katherine J. Hayes
HOGAN & HARTSON L.L.P.
555 Thirteenth Street, N.W.
Washington, D.C. 20004-1109
(202) 637-5766

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Counsel for Amici Curiae

CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 32(a)(7)(C), I hereby certify that this brief was produced in Times New Roman 14 point typeface using Microsoft Word 2003 and contains 6996 words.

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Jonathan S. Franklin

CERTIFICATE OF SERVICE

I hereby certify that on this 9th day of July, 2004, two copies each of the foregoing Brief for Amici Curiae The American Academy of Pediatrics and the American Medical Association Supporting Appellees and Affirmance were served by overnight delivery on:

Bill Lockyer, Esq.
Attorney General
Irene K. Tamura, Esq.
Deputy Attorney General
Office of the Attorney General of the State of California
1300 I Street
Sacramento, CA 94244-2550

Craig Cannizzo, Esq.
Hooper, Lundy & Bookman, Inc.
180 Montgomery Street, Suite 1000
San Francisco, CA 94104

Lynn S. Carmen, Esq.
Attorney at Law
1035 Cresta Way #3
San Ravael, CA 94903

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Jonathan S. Franklin