2001 WL 34094767 (C.A.9) (Appellate Brief)
United States Court of Appeals,
Ninth Circuit.

Khachik SIMONYAN, Oganes Nagapetyan, Plaintiffs-Appellees,
v.
Kathleen CONNELL, Controller of the State of California, and S. Kimberly Belshe, Director of the Department of Health Services of California, Defendants-Appellants;
SAN LAZARO ASSOCIATION, INC., dba Biomedical Laboratory, Plaintiff-Appellee,
v.
Kathleen CONNELL, Controller of the State of California, Defendant-Appellant;
CLINICAL CARE LABORATORY, INC., Plaintiff-Appellee,
v.
Kathleen CONNELL, Controller of the State of California, and S. Kimberly Belshe, Director of the Department of Health Services of California, Defendant-Appellant.

Nos. 00-55377, 00-55065, 00-55610, 00-55963.
January 4, 2001.

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

Amicus Brief for the United States Department of Health and Human Services, in Support of Defendants-Appellants, and in Favor of Reversal of the Judgments Below

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***1 STATEMENT OF INTEREST OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES**

These are significant cases regarding the administration of the Medicaid program, and are ones of first impression in the ***2** courts of appeals. The United States Department of Health and Human Services (HHS), as the department of the federal government that is responsible for Medicaid, has a clear interest in the proper interpretation of the program's underlying statute and implementing regulations. In particular, HHS is concerned that the regulation at issue here not be interpreted to confer "rights" on Medicaid providers and to bar a state's designated Medicaid agency from using another state agency to conduct audits. Such interpretations would unduly constrain the ability of the states to combat waste, fraud, and abuse by Medicaid providers. HHS files this brief pursuant to Fed. R. App. P. 29(a).

STATEMENT OF THE ISSUES PRESENTED FOR REVIEW

1. Whether Medicaid providers are intended beneficiaries of the single state agency requirement (42 U.S.C. 1396a(a)(5); 42

C.F.R. 431.10(e)((1)(i)) so that they have a "right[]," enforceable through 42 U.S.C. 1983, to compel a state's compliance with that requirement.

2. Whether the Medicaid regulation prohibiting the designated state Medicaid agency from delegating to another state agency the "[e]xercise [of] administrative discretion in the administration or supervision of the plan" (42 C.F.R. 431.10(e)(1)(i)), may reasonably be interpreted not to bar the ***3** designated agency from selecting another state agency to audit Medicaid payments and claims.

STATEMENT OF THE CASE

In these three cases, Medicaid providers claim that federal law permits only California's designated Medicaid agency, The Department of Health Services (DHS) to conduct audits under California's Medicaid program (Medi-Cal) They further claim that when audits are conducted by "the wrong state agency," here the state's Controller, the state may not withhold payments to the providers notwithstanding the audits having disclosed the submission of improper claims. The district court held that the authorization of the Controller to conduct the audits violated the applicable federal Medicaid regulation and that consequently, the withholding was invalid.

I. Course Of Proceedings

In *Simonyan,* the court granted summary judgment in favor of the plaintiffs, Simonyan and Nagapetyan (ER 1220-39), and attorneys' fees. *Id.* at 1613-16. The court enjoined the Controller from conducting audits of the plaintiff-providers, and further enjoined the withholding of Medicaid payments from them based on audits by the Controller. ER 1246-47. The court denied a motion to alter or amend its judgment. ER 1506-82.

In *San Lazaro,* the court initially also granted summary judgment to the plaintiff, and enjoined audits by the Controller. ***4** ER 438-60. But subsequently, the court vacated its decision and order as moot on the ground that San Lazaro had cancelled its California Clinical Laboratory license. ER 757-765 Subsequently, however, the court granted San Lazaro attorneys' fees. *Id.* at 848-853. Finally, the court denied a motion to alter or amend its judgment *Id.* at 906-07.

