UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

THE ARC OF CALIFORNIA; UNITED CEREBRAL PALSY ASSOCIATION OF SAN DIEGO,

Plaintiffs,

v.

TOBY DOUGLAS, in his official capacity as Director of the California Department of Health Care Services; CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICE; TERRI DELGADILLO, in her official capacity as Director of the California Department of Developmental Services; CALIFORNIA DEPARTMENT OF DEVELOPMENTAL SERVICES; and DOES 1-100, inclusive,

Defendants.

No. 2:11-cv-02545-MCE-CKD

MEMORANDUM AND ORDER

The present lawsuit challenges several changes California has implemented with respect to its payment for services provided to developmentally disabled individuals under the federally funded Medicaid program.

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Plaintiffs are the ARC of California ("ARC") and the Cerebral Palsy Association of San Diego ("CPA").[1] ARC is a statewide organization comprised of individuals with intellectual and developmental disabilities (""I/DD"), their families, and their home and community-based service providers. CPA is a non-profit organization serving the needs of individuals with cerebral palsy in San Diego and is affiliated with the national cerebral palsy association.

According to Plaintiffs, the California Department of Health Care Services and the California Department of Developmental Services,[2] both of which are involved in administering the provision of support provided to disabled individuals, have violated federal law in reducing certain payments to the providers of those services. Plaintiffs initially allege, in their First Claim for Relief, that Defendants have violated the provisions of the Medicaid Act by administering its payments for community-based services to the disabled absent compliance with the provisions of 42 U.S.C. §1396(a)(30)(A). Plaintiffs go on to assert, in their Second and Third Claims for Relief, that Defendants' payment reductions also violate the Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 et seq. ("ADA") and the Rehabilitation Act of 1973, 29 U.S.C. § 794, et seq. ("Rehabilitation Act"), respectively. Declaratory relief, under the Federal Declaratory Judgment Act, 28 U.S.C. § 2201, is also requested by way of the Sixth Claim. Finally, Plaintiffs seek injunctive, mandamus and declaratory relief through pendant state law claims.

Defendants' Motion to Dismiss now before the Court contends that the allegations set forth in Plaintiffs' Complaint fail to state any federal claim upon which relief can be granted pursuant to Federal Rule of Civil Procedure 12(b)(6).

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[1] Unless otherwise noted, both ARC and CPA will be collectively referred throughout this Memorandum and Order as "Plaintiffs".

[2] Both California agencies are sued through their respective Directors and will be collectively referred to as "Defendants" or the "State" throughout this Memorandum and Order unless otherwise specified.

In the absence of a claim sounding under either the Medicaid Act, the ADA or the Rehabilitation Act, Defendants go on to assert that the Court should decline to exercise jurisdiction over the pendent state law claims. Alternatively, Defendants argue that Plaintiffs' state law claims are barred by the doctrine of sovereign immunity in any event.

As set forth below, Defendants' Motion to Dismiss will be granted in part and denied in part.

BACKGROUND

Medicaid is a cooperative federal state program designed to provide, pursuant to the Medicaid Act, federal assistance to participating states for the costs of providing medical treatment and services to the poor, elderly and disabled. 42 U.S.C. § 1396. Although state participation in funding available from Medicaid is voluntary, if a state does participate, it must comply with the Medicaid Act and its implementing regulations promulgated by the Secretary of Health and Human Services ("HHS"). Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 502 (1990). Administration of the Medicaid program, however, is entrusted by HHS to CMS.

A state choosing to participate in the Medicaid program must prepare and submit a "State Plan" for federal approval that includes a comprehensive written statement describing the nature and scope of its Medicaid program. A State Plan must also contain assurances that it will be administered in accordance with the dictates of Medicaid law. Wilder v. Virginia Hospital Assn., 496 U.S. 498, 502. Additionally, if a state wants to change its Medicaid plan once approved, it must obtain approval from CMS in the form of a so-called State Plan Amendment ("SPA") to do so. Exeter Memorial Hosp. Ass'n v. Belshe, 145 F.3d 1106, 1108 (9th Cir. 1998).

