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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF LOS ANGELES, CENTRAL DISTRICT

CALIFORNIA MEDICAL ASSOCIATION; CALIFORNIA HOSPITAL ASSOCIATION; CALIFORNIA DENTAL ASSOCIATION; CALIFORNIA ASSOCIATION FOR ADULT DAY SERVICES; AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, STATE CHAPTER OF CALIFORNIA, INC.; CALIFORNIA PHARMACISTS ASSOCIATION; and CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS,

Petitioners,

vs.

SANDRA SHEWRY, DIRECTOR OF THE DEPARTMENT OF HEALTH CARE SERVICES, STATE OF CALIFORNIA; CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES,

Respondents.

CASE NO. BC390126

CLASS ACTION

PETITIONERS' REPLY BRIEF IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION

[Supp. Schedule of Decs.; Supp. RJN; Pets. Response to Resps. Objections to RJN; Pets. Responses to Resps. Objections to Declarations; Pets. Objections to Decs. Submitted by Resps.; and Pets. Objections to Resps. RJN filed concurrently herewith]

Date: July 25, 2008
Time: 11:00 a.m.
Dept.: 307

Hon. William F. Highberger, Judge Presiding

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I. INTRODUCTION

While Petitioners are fully cognizant of California's current budget crisis, it is well established that a state may not flout the Medicaid Act's requirements for adequate beneficiary access to care solely for budgetary reasons. It's absurd to characterize compliance with the law as a hardship to its citizens. This is precisely what Respondents have done here, with potentially disastrous results. The Medi-Cal program has a history of financial crisis and inadequate funding (lowest in the nation) that stems from the Department's ongoing refusal to comply with minimum funding standards. Surely the public interest would be disserved by permitting the Department to violate its duty to administer a viable Medi-Cal program consistent with controlling standards.

II. THIS COURT HAS THE AUTHORITY TO GRANT A PRELIMINARY INJUNCTION BASED ON CODE OF CIVIL PROCEDURE SECTION 1085.

Petitioners satisfy the two requirements for a writ of mandate: (1) a ministerial duty on the part of a government official, and (2) a beneficial interest to perform that duty. Petitioners discuss the ministerial duty in Section A, and the beneficial interest in Section B. When these two requirements are met, the petitioner "is entitled as a matter of right to the writ, or, in other words, it would be an abuse of discretion to refuse it." *May v. Bd. of Directors of El Camino Irr. Dist.* (1949) 34 Cal.2d 125, 133-134.

A. A Writ of Mandate Lies To Compel the Performance of a Ministerial Duty.

Mandamus is an appropriate remedy to compel a government official to perform ministerial acts required by law. Code of Civ. Proc. § 1085 ("§ 1085"); see *Jenkins v. Knight* (1956) 46 Cal.2d 220, 222-223. Respondents must comply with federal Medicaid law, including all of the provisions of 42 U.S.C. § 1396a ("§ 1396a"). *Wilder v. Va. Hosp. Assn.* (1990) 496 U.S. 498, 502; *Doctor's Medical Laboratory, Inc. v. Connell* (1999) 69 Cal.App.4th 891, 896 ("*Doctor's Med. Lab.*"). The State Plan also creates a mandatory duty enforceable by a writ of mandate. See *Cal. Assn. for Health Servs. at Home v. Dept. of Health Servs.* (2007) 148 Cal.App.4th 696, 706 ("*CAHSH*"). Lastly, it is undisputed that Respondents have a mandatory duty to comply with the California Constitution and state law. See *Bramberg v. Jones* (1999) 20 Cal.4th 1045, 1055, fn. 15 (citing *Wenke v. Hitchcock* (1972) 6 Cal.3d 746, 751).

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1. Section 30(A) Sets Forth Duties that Can Be Enforced Through Mandamus.