In *Clinical Care,* the court again granted summary judgment in favor of the plaintiff. ER 806-17. But, unlike, *San Lazaro,* the court determined that the case was not moot despite a similar cancellation of the provider's license. The court relied on the existence of a pending administrative appeal at which the Controller's findings would be at issue. *Id.* at 9-10. The court's judgment enjoined the Controller from future auditing of Clinical Care's Medi-Cal claims, and from representing DHS in connection with Clinical Care's pending administrative appeal. *Id.* at 830-32. Finally, the court granted attorneys' fees. *Id.* at 830-32.

An appeal was taken in each case. This Court consolidated the three appeals.

II. The Medicaid Program

Title XIX of the Social Security Act (Medicaid), 42 U.S.C. 1396 *et seq.,* is a jointly financed cooperative venture between the federal and state governments to assist the states in the provision of adequate medical care to eligible needy individuals ***5** and families with low incomes and resources. Medical and health-related services are provided to approximately 36 million individuals, including children, the aged, the blind, and/or disabled. With federal appropriations of $106.2 billion in FY 1999 and $115 billion in FY 2000, Medicaid is the largest Federal Program jointly administered with the States. The federal share of expenditures is determined annually for each state by a formula that compares the state's average per capita income level with the national average. 42 U.S.C. 1396b(a).

To date, all 50 states and District of Columbia, and several territories, have elected to establish Medicaid programs. Within broad federal guidelines each of these entities (1) establishes its own eligibility standards, (2) determines the type, amount,

duration, and scope of services, and (3) administers its own program. Thus, the Medicaid program varies considerably from state to state, as well as within each state over time.

States and other entities participating in the program must "provide for the establishment or designation of a single State agency to administer or to supervise the administration of the [Medicaid] plan * * *." 42 U.S.C. 1396a(a)(5)).[1] The regulation implementing this provision bars the designated state agency from "delegat[ing]" to another agency the "[e]xercise [of] discretion ***6** in the administration or supervision of the plan." 42 C.F.R. 431.10(e)(1)(1)). The regulation further provides that "[i]f other State or local agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency." 431.10(e)(3).

Medicaid is a vendor program, with payments made directly to participating providers. The providers must accept the Medicaid reimbursement level as payment in full. Each state has relatively broad discretion in determining (within federally imposed upper limits and specific restrictions) the reimbursement methodology and the resulting rates for services.

State Medicaid agencies often use state audit organizations or certified public accountants to audit individual Medicaid providers for compliance with Medicaid laws and regulations Medicaid regulations allow the designated state agency to withhold payments from a provider whenever the agency receives reliable evidence that the provider has engaged in "fraud or willful misrepresentation." 42 C.F.R. 455.23(a). Unfortunately, serious instances of waste, fraud, and abuse involving Medicaid have been uncovered. *See, e.g.*, *Hanlester Network v. Shalala*, 51 F.3d 1390 (9th Cir. 1995) (violation of Medicare and Medicaid ***7** anti kickback provisions); *United States v. Woodley*, 9 F.3d 774 (9th Cir. 1993) (Medicaid and Medicare as mail fraud victims), *United States v. Kahn*, 53 F.3d 507 (2d Cir. 1995), *cert denied*, 516 U.S. 1042 (1996) (defrauding New York's Medicaid system); *United States v. Nazon*, 940 F.2d 255 (7th Cir. 1991) (Medicaid fraud).

III. Facts Of These Cases

A. *Simonyan*

The FBI, in conjunction with the California State Controller's Office, the California State Attorney General's Office and the United States Attorney, conducted a task force to investigate Medicaid fraud in California. Based upon the evaluation of information received from the FBI in connection with this investigation, DHS initiated withholds on Medi-Cal payments to Eagle Medical Supply (Simonyan) and Nari Pharmacy (Nagapetyan). ER 218-228, 274-285, 629-634. After having initiated the initial withholds, DHS subsequently reviewed audit reports by the Controller as well as additional information showing that the providers had billed Medi-Cal for providing more goods than they could support having purchased. ER 218-228, 274-285, 629-34. The providers filed suit in federal district court to challenge the withholds.