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Among the prerequisites to participation in the Medicaid program is compliance with the requirements set forth within 42 U.S.C. § 1396(a)(30)(A) ("Section 30(A)") which requires, inter alia that payment for services to the disabled be consistent with "efficiency, economy, and quality of care." Additionally, in 1981, Congress responded to the large percentage of Medicaid resources being used for long-term institutional care for the disabled by authorizing a home and community based services ("HCBS") waiver program. 42 U.S.C. § 1396n. Development of that program was prompted by studies showing that many disabled persons then residing in institutions could in fact live at home, or in the community, if additional support services were available. The HCBS waiver program is designed to make such services available to those who would benefit from less restrictive care, but who otherwise would be eligible for Medicaid benefits only in an institutional setting. Id. at § 1396n(c)(1). In order to obtain a waiver, a State has to certify that its treatment program is cost-neutral in the sense that the costs of providing services to individuals enrolled in the waiver program will be less than or equal to in the cost of institutional care. Id. at § 1396n(c)(2)(D); Sanchez v. Johnson, 416 F.3d 1051, 1054 (9th Cir. 2005).

States must submit their waiver application to the Centers for Medicare and Medicaid Services ("CMIS"), the federal agency responsible for administering Medicaid based programs, for review. CMS' approval of a submitted application "waives" three requirements of the overall federal Medicaid statute: 1) statewideness; 2) comparability of services; and 3) income and resource rules. Id. at § 1396n(c)(3). All other requirements of the Medicaid Act are deemed satisfied upon CMS's approval of the waiver request 42 C.F.R. § 400.200; 430.25(g)(1). In the present case, CMS approved California 's waiver application, including the rates paid to regional centers responsible for delivering care, on March 29, 2012, for an additional term of five years.[3]

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[3] Plaintiffs' Request for Judicial Notice of that Application, as subsequently approved by CMS, is unopposed and is granted under Federal Rule of Evidence 201.

Unlike other states, California has made its own commitment under the so-called Lanterman Act to pay for services and support to the disabled from its own general funds. The Lanterman Act (Cal. Welf. & Inst. Code § 4500 et seq.) was enacted in 1967, some fourteen years before implementation of the federal HCBS waiver program, to prevent or minimize the institutionalization of developmentally disabled persons. In order to accomplish that objective, disabled persons under the Lanterman Act are entitled to services and supports at California's expense. Ass'n for Retarded Citizens v. Dept. of Developmental Servs., 38 Cal. 3d 384, 391 (1985). Because of that right, enrollment by Californians in the waiver program is voluntary and serves primarily as a vehicle for the state to recoup expenses it would already have been obligated to pay under the Lanterman Act (the Medicaid matching funds California receives covers about half of the costs of services the regional centers provide to the disabled community) . See Sanchez v. Johnson, 416 F.3d at 1065. Many of the disabled persons eligible for services under the Lanterman Act, in fact, lack the extent of impairment qualifying them for federal funds under the HCBS waiver program. Id.

In California, the Department of Health Care Services ("DHCS") is the state agency responsible for administering the federal Medicaid program, known as Medi-Cal in California. The California Department of Developmental Services ("DDS"), however, is responsible for coordinating the provision of services and supports for individuals with developmental services under both the Lanterman Act and for those covered under the HCBS waiver. DDS is accordingly charged with monitoring the 21 regional centers in California who contract out services for compliance with both federal and state law, and to ensure that high quality services and supports are being provided. Cal. Welf. & Inst. Code § 4434(a)-(b), 4500.5(d), 4501. DDS is further charged with promoting uniformity and cost-effectiveness in the operation of regional centers. Ass'n for Retarded Citizens, 38 Cal. 3d at 389. Despite this mandate, however, DDS' role "does not extend to the manner in which [regional] centers provide services or in general operate their programs."

Id. at 389-90. Instead, the regional centers themselves determine eligibility, assess needs, and coordinate the provisions of services to individuals within a defined geographic area. Cal. Welf. & Inst. Code § 4620. The centers do this through the preparation of an individual program plan ("IPP") for each disabled client and provides services pursuant to the IPP. Although Plaintiffs take issue with the budget cuts prompted by California's recent fiscal crisis, according to the State, any regional center/provider contract must include a provision that payment under the contract is dependent upon the availability of state funds, and that vendors must agree to accept rates established, revised or adjusted by the Department, as payment in full for all services provided. Cal. Code of Regs, Title 17, §§ 50609, 54326.

Despite that admonition, Plaintiffs challenge four bills, as enacted by the California Legislature since 2009, which operate to reduce of freeze rates to HCBS providers. Using payment levels from 2003, the Legislature initially enacted a three percent reduction from those rates effective February 1, 2009, through June 30, 2010. That reduction, along with an additional 1.25 percent cut, was ultimately extended through June 30, 2012. After June 30, 2012, the reimbursement reduction was decreased to only 1.25 percent, where it remains at present. In addition, as indicated above, another bill sets forth 14 unpaid holidays for which vendors are not reimbursed for their services. Finally, the so-called half-day billing rule limited regional centers to payment for only a half day if a patent was present less than 65 percent of a program day. The State maintains that those reductions apply to all disabled individuals irrespective of whether they qualify for services under the waiver or under the Lanterman Act.