The Department spends most of its Opposition arguing that 42 U.S.C. § 1396a(a)(30)(A) ("§ 30(A)") does not impose ministerial duties enforceable under § 1085, relying largely on *Sanchez v. Johnson* (9th Cir. 2005) 416 F.3d 1051. *Sanchez* establishes that providers do not have a private right of action to enforce § 30(A) in federal court through 42 U.S.C. § 1983 ("§ 1983").[1] However, the observation in *Sanchez* that § 30(A) is "ill-suited" to judicial remedy cannot extend beyond evaluating the existence of a privately enforceable right under § 1983. Both before and after a change in Supreme Court jurisprudence regarding § 1983 standing, which heavily informed *Sanchez*, numerous federal courts interpreted and applied § 30(A) in reviewing state Medicaid agency rate making decisions. See, e.g., *Orthopaedic Hosp. v. Belshe* (9th Cir. 1997) 103 F.3d 1491, cert. den. (1998) 522 U.S. 1044 ("*Orthopaedic*"); *Ark. Med. Soc'y., Inc. v. Reynolds* (8th Cir. 1993) 6 F.3d 519; *Visiting Nurse Assn. of North Shore, Inc. v. Bullen* (D.Mass. 1994) 866 F.Supp. 1444, affd. and revd. on other grounds (1st Cir. 1996) 93 F.3d 997; *Methodist Hosps., Inc. v. Sullivan* (7th Cir. 1996) 91 F.3d 1026; *Ill. Hosp. Assn. v. Ill. Dept. of Pub. Aid* (D.Ill. 1983) 576 F.Supp. 360. The fact that multiple courts found § 30(A) definite enough to determine whether state agencies complied with the statute undermines any suggestion in *Sanchez* that § 30(A) is completely unenforceable.

Even more telling, the Department fails to overcome recent controlling California case law. The *CAHSH* court issued a writ of mandate compelling the Department to adhere to a portion of the State Plan regarding the establishment of reimbursement rates for home health providers. The State Plan provision at issue expressly incorporated the terms of § 30(A). *CAHSH*, *supra*, 148 Cal.App.4th at 702. The Department claimed *Sanchez* determined that § 30(A) was too vague to be judicially enforceable. *CAHSH*, *supra*, Respondent's Brief, 2006 WL 3096304, at fn. 5. The Court of Appeal squarely rejected this contention, holding that –notwithstanding *Sanchez*—the

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[1] The Ninth Circuit recently clarified that § 30(A) is enforceable in federal court under the Supremacy Clause. Petitioners' Supplemental Request for Judicial Notice ("Supp. RJN") Exh. A (*Indep. Living Ctr. of S. Cal. v. Shewry* (9th Cir., Jul. 11, 2008, No. 08-56061) ["*ILCSC*"]) at 1-2.

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Department's failure to comply with the State Plan violated ***both*** state (Cal. Code Regs., tit. 22, § 50004(b)(1)) and federal (§ 30(A)) regulatory requirements that were enforceable through a § 1085 mandate. *CAHSH, supra*, 148 Cal.App.4th at 706-708. The *CAHSH* court noted that "(t)he nature of the remedy afforded by section 1983 is more limited than the broader remedy available under [C.C.P. § 1085]," citing *Cal. Homeless & Housing Coal. v. Anderson* (1995) 31 Cal.App.4th 450, 458. Thus, *CAHSH* held that the plaintiff providers could enforce by mandamus the Department's duties under the State Plan to assure that payment rates are "sufficient to enlist enough providers so that care and services are available under the plant at least to the extent that such care and services are available to the general population in the geographic area." *Id*. at 707 (citing § 30(A) and *Frank v. Kizer* (1989) 213 Cal.App.3d 919, 922, fn. 2).

The facts here are remarkably similar. Here, the State Plan imposes a mandatory legal duty on the Department to establish rates adequate to ensure access to services for Medi-Cal beneficiaries at a level at least equal to the general insured population before it may implement the Rate Reduction. Attachment 4.19-B states that the Department may implement rate changes required by state statute only if the it assures that "all applicable requirements of 42 C.F.R. Part 447 are met." RJN Exh. C (excerpt of State Plan Attachment 4.19-B). 42 C.F.R. § 447.204 ("§ 447.204") requires that provider "payments must be sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general public." The Department concedes it has not conducted an analysis to assess whether the proposed Rate Reduction would reduce access below the minimum level the State Plan and § 447.204 establish. Silva Decl. ¶¶ 8-10. Based on the Department's abject failure to perform its ministerial duty to review the adequacy of Medi-Cal beneficiary access to services, a writ of mandate and injunction should issue to compel a review of the adequacy of the proposed (reduced) rates and beneficiary access to services before implementation of the Rate Reduction.