***8** B. *San Lazaro*

DHS imposed a withhold on Medi-Cal payments to San Lazaro based on information received from the Controller, that the provider had engaged on fraud and willful misrepresentation under the Medi-Cal program. Among other things, the evidence showed that the provider had used invalid or inactive referring physician numbers on 64% of the claims paid. ER 88-114, 328-359, 465, 511-527, 672-98. A final audit report determined that San Lazaro could not support $5,661,953 of Medi-Cal claims for the review period, which determination San Lazaro did not appeal. ER 328-359. Subsequent to the withholds, San Lazaro closed its laboratory and requested that the cancellation of its California Clinical Laboratory and federal CLIA (Clinical Laboratory Improvements Amendments of 1988). ER 800-802, 854-865. The provider filed suit in federal district court to challenge the withholds.

C. *Clinical Care*

DHS imposed a withhold on Medi-Cal payments to Clinical Care based on information received from the Controller that the provider had engaged on fraud or willful misrepresentation in its Medi-Cal billings. ER 124-54. There was evidence that the provider had billed Medi-Cal for lab tests that were never ordered, that these false claims represented 43% of Clinical Care's total billings in a sample of about 100 laboratory claims, ***9** and that the Medi-Cal program paid over $3.2 million to the provider during the review period. Ultimately, the Controller's audit determined that Clinical Care had been overpaid by nearly $2 million. ER 566-576. Subsequently, DHS terminated Clinical Care's California Laboratory License pursuant to the provider's notification to that it was closing its laboratory. ER 449-55. The provider filed suit in federal district court to challenge the withholds.

IV. District Court's Opinions

The court first held that the plaintiff-providers had a private right of action, under 42 U.S.C. 1983. The court found to be "meritless" the Controller's argument that the provisions at issue "were intended to further the efficient operation of the Medi-Cal program and properly allocate authority within the state and between the state and federal governments," and that "Medi-Cal service providers * * * are, at most, incidental beneficiaries of the single state agency requirement." *San Lazaro* (vacated). ER 458-59. *See Simonyan.* ER 1236-38; Rather, the court concluded that "the single state agency requirements 'were undoubtedly intended to benefit [Medi-Cal service providers], and not merely to promote the efficient administration of the state plan.'"[2] *Simonyan.* ER 1237-38.

***10** On the merits, the court held that "[a]ny form of review or analysis by the Controller is discretionary * * *." *Id.* at 1233 The court stated that "[w]hether directly, through audits and recommendations submitted immediately to DHS itself, or indirectly, through findings submitted to the FBI, wh[ich] then makes recommendations based upon the Controller's findings to DHS,[3] the Controller's audit may not be used as reliable evidence for determining a proper withhold."[4] *Id.* The court reasoned that "[b]ecause any review and analysis by the Controller involves some measure of discretion, it is in direct violation of ***11** the Medicaid regulation * * *." *Simonyan.* ER 1233. *See also San Lazaro* (vacated) (ER 451); *Clinical Care* (ER 813-14).[5]

SUMMARY OF ARGUMENT

In this case, providers believed to have presented fraudulent or misrepresented claims for payment to Medi-Cal assert a right to have been audited by one state agency (DHS) versus another (California's Controller). But the Medicaid regulation they cite, implementing Medicaid's single state agency requirement, confers on providers no legally cognizable "right[]," enforceable under 42 U.S.C. 1983. Moreover, that regulation does not mandate that only the designated single state agency may do audits.

1. Relief under 42 U.S.C. 1983 may be based on a violation of only a federal statute that creates an enforceable "right[," *i.e.*, one that exists only if "Congress * * * intended that the provision in question benefit the plaintiff." *Blessing v. Freestone,* 520 U.S. 329, 340 (1997) (Title IV-D child support enforcement plan standards exclusively a matter between federal government and states, and not enforceable by mothers). Here, as ***12** in *Blessing,* the statute and implementing regulation are intended to benefit only the federal government in supervising Medicaid.

Like the *Blessing* standards, the single state agency clause is not phrased in terms of benefitting private parties. It provides solely a focal point of accountability to the federal government for a state's administration of Medicaid. As with the Title IV-D standards that provided incidental benefits to the mothers, the efficiency advanced by the single state agency requirement may incidentally benefit Medicaid providers. But such benefit is too remote to confer an unambiguous federal "right'[]" enforceable under Section 1983. The legislative history of the single agency requirement supports this conclusion. The requirement was included in the original Social Security Act for reasons of efficiency, and for similar reasons was incorporated into Medicaid.