It should also be noted that irrespective of these reductions, regional centers can still obtain an exemption from reduced payments (but not apparently for the holiday or half-day rule limitations) upon a showing that a non-reduced payment is necessary to protect the health and safety of the individual from whom the services and supports are proposed to be purchased. SB 853, AB 104.

Moreover, patients themselves (or their representatives) can avail themselves of a tiered appeal process should they believe that the services being provided are inadequate. Finally, consumers can submit a complaint directly to DDS if their particular problem does not fit within other grievance mechanisms.

STANDARD

On a motion to dismiss for failure to state a claim under Federal Rule of Civil Procedure 12(b)(6), all allegations of material fact must be accepted as true and construed in the light most favorable to the nonmoving party. Cahill v. Liberty Mut. Ins. Co., 80 F.3d 336,337-38 (9th Cir. 1996). Rule 8(a)(2) requires only "a short and plain statement of the claim showing that the pleader is entitled to relief" in order to "give the defendant fair notice of what the . . . claim is and the grounds upon which it rests." Bell Atl. Corp. v. Twombly, 550 U.S. 544, 555 (2007) (quoting Conley v. Gibson, 355 U.S. 41, 47 (1957)). A complaint attacked by a Rule 12(b)(6) motion to dismiss does not require detailed factual allegations. However, "a plaintiff's obligation to provide the grounds of his entitlement to relief requires more than labels and conclusions, and a formulaic recitation of the elements of a cause of action will not do." Id. (internal citations and quotations omitted). A court is not required to accept as true a "legal conclusion couched as a factual allegation." Ashcroft v. Iqbal, 129 S. Ct. 1937, 1950 (2009) (quoting Twombly, 550 U.S. at 555). "Factual allegations must be enough to raise a right to relief above the speculative level." Twombly, 550 U.S. at 555 (citing 5 Charles Alan Wright & Arthur R. Miller, Federal Practice and Procedure § 1216 (3d ed. 2004) (stating that the pleading must contain something more than "a statement of facts that merely creates a suspicion [of] a legally cognizable right of action.")). In addition, a motion to dismiss under Rule 12(b)(6) is appropriate where a plaintiff has not demonstrated entitlement to a legal remedy even when the material allegations in the complaint are accepted as true. De La Cruz v. Tormey, 582 F.2d 45, 48 (9th Cir. 1978).

A court granting a motion to dismiss a complaint must then decide whether to grant leave to amend. Leave to amend should be "freely given" where there is no "undue delay, bad faith or dilatory motive on the part of the movant, . . . undue prejudice to the opposing party by virtue of allowance of the amendment, [or] futility of the amendment . . . ." Foman v. Davis, 371 U.S. 178, 182 (1962); Eminence Capital, LLC v. Aspeon, Inc., 316 F.3d 1048, 1052 (9th Cir. 2003) (listing the Foman factors as those to be considered when deciding whether to grant leave to amend). Not all of these factors merit equal weight. Rather, "the consideration of prejudice to the opposing party . . . carries the greatest weight." Id. (citing DCD Programs, Ltd. v. Leighton, 833 F.2d 183, 185 (9th Cir. 1987). Dismissal without leave to amend is proper only if it is clear that "the complaint could not be saved by any amendment." Intri-Plex Techs. v. Crest Group, Inc., 499 F.3d 1048, 1056 (9th Cir. 2007) (citing In re Daou Sys., Inc., 411 F.3d 1006, 1013 (9th Cir. 2005); Ascon Props., Inc. v. Mobil Oil Co., 866 F.2d 1149, 1160 (9th Cir. 1989) ("Leave need not be granted where the amendment of the complaint . . . constitutes an exercise in futility . . . .")).

In ruling on a motion to evidence, the Court may properly consider not only the complaint along with any evidence in documents attached or referred to in the complaint, but also matters that may be judicially noticed pursuant to Federal Rule of Evidence 201. Mir v. Little Co. of Mary Hosp., 844 F.2d 646, 649 (9th Cir. 1988).