2. Medicaid's single state agency regulation (42 C.F.R 431.10) enhances the states' ability to efficiently manage the program by providing that "other State or local agencies or offices" may "perform *services* for the Medicaid agency" (emphasis supplied). 431.10(e)(3). There are two qualifications to such use, first, a general proscription on delegation of the "[e]xercise

[of] *administrative discretion* in the *administration or supervision* of the plan" (431.10(e)(1)(i))(emphasis supplied), and second, a more specific one that the agencies "must not have ***13** the authority to change or disapprove any *administrative decision* of [the Medicaid agency], or otherwise *substitute their judgment* for that of the Medicaid agency with respect to the *application of policies, rules, and regulations* issued by the Medicaid agency" (emphasis supplied) 431.10(e)(3).

Here, the auditor's low level judgments do not detract from the overall supervisory power and "administrative" discretion properly retained by DHS. Nor do such judgments involve the "substitu[tion]" of judgement for that of DHS as to "the application of policies, rules, and regulations." To read the single state agency regulation to mandate that the designated agency retain the actual task of auditing would not advance the accountability objective of the underlying statutory provision. In fact, such a reading would likely render the implementing regulation inconsistent with that provision, which specifies that the single state agency may "*supervise* the administration of the [Medicaid] plan" (emphasis supplied). Finally, that reading would prevent DHS from using the resource within state government that it deems best qualified to do audits. At the least, the interpretation by HHS of its own regulation as not to impose this counterproductive limitation is reasonable, and therefore must be respected.

***14 ARGUMENT**

Medicaid providers believed to have submitted unsupportable Medicaid bills for payment[6] claim that California may not validly withhold or recoup "Medi-Cal" (California's Medicaid agency) payments based upon otherwise valid audits conducted by the state's Controller. More specifically, they claim that under a federal regulation the Controller is the wrong state agency to conduct the audits, that instead the state's designated Medicaid agency, the Department of Health Services (DHS), must do so First, the federal regulation confers on the providers no legally cognizable "right[]," enforceable under 42 U.S.C. 1983. Second, the providers' wrongly interpret the federal regulation at issue ***15** to require that such audits be conducted by one state agency versus another.

I

MEDICAID PROVIDERS ARE NOT THE INTENDED BENEFICIARIES OF THE SINGLE STATE AGENCY REQUIREMENT, AND THUS HAVE NO "RIGHT[]," ENFORCEABLE THROUGH 42 U.S.C. 1983, TO COMPEL A STATE'S COMPLIANCE WITH THAT REQUIREMENT

A. Only The Intended Beneficiaries Of A Statute Have A "Right[]" That They May Enforce Under 42 U.S.C. 1983

Relief under 42 U.S.C. 1983[7] may be based on violations of only those federal statutes that create enforceable "rights" within the meaning of the Section. *Blessing v. Freestone,* 520 U.S. 329, 340 (1997); *Legal Servs. of Northern California v. Arnett,* 114 F.3d 135, 138 (9th Cir. 1997). There is an enforceable "right[]" only if "Congress * * * intended that the ***16** provision in question benefit the plaintiff."[8] *Blessing,* 520 U.S. at 340.

In *Blessing,* mothers whose children were eligible for child support services unsuccessfully sought to enforce against the state the plan requirements of Title IV-D of the Social Security Act (child support enforcement provisions). The Court recognized that compliance with such requirements was exclusively a matter between the federal government and the states.

More specifically, the Court held that the requirement that "a State operate its child support program in 'substantial compliance' with Title IV-D was not intended to benefit individual children and custodial parents, and therefore it does ***17** not constitute a federal right." 520 U.S. at 343. Rather, "the standard [was] simply a yardstick for the Secretary to measure the systemwide performance of a State's Title IV-D program." *Id.* The Court pointed out that provisions like the 'substantial compliance' standard are designed only to guide the State in structuring its systemwide efforts at enforcing support obligations," and noted that "[t]hese provisions may ultimately benefit * * * [eligible] * * * [individuals], but only indirectly." *Id.* at 343-44. Finally, the Court discussed two other Title IV-D mandates - "detailed requirements for the State's data processing system," and the requirement that "each participating State * * * establish a separate child support

enforcement unit 'which meets staffing and organizational requirements as the Secretary may by regulation prescribe.'"[9] *Id.* at 344. The Court held that these standards "do not give rise to individualized rights" but "are simply intended to improve the overall efficiency of the State's child support enforcement scheme." *Id.* at 345.

Here, as in *Blessing*, there is no intent to confer a right on private parties. Rather, as we demonstrate below, the statute ***18** and implementing regulation[10] are intended to benefit only the federal government in its supervision of Medicaid, not Medicaid providers seeking withheld payments.

B. Medicaid Providers Are Not The Intended Beneficiaries Of The Single State Agency Requirement

1. Statutory And Regulatory Language

The single state agency requirement does not confer on providers a right that they may invoke to escape the withholding of Medicaid payments to which they are not entitled. Rather, the requirement resembles the structural standards considered in *Blessing.* Like the *Blessing* standards, the single state agency clause is not phrased in terms of benefitting private parties. And unlike the provisions at issue in decisions where the Supreme Court has found such an intended benefit,[11] "neither the statute ***19** nor the regulation unambiguously confers a benefit on recipients or providers." *Sobky v. Smoley*, 855 F. Supp. 1123, 1145 (E D Cal. 1994) (also involving the Medi-Cal program).

The single state agency requirement provides a focal point of accountability to the federal government for a state's administration of the Medicaid program. *Hillburn v Maher*, 795 F.2d 252, 261 (2d Cir. 1986) ("reason for the requirement that a state designate a 'single State agency' * * * was to avoid a lack of accountability for the appropriate operation of the program"), *cert. denied*, 479 U.S. 1046 (1987). Both the statute and the implementing regulation are directed to the efficient and uniform operation of the program, rather than to the provision of a direct or immediate benefit to Medicaid recipients or providers Certainly, as with the Title IV-D standards that provided incidental benefits to the mothers in *Blessing*, Medicaid providers may incidentally benefit from the single state agency requirement in so far as it enhances the efficiency of the Medicaid system.[12] This benefit is too remote, however, to ***20** confer an unambiguous federal right to enforce the statute or regulation through a Section 1983 cause of action. *Sobky* 855 F. Supp. at 1144[13]

2. Legislative History

As ably summarized by the court in *Sobky*, 855 F. Supp. at 1144-46, the legislative history of the single agency requirement supports the conclusion that the requirement is intended for the sole benefit of the federal government, not the providers.[14] The requirement was included in the original Social Security Act to ensure a successful and workable national social security program. *Id* at 1145 (*citing* Robert B. Stevens, *Statutory History of the united States; Income Security* 78 (1970); *Guidice v. Jackson*, 726 F. Supp. 632, 635 (E.D. Va. 1989), *aff'd,* ***21** 915 F.2d 1564 (4th Cir. 1990) (table)). For similar reasons of administrative efficiency, the requirement was made part of the Medicaid Act. *Sokby*, 855 F. Supp. at 1145. The only debate in Congress related to which state agency was to be entrusted with the administrative responsibility. *Sokby*, 855 F. Supp. at 1145.

The House bill "provided that the agency responsible for eligibility determinations under the existing Social Security programs should also administer Medicaid," with the "purpose * * * primarily to ensure that beneficiaries received prompt determinations of eligibility." *Id.;* H.R. Rep. No. 89-213 (1965) *reprinted in* 12665-2 House Miscellaneous Reports on Public Bills II 65. The Senate, however, concluded that as a matter of administrative efficiency, the program might be better administered by public health agencies. Thus, the Senate bill allowed the states themselves to select the administering agency *Sokby*, 855 F. Supp. at 1145; S. Rep. No. 89-404 (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 2016, 2295. Ultimately, Congress enacted the Senate version, with its emphasis on administration, over the House's verison, with its concern regarding eligibility determinations. *Sokby*, 855 F. Supp. at 1145; H.R. Conf. Rep. No. 89-682 (1965), *reprinted in* 1965 U.S.C.C.A.N. 2228, 2245.