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ANALYSIS

A. Violation of the Medicaid Act

Preliminary Considerations: In challenging the sufficiency of Plaintiffs' First Claim for Relief, which alleges a violation of the Medicaid Act, Defendants initially challenge whether the violations Plaintiffs identify are ripe for adjudication in the first instance, and whether Plaintiffs have standing to assert any claim based on the Medicaid Act in any event. In determining whether a case is ripe, issues of timing may be crucial. If claims remain unduly speculative they may never in fact occur, and in that event should not be the subject of a federal lawsuit. Wolfson v. Brammer, 616 F.3d 1045 (9th Cir. 2010. By avoiding premature adjudication, the ripeness doctrine prevents courts from becoming enmeshed in abstract disagreements. Id. Defendants' basic argument in this regard is that Plaintiffs have failed to identify specific services or supports available under the HCBS waiver program that have been denied or eliminated as a result of reimbursement reduction to the regional centers for such services. Plaintiffs go on to argue that in the absence of specific evidence that Plaintiffs sought an exemption for reductions impacting the health and safety of the disabled consumers, there also is no issue fit for judicial resolution.

Defendants' related standing issue also focuses on the alleged speculative nature of the impact of Defendants' reductions on disabled consumers, as well as the same lack of any exemption claim. In order to have standing, Plaintiffs must show both an actual or imminent concrete and particularized injury in fact arising from the invasion of a legally protected interest. Plaintiffs must also show both a causal connection between that injury and defendant's alleged conduct, and likelihood that the injury can be redressed by the Court. Lujan v. Defenders of Wildlife, 504 U.S. 555, 560-61 (1992).

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In arguing standing is not present, Defendants also point to the fact that the disabled community is entitled to community-based services under the Lanterman Act irrespective of whether they also may qualify for such services under an HCBS waiver. Defendants therefore claim that any distinction between the two programs is all but illusory.

In this Court's view, Defendants overstate the burden Plaintiffs must carry to overcome a pleadings challenge made in the context of a motion to dismiss. At the pleading stage, general factual allegations of injury resulting from a defendant's conduct are all that is required given the presumption that general allegations "embrace those specific facts that are necessary to support the claim." Lujan, 504 U.S. at 561. As Twombly instructs, only a short and plain statement sufficient to put a defendant on notice of the claims being asserted is required, so long as that statement is more than a formulaic conclusion. Twombly, 550 U.S. 544, 555.

Here, Plaintiffs' allegations include representations that the reduced payments place providers at risk of insolvency and have destabilized and degraded the quality of care available to disabled individuals. Plaintiffs further allege and that individuals with the more severe impairment require the most intensive and costly care, therefore placing them at more risk of being disparately impacted by the subject cuts. See Compl., ¶¶ 32, 38, 42, 52). Those allegations, and all reasonable inferences therefrom, must be deemed true and construed in the light most favorable to Plaintiffs, and are sufficient to overcome any pleading challenge based on ripeness or standing. See Livid Holdings, Ltd. v. Solomon Smith Barney, Inc., 416 F.3d 940, 946 (9th Cir. 2005); Keams v. Tempe Tech. Inst, 39 F.3d 222, 224 (9th Cir. 1994).

The Court further rejects Defendants' contention that Plaintiffs' claims are moot because the 4.25 percent reimbursement reduction referred to in the complaint (filed in September of 2011) has in fact been converted to 1.25 percent since the remaining three percent sunsetted in June of 2012. As Plaintiffs point out, that reduction goes only to the amount of financial impact and does not obviate the impact entirely, particularly for purposes of a motion to dismiss.

The fact that some of the statutory cuts have expired, with others still remaining in effect, does not obligate Plaintiffs to file an amended complaint since the discrepancy is a matter of proof as opposed to a factor bearing on liability itself.

Plaintiffs' success in bridging any hurdle to ripeness or standing ultimately makes no difference to the viability of their Medicaid Act noncompliance claim; however, since, as discussed below, that claim fails on the merits as a matter of law. We first examine the setting in which Plaintiffs allege that Defendants failed to abide by the provisions of the Act.

Alleged Medicaid Violation: Plaintiffs basically contend that the State failed to comply with the rate setting requirements set forth in 42 U.S.C. § 1396a(a)(30)(A) ("Section 30(A)"). Section 30(A) requires that payment for services must be "consistent with efficiency, economy, and quality of care." The Ninth Circuit, in its Orthopaedic decision, interpreted this statutory language as meaning that "payments must be sufficient to enlist enough providers to provide access to Medicaid recipients." Orthopaedic Hosp. v. Belshe, 103 F.3d 1491, 1496 (9th Cir. 1997). The Orthopaedic case further found that DHCS "must set hospital outpatient reimbursement rates that bear a reasonable relationship to an efficient and economical hospital's costs of providing quality services, with such determinations resting on "responsible cost studies" that "provide reliable date as a basis for its rate setting." Id. Plaintiffs claim that the State has done nothing to ascertain whether the challenged payment reductions are consistent with federal rate-setting standards and requirements.