***22 II.**

MEDICAID REGULATIONS (42 C.F.R. 431.10) PERMIT THE DESIGNATED STATE MEDICAID AGENCY TO SELECT ANOTHER STATE AGENCY TO CONDUCT AUDITS OF MEDICAID PROVIDERS.

In many states, the state Medicaid agency augments its resources by contracting with state audit organizations or certified public accountants to audit individual Medicaid providers for compliance with Medicaid laws and regulations. Medicaid regulations (42 C.F.R. 431.10) permit this practice[15] that enhances the states' ability to efficiently manage the program in compliance with applicable laws and regulations.[16]

The regulation expressly contemplates that "other State or local agencies or offices" may "perform *services* for the Medicaid agency" (emphasis supplied). 431.10(e)(3). The use of such ***23** agencies is circumscribed, however, by two requirements, first, the general one that the single state agency may not delegate to such agencies the [e]xercise [of] *administrative discretion* in the *administration or supervision* of the plan" (431.10(e)(1)(i)) (emphasis supplied),[17] and second, the more specific one that the agencies "must not have the authority to change or disapprove any *administrative decision* of [the single state agency], or otherwise *substitute their judgment* for that of the Medicaid agency with respect to the *application of policies, rules, and regulations* issued by the Medicaid agency" (emphasis supplied) 431.10(e)(3).

In this case, the district court focuses on certain judgmental aspects of the auditing process. Under generally accepted auditing standards, however, the performance of audits is not a "discretionary" responsibility, but involves the review of documents and other factual material to make findings and recommendations that may then be acted upon by other officials with discretionary responsibilities. Thus, the exercise of this low level of judgment by the auditor does not detract from the overall supervisory power and "administrative" discretion properly retained by DHS. Nor does such exercise involve the ***24** "substitu[tion]" of judgement for that of DHS as to "the application of policies, rules, and regulations." *See Association of American Medical Colleges v. United States,* 217 F.3d 770, 780-81 (9th Cir. 2000) (Medicare "audits themselves do not 'impose an obligation, deny a right, or fix some legal relationship as a consummation of the administrative process'" (citation omitted)); *General Dynamics Corp. v. United States,* 139 F.3d 1280, 1284-85 (9th Cir. 1998) ("no danger to the FTCA when a totally separate exercise of discretion stands between the generators of a report and the commencement of a prosecution").

Rather, the critical discretionary elements - establishing the criteria governing selection of the providers to be audited and evaluation of the audit results for appropriate action - remain, as they must, with the designated single State agency, here DHS.[18] To read the single state agency regulation to mandate that the designated agency retain not only these elements of discretion but the very task of auditing would not advance the accountability objective of the single state agency statutory provision. In fact, the district court's reading of the ***25** regulation would likely render the regulation inconsistent with that provision given its language allowing the state's plan to provide that the single state agency to "supervise the administration of the [Medicaid] plan." Finally, the district court's reading would prevent DHS from using the resource within the state government best qualified to perform the auditing function.[19]

At the least, the interpretation by HHS of its own regulation as not to impose such a counterproductive limitation is reasonable and therefore must be respected.[20] *See Thomas Jefferson Univ. v. Shalala,* 512 U.S. 504, 511-12 (1994); *Alaska Ctr. For The Env't v. U.S. Forest Serv.,* 189 F.3d 851, 857 (9th Cir. 1999) ("[w]hen reviewing an agency's application of its own regulation, the agency's interpretation of its regulation must be given controlling weight unless it is plainly erroneous or inconsistent with the regulation").

***26 CONCLUSION**

For the foregoing reasons, the judgments of the district court should be reversed.

Footnotes

1 The California Medicaid State Plan has designated the California Department of Health Services (DHS) as the single state agency,

[2] The court declined to follow the contrary decision in *Sobky v. Smoley,* 855 F. Supp. 1123 (E.D. Cal. 1994). *San Lazaro* (vacated). ER 456-59.

[3] The State had argued that "DHS made the withhold at the express recommendation of the FBI, not the Controller, so that anything that the Controller's office did in auditing was irrelevant to the decision to withhold payments." *Simonyan* ER 1231.

[4] In *Simonyan*, the court noted that "[i]t is not clear how the audit was initiated, under whose authority it began or for what purpose." ER 1229. In *San Lazaro* (vacated), the court stated that "it is undisputed that DHS exercised its own discretion when it authorized the withhold of Medi-Cal payments to Biomedical," albeit "at the express request of the Controller." ER 448. The court later stated, however, that DHS ordered the withholding "without reviewing the Controller's work papers." ER 450. In *Clinical Care*, the court stated that "[t]here is * * * nothing about * * * this case that distinguishes it from the other related cases * * * as to this issue of exercising discretion * * *." ER 813.

[5] The district court largely relied on a California state court decision, *Doctor's Medical Laboratory v. Connell,* 81 Cal. Rptr.2d 829, 69 Cal. App.4th 891, *review denied* (1999), which in turn relied on the district court's unpublished decision in *Health Line Clinical Lab., Inc. v. Connell,* No. CV-98-1620-RJK (D.C. Cal. 1998). 69 Cal. App.4th at 896 n.1. *Simonyan.* ER 1234-1238; *San Lazaro* (vacated). ER 450-53.

[6] The audits at issue found the following: (1) San Lazaro Association, Inc. - excess claim of $5,661,953 (*San Lazaro* ER 328-59), (2) Simonyan (Eagle Medical Supply) and Nagapetyan (Nari Pharmacy and Medical Supply) - 100% of Medi-Cal payments withheld on evidence of fraud or willful misrepresentation (*Simonyan* ER 218-28, 274-85, 629-34), and (3) Clinical Care Laboratory, Inc. overpayment by Medi-Cal of nearly $2,000,000 (*Clinical Care* ER 566-76).

In fact, on November 22, 1999, one of the two plaintiffs in *Simonyan*, Oganes Nagapetyan, pled guilty to Health Care Fraud (18 U.S.C. 1035) and to False Statement Relating To Health Care Matters (18 U.S.C. 2) in relation to a scheme to defraud Medi-Cal. *See* Criminal Docket for The United States District Court For The Eastern District of California, Case No. 99-CR-434-ALL, and plea agreement filed November 19, 1999. ER 1359, 1366. The plaintiff, Khachik Simonyan remains under investigation, and was implicated in an Information filed November 3, 1999 in *United States v. Hakop Simonyan,* United States District Court for the Eastern District of California, CR. No. CRS 99-481 GEB. ER 1134, n.1, 1163.

[7] Section 1983 provides, in pertinent part, that "[e]very person who, under color of any statute, ordinance, regulation, custom, or usage, of any State * * *, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress * * *."

[8] There are additional requirements that are not in serious question here. First, "the plaintiff must demonstrate that the right assertedly protected by the statute is not so 'vague and amorphous' that its enforcement would strain judicial competence." 520 U.S. at 340-41 (citations omitted). Second, "the statute must unambiguously impose a binding obligation on the States. *Id.* Further, "dismissal is proper if Congress 'specifically foreclosed a remedy under § 1983'" "by forbidding recourse to § 1983 in the statute itself, or impliedly, by creating a comprehensive enforcement scheme that is incompatible with individual enforcement under § 1983." *Id.* at 341.

Here, the statutory requirement is both mandatory in its terms and specific and detailed in its command. Further, Medicaid does not specifically foreclose recourse to Section 1983, nor does it offer a comprehensive federal remedial scheme.

We, note, however, that Section 1983 is limited to cases in which the state officials act "under color of state law." Here, as in the case of Medicare, the officials administering Medicaid under federal standards act under color of federal law. This point, however,

was not presented to the district court.

9 The implementing regulations provided that "each level of the State's organization must have 'sufficient staff' to fulfill functions." 520 U.S. at 344-45.