Defendants take issue with Plaintiffs' argument in several ways. First, they argue that Section 30(A), while applicable to Medicaid in general, nonetheless does not apply to an HCBS waiver like that at issue here. According to Defendants, the HCBS waiver regulations themselves appear to exempt waiver applicants from the Section 30(A) requirements.

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Second, Defendants point to a recent Ninth Circuit decision, Managed Pharmacy Care v. Sebelius, 2013 WL 2278620 (9th Cir. May 24, 2013)[4] that they claim is controlling here. Managed Care found that where, as here, CMS approves state provisions that include reimbursement reductions, that approval is entitled to so-called Chevron deference.

Section 30(A) provides that a state plan for medical assistance under the Medicaid Act 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 safeguard against unnecessary utilization of such care and services and 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) (emphasis added).

This language, as the Ninth Circuit recognizes, is "broad and diffuse." Sanchez v. Johnson, 416 F.3d at 1060. By using terms like "consistent", "sufficient," efficiency," and "economy," without describing the specific steps a take must take in order to meet such standards, the amorphous language of the statute indicates that agency expertise is relevant in determining its application. Managed Care, 2013 WL at *9, citing Douglas v. Indep. Living Ctr. of S. Cal., 132 S. Ct. 1204, 1210 (2012).

In Orthopaedic, the Ninth Circuit interpreted the statutory mandate of Section 30(A) as requiring Medicaid reimbursement rates to "bear a reasonable relationship to efficient and economical" hospital costs for providing quality services. To do this, the Orthopaedic court reasoned, the state had to "rely on responsible cost studies, its own or others, that provide reliable data as a basis for its rate setting." 103 F.3d at 1496.

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[4] The Managed Care decision was initially issued on December 13, 2012. Managed Pharmacy Care v. Sebelius, 705 F.3d 934 (9th Cir. 2012). On May 24, 2013, after no rehearing en banc was requested, the initial decision was withdrawn and reissued without significant change at 2013 WL 2278620.

As Defendants note, this interpretation of Section 30(A) as requiring cost studies is not found in the statute itself and was made in the absence of any agency approval for the reimbursement reductions that the Orthopaedic court considered.

The Managed Care decision looks at the issue anew under circumstances where CMS had in fact approved reimbursement reductions incorporated within a proposed State Plan Amendment ("SPA") for the provision of Medicaid services in general. Plaintiffs in that case argued that because cost data had not been provided in the SPA submitted by California, the Ninth Circuit's prior Orthopaedic decision mandated that any reimbursement reduction approval be voided. Even the Orthopaedic court, however, recognized that "our standard of review might have been different had the agency spoken on the issue." See Managed Care, 2013 WL 2278620 at *7. Significantly, in Managed Care, unlike Orthopaedic, CMS did explicitly approve the SPA at issue, even though no cost studies had been submitted. The Managed Care court held that the agency's decision in that regard was entitled to deference, and found that California is not required to conduct cost studies or follow any specific procedural steps before reducing Medicaid reimbursement rates under Section 30(A). Managed Care, 2013 WL 2278620 at *2.

Defendants argue that because CMS in this case approved the HCBS waiver submitted by California, then Managed Care disposes of Plaintiffs' seminal claim that the reimbursement reductions run afoul of Medicaid law. Plaintiffs, on the other hand, try to distinguish Managed Care on grounds that it involved approval of an SPA amendment, not an HCBS waiver and should, accordingly, be distinguishable. Plaintiffs further contend that CMS lacked any real cost of service information, and that any approval without that information was in error.

The fact that Managed Care involved an SPA amendment and the present case revolves around an HCBS waiver is not of consequence. In both instances, CMS approval for state Medicaid programs involving reimbursement reductions is involved.

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Moreover, with respect to whether adequate information was presented to CMS with respect to cost was presented, in accordance with Managed Care, that question is superseded by the fact that CMS approved the waiver. Here, California submitted a waiver application in excess of 200 pages. That application was required to provide information about 1) methods for assessing financial accountability and cost-neutrality; 2) information regarding the utilization of services by consumers, including the number of participants and information regarding the utilization of specified services; and 3) assurances that the state will protect the health and welfare of beneficiaries, including assurances that the state will provide ongoing assessment of a consumer's need for services, and a plan for evaluation. 42 C.F.R. §§ 441.302-303. While Plaintiffs contend that CMS never required any specific information with regard to rates or rate methodology in the HCBS waiver, CMS nonetheless approved the waiver application on the basis of the detailed application that was submitted. Significantly, to counter any claim that insufficient information was in fact provided, CMS also has authority to revoke an HCBS waiver application at any time if it determines, post-approval, that a state is not in compliance. Id. at §§ 430.25, 441.300-310.

Given these requirements, the Court concludes that CMS' determination in approving California's 2012 waiver application is entitled to Chevron deference just as the SPA approval was so deemed in Managed Care. To the extent that CMS approved the waiver in error for any reason, as the Supreme Court notes that shortcoming should be brought to CMS' attention directly by way of a claim under the Administrative Procedures Act, 5 U.S.C. § 701, et seq., rather than through the present lawsuit against California. See Douglas v. Indep. Living Ctr. of S. Cal., 132 S. Ct. at 1210.

Secondly, and just as importantly, the cost study information that Plaintiffs argue should have been included does not appear to have been required for a waiver in any event. 42 C.F.R. § 441.303(g) indicates that cost analysis is optional, rather than required, in the context of waiver applications. As the regulations state: "The State, at its option, may provide for an independent assessment of its waiver that evaluates the

quality of care provided, access to care, and cost neutrality." Id. Significantly this language for all intents and purposes incorporates the considerations set forth in Section 30(A). By expressly indicating that such information is not mandatory, a persuasive argument can be made that Section 30(A) compliance is not required, just as Defendants contend. At the very least, that interpretation of the regulations is a reasonable one. Agency interpretation and application of its own regulations is entitled to deference. Chase Bank USA v. McCoy, 131 S. Ct. 871, 880-82 (2011); Auer v. Robbins, 519 U.S. 452, 461 (1997) (federal agency's interpretation of regulation entitled to deference unless "plainly erroneous or inconsistent with the regulation").

It follows that the crux of Plaintiffs' merits argument fails on the merits, since CMS' approval of Defendants' waiver application, which encompasses the reductions at issue, is entitled to deference under Managed Care. CMS' approval also forecloses the procedural means by which Plaintiffs sought to assert their Medicare claim in the first place. Analyzing Plaintiffs' procedural options shows yet another reason why Plaintiffs' Medicaid Act claim fails.

Procedural Alternatives: Plaintiffs concede that their Medicaid Act claim must be premised either on 42 U.S.C. § 1983 or upon the Supremacy Clause of the United States Constitution. Neither alternative, however, is an option under the facts of this case.

First, with respect to 42 U.S.C. § 1983, Plaintiffs acknowledge that the Ninth Circuit has already recognized the unavailability of a § 1983 action to challenge a state's violation of the Medicaid Act. Devl. Services Network v. Douglas, 666 F.3d 540, (9th Cir. 2011). Since the Ninth Circuit has further barred the use of § 1983 for a private cause of action challenging the State's compliance with the requirements of Section 30(a), Sanchez, 416 F.3d at 1060; Ball v. Rodgers, 492 F.3d 1094, 1107-09 (9th Cir. 2007), Plaintiffs can only rely on the Supremacy Clause to support their Medicaid Act claim.

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Plaintiffs note that Douglas, in finding § 1983 unavailable for purposes of making a Medicaid Act claim, did not address the availability of the Supremacy Act for that purpose. Douglas, 666 F.3d at 548, n.29. That brings us to the next potential avenue for Plaintiffs' requested relief.

Because the Secretary has already approved the reimbursement rates at issue by way of the HCBS waiver, Plaintiffs' Supremacy Clause claim would appear to be foreclosed. A Supremacy Clause remedy may be available with respect to a State's determination as to a matter, like the reimbursement provisions at issue here, that bear upon eligibility for federal benefits (here Medicaid). In the absence of federal approval for such provisions, Plaintiffs can at least conceivably seek federal adjudication of the state action through the Supremacy Clause. The Ninth Circuit's Managed Care decision, however, while not definitively deciding the issue, expressed strong reservations as to whether a Supremacy Clause action is available where, as here, the responsible federal agency has approved the reimbursement cuts at issue. Managed Care, 201e WL at 2278620 at *14. As Managed Care recognized, a reasoned decision in that regard is entitled to deference. Id. at * 9. Where Congress has given an agency authority to regulate a subject matter, it is appropriate for courts to give deference to the agency's resolution of issues related thereto. U.S. v. W. Pac. R.R. Co., 352 U.S. 59, 64-65 (1956) (recognizing an agency's power to determine issues "that have been placed in the special competence of that administrative body"). Here CMS approves a waiver only if it determines that a state complies with the Act. 42 C.F.R. 430.25(g). Moreover, as already indicated, if CMS determines after that approval that a state is not in compliance with the Act and its waiver requirements for any reason, it has the authority to revoke the waiver. 42 C.F.R. §§ 441.302, 441.304.