10 Neither the Supreme Court, nor this Court has yet addressed the matter of using Section 1983 to enforce federal regulations as such. The courts of appeals have reached "widely divergent conclusions" as to the extent, if any, "that section 1983 provides a remedy for violations of rights established by the Code of Federal Regulations." Todd E. Pettys, *The Intended Relationship Between Administrative Regulations And Section 1983's "Laws,"* 67 Geo. Wash. L. Rev 51, 52-53 (1998) (arguing that "section 1983 does not provide a remedy for purely regulatory rights"). But the regulation at issue satisfies even the most limited approach, taken by the Fourth and Eleventh Circuits, "that regulations can never create section 1983 rights that are not at least implicit in the corresponding statutes" (*id.* at 53). *Smith v. Kirk*, 821 F.2d 980, 984 (4th Cir. 1987). *Harris v. James*, 127 F.3d 993, 1008-12 (11th Cir. 1997).

11 *Wilder v. Virginia Hosp. Ass'n,* 496 U.S. 498 (1990); *Suter v. Artist M*, 503 U.s. 347 (1992).

12 The state court in *Doctor's Medical Laboratory* suggested that such possible benefits (avoiding delay in processing claims for payment, assuring that processing agency will have requisite centralization of "knowledge and expertise") were "some of these reasons" for the enactment of the single state agency requirement, 69 Cal. App.4th at 897-98. But the court offered no legislative history to support its conclusion. In fact, as shown by our discussion of the legislative history (*infra* 20), there is no such support. Further, the state court did not demonstrate that the asserted benefits to providers were any less incidental than those at issue in *Blessing.*

13 *See also Graus v. Kaladjian*, 2 F. Supp.2d 540, 544 (S.D.N.Y. 1998) ("[o]n its face, this [statutory] provision [(42 U.S.C. 1396a(a)(5))] is not intended for the benefit of private plaintiffs" so "[i]t follows that 42 C.F.R. § 431.10 * * * does not create a basis on which to ground a private enforcement action * * *"); *Ralabate v. Wing*, 1996 WL 377204, at *3 n.28 (W.D.N.Y. 1996) ("Court doubts that the single-agency requirement provides a basis upon which relief can be granted * * * under section 1983"). *But see Doctor's Medical Laboratory.*

14 In *Doctor's Medical Laboratory*, the court noted that "[n]either side has cited legislative history or case law discussing the legislative and regulatory reasons for the single agency and nondelegation rules." 69 Cal. App.4th at 897.

15 We additionally note that the Single Audit Act of 1984, as amended by the Single Audit Act Amendments of 1996, requires independent evaluations (audits) of the more than $300 billion in federal funds expended annually by the states, local governments, and not-for-profit organizations. 31 U.S.C. 7502. The auditor performing the single audit may be a public accountant or a federal, state, or local government audit organization that meets the general standards specified in generally accepted accounting standards. Single audits of States have been performed by certified public accountants and state audit organizations. 31 U.S.C. 7501(8)(A), (B) (defining "independent auditor").

16 The March 24, 1999 (Richardson) letter to DHS concluded that the interagency Agreement between DHS and the Controller, providing for such audits, was "fully compliant with federal single State agency requirements." ER *(San Lazaro*) 374. Effective July 1, 1998, HHS amended the State's plan "to reflect the fact that the State Controller's Office performs audits of Medi-Cal expenditures on behalf of the Department of Health Services (DHS)." *Id.* at 739.

17 Significantly, the statute that this regulation implements, 42 U.S.C. 1396a(a)(5), allows the designated single state agency either "to administer" the plan *or* "to supervise the administration of the plan."

18 Here, the district court focused solely on what it considered to be the discretion inherent in the audit process itself. Further, the facts of these cases do not clearly involve the Controller's exercise of any discretion that HHS's view would forbid. While the Controller conducted the audits, DHS made the decisions to withhold the payments. *See San Lazaro* (vacated). ER 448. And the court made no finding on whether DHS or the Controller initiated the audits. *See Simonyan*, ER 1229; *Clinical Care*, ER 813.

19 The district court recognized that permitting the single state agency "to contract with third-party agencies or firms to perform Medicaid audits * * * "helps the Medicaid agency." ER (*Simonyan*) 1463-64.

20 The district court did not discuss deference, but simply acknowledged that the Health Care Financing Administration * * * seems to approve of these contracts" "with third-party agencies or firms to perform Medicaid audits." ER (*Simonyan*) 1463-64.

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