In the instant matter, as indicated above, CMS approved California's waiver program after reviewing the extensive 200-page HCBS application.[5]

[5] Contrary to Plaintiffs' argument, there appears to be no requirement under the HCBS waiver program that express federal approval be obtained before implementing payment reductions. See Defs.' Reply, pp. 8-9. To the extent that CMS should not have approved reimbursement reductions that went

As the Supreme Court has also recognized, "to allow a Supremacy Clause action to proceed once the agency has reached a decision threatens potential inconsistency or confusion." Douglas, 132 S. Ct. at 1210. Instead, as indicated above, the more appropriate means of redress would be not the Supremacy Clause challenge Plaintiffs have mounted against the State but rather a review of CMS' approval determination itself under the APA. The Supreme Court's Douglas decision expressly points out that the APA provides for judicial review of final actions and allows agency action found to be arbitrary and capricious to be set aside. Id. citing the APA at 5 U.S.C. §§ 704, 706(2)(A).

In sum, while preliminary considerations of ripeness and/or standing do not appear to bar Plaintiffs' Medicaid Act claims in this matter, those claims ultimately fail on the merits and are not cognizable procedurally under either Section 1983 or the Supremacy Clause in any event. Therefore, Plaintiffs' First Claim for Relief, for Violation of the Medicaid Act, fails, and Defendant's Motion to Dismiss that Claim is granted.

B. ADA and Rehabilitation Act Claims

Plaintiffs' Second and Third Claims seek injunctive relief under the Rehabilitation Act and the ADA, respectively. To establish a violation under either of those statutory schemes, Plaintiffs must show 1) that they are qualified individuals with a disability; 2) that they were excluded from participation in or otherwise discriminated against with regard to a public entity's services, programs, or activities; and 3) that such exclusion or discrimination was by reason of their disability. See Lovell v. Chandler, 303 F.3d 1039, 1052 (9th Cir. 2002). The prohibition against discrimination requires that "meaningful access" be provided. Lonberg v. City of Riverside, 571 F.3d 846, 851 (9th Cir. 2009).

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into effect before it issued its approval, however, redress at this point would be against CMS under the auspices of the APA rather than the present suit against the State.

Because the ADA and Rehabilitation Act contain nearly identical language, they are evaluated as mutually coextensive and claims under either are generally treated as one and the same. Sanchez, 416 F.3d at 1016.

With respect to Plaintiffs' capacity to bring these claims on behalf of affected developmentally disabled individuals, Defendants assert that Plaintiffs lack associational standing to challenge the funding cuts, arguing that such standing requires that a group's individual members need not participate in the lawsuit. While the capacity of individually disabled individuals to meaningfully participate in this litigation other than auspices of a group or other individuals seems questionable on its face, it would appear that Plaintiffs, at the very least, have representational standing. Even if an organization has not itself suffered injury (Plaintiffs are non-partisan, non-profit organizations representing the rights and interests of individuals with I/DD, their families and their community providers), the organization can still sue in a representative capacity for injuries to its members as long as at least one member has standing to sue in his or her own right, the interests sought to be protected are germane to the association's purpose, and neither the claims asserted nor relief requested requires member participation in the suit individually. Hunt v. Washington State Apple Advertising Comm'n, 432 U.S 333, 343 (1977). Moreover, to the extent that Plaintiffs seek declaratory and injunctive relief, individual members of Plaintiffs' organizations are not required to participate in the action in any event. See Or. Advocacy Ctr. v. Mink, 322 F.3d 1101, 1112-13 (9th Cir. 2003). Finally, and perhaps more significantly, the Ninth Circuit has already recognized the associational standing of organizations like ARC in similar cases. See, e.g., ARC of Washington State v. Braddock, 427 F.3d 615 (9th Cir. 2005) (alleging violation of the ADA). Consequently, the Court does not find standing to pose a bar to Plaintiffs' claims under the ADA and the Rehabilitation Act.

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In addition to challenging Plaintiffs' standing, the defense also argues that Plaintiffs cannot state a prima facie case of discrimination in the first place, arguing that Plaintiffs have failed to show that either providers or consumers will suffer a disparate impact, or that Defendant's challenged actions were due to their disability. On the basis of the allegations contained in Plaintiffs' Complaint, however, which must be accepted as true in the context of a motion to dismiss, the challenged reductions will decrease the risk of institutionalization for the disabled served under the waiver (see Compl., ¶¶ 32, 45-49), with the most seriously disabled being most at risk since they require the most intensive and costly care and therefore will be impacted most as a result of payment cuts. Id. at ¶¶ 38, 42, 45-49, 52. These allegations are sufficient to survive Defendants' Motion to Dismiss Plaintiffs' ADA and Rehabilitation Act claims.

C. Declaratory Relief

Plaintiffs' Sixth Claim for Relief seeks declaratory relief, under the Federal Declaratory Judgment Act, 28 U.S.C. § 2201. In particular, Plaintiffs seek a declaration of the respective rights and duties with respect to the implementation, administration, and interpretation of the Medicaid Act, the HCBS waiver program, and the Lanterman Act. Compl., ¶ 72. Plaintiffs argue that because Plaintiffs have not otherwise stated any claim for relief in their Complaint, the Federal Declaratory Judgment Act cannot create an independent basis for the Court to exercise its jurisdiction. S. Pac. Co., v. McAdoo, 82 F.2d 121, 122 (9th Cir. 1936). Because the Court has not dismissed Plaintiffs' claims under the ADA and the Rehabilitation Act, however, the basis for Plaintiff's challenge to any potential federal declaratory relief in this matter fails.

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D. State Claims

Plaintiffs' state law claims, as set forth in their Fourth and Fifth Claims for Relief, seek injunctive relief under the Unruh Civil Rights Act, Cal. Civil Code § 51, et seq., as well as mandamus relief under California Code of Civil Procedure § 1085.[6] Defendants allege that those claims are barred by the doctrine of sovereign immunity in accordance with the Eleventh Amendment to the United States Constitution. It is well established that sovereign immunity does not, however, bar actions to compel a state official's prospective compliance with a plaintiff's federal civil rights. Independent Living Center of So. Cal., Inc. v. Maxwell-Jolly, 572 F.3d 644, 660 (9th Cir. 2009), citing Ex parte Young, 209 U.S. 123, 156 (1908), vacated on other grounds by Douglas, 132 S. Ct. 1204. Consequently there is no doubt that Plaintiffs' federal claims, which uniformly seek injunctive relief and are asserted against state officials, are proper.

Plaintiffs' state claims are similar to their claims premised on federal law in seeking only prospective injunctive and declaratory relief as opposed to any retroactive award of money damages. The Court agrees that those state claims are "so related" to the federal claims that they form part of the same case or controversy under 28 U.S.C. 1367(a), the statute authorizing supplemental jurisdiction over state claims in any civil action over which the federal court has original jurisdiction. Because Plaintiffs' federal claims under the ADA and the Rehabilitation Act here unquestionably invoke this Court's original jurisdiction, supplemental jurisdiction over Plaintiffs' remaining state law claims is also proper.[7]

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[6] In the Sixth Cause of Action, declaratory relief is also sought under California Code of Civil Procedure § 1060 in addition to declaratory relief under the Federal Declaratory Judgment Act as discussed above.

[7] Defendants' reliance on Raygor v. Regents of Univ. of Minn., 534 U.S. 533 (2002), is inapposite because in that case, Plaintiffs' federal claims had already been adjudicated at the time Plaintiffs attempted to characterize refiled state law claims as supplemental. In the present matter, on the other hand, viable federal claims still exist in addition to the supplemental state claims.

CONCLUSION

For all the foregoing reasons, Defendants' Motion to Dismiss (ECF No. 53). Is GRANTED in part and DENIED in part. The Motion is granted as to Plaintiffs' First Claim for Relief, for injunctive relief under the Medicaid Act, but denied as to all remaining Counts. Because the Court concludes that the deficiencies of Plaintiffs' First Claim for Relief cannot be rectified by amendment under the circumstances present herein, no leave to amend that Claim will be permitted.

IT IS SO ORDERED.

Dated: July 1, 2013

MORRISON C. ENGLAND, JR, CHIEF JUDGE
UNITED STATES DISTRICT COURT