2. Valid Federal Authorities Define Respondents' Duties

Section 30(A) states that the Department is required to provide methods and procedures to "to assure that payments are consistent with efficiency, economy, and quality of care" and sufficient to provide equal access to for Medi-Cal beneficiaries. The key question for determining

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whether a state is violating the equal access requirements of § 30(A) and § 477.204 is a comparison of the access of beneficiaries to the access of other individuals in the same geographic areas with public or private insurance coverage. *Clark v. Kizer* (E.D.Cal. 1990) 758 F.Supp. 572, 575, affd. in relevant part sub nom. *Clark v. Coye* (9th Cir. 1992) 967 F.2d 585. Congress has clarified its intent that the determination of "whether services are available to Medicaid beneficiaries at least to the extent that services are available to the general population, will compare the access of beneficiaries to the access of other individuals in the same geographic area with private or public insurance coverage …." H.R.Rep. No. 101-247, 1st Sess., pp. 390-391 (1989); see *id*. This standard is not so imprecise or uncertain as to evade judicial enforcement.

Likewise, the "efficiency, economy and quality of care" standards are equally proper for judicial enforcement. As established in *Orthopaedic*, the only way that a state can satisfy this mandate is to perform studies and/or analyze relevant data, including information about provider costs, before setting rates. See *Orthopaedic*, *supra*, 103 F.3d at 1495-1500.[2] *Sanchez* did not mention *Orthopaedic*, let alone overrule it. *Orthopaedic* focused only on the substantive requirements of § 30(A), while *Sanchez* was concerned only with whether § 30(A) is enforceable under § 1983. The observation in *Sanchez* that § 30(A) is "ill-suited" to judicial remedy does not extend beyond the § 1983 standing analysis.

The Ninth Circuit affirmed the continued vitality of *Orthopaedic* one month *after Sanchez* in *Alaska*, *supra*, 424 F.3d at 940. *Alaska* rejected the suggestion that the repeal of the Boren Amendment made § 30(A) unenforceable. Addressing the Boren Amendment, the court stated that, "… its repeal, like its enactment, modified § 13(A) alone; it effected no change to § 30(A).

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[2] This court should afford no deference to a stale litigation position of the U.S. Department of Health and Human Services ("HHS") in an *amicus* brief, purportedly showing HHS's earlier disagreement with the Ninth Circuit's ruling in *Orthopaedic*. HHS' opinions about § 30(A)'s requirements–whatever they are–are not determinative of whether the Department complied with the law in this case. *AMISUB v. Colo. Dept. of Soc. Servs* (10th Cir. 1989) 879 F.2d 789, cert. den. (1990) 496 U.S. 935 ("*AMISUB*"). Further, the decision in *Alaska Dept. of Health & Soc. Servs. v. Ctrs. for Medicare & Medicaid Services* (9th Cir. 2005) 424 F.3d 931 ("*Alaska*") reflects that HHS has now reconciled itself to the court's holding in *Orthopaedic*. In *Alaska*, HHS cited *Orthopaedic* in support of its disapproval of a state Medicaid plan amendment made by the State of Alaska. See *Alaska*, *supra*, Respondent's Brief, 2004 WL 3155124, at 31-32.

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Moreover, the relevant language of § 30(A) remains unchanged since *Orthopaedic*, and thus our interpretation of its purpose, and the State's obligations thereunder still holds."[3] *Id.*

3. The Department's Failure to Adhere to Its State Plan Obligations Violates State Law, Which AB 5 Neither "Superseded" nor "Repealed."

Respondents concede they have not complied with Attachment 4.19-B of the State Plan, which precludes implementation of the legislatively-mandated rate reduction until they review the impact on access, or submitted a State Plan Amendment ("SPA") for certain services (e.g., hospital) for which the Department cannot change rates at all without an SPA, even if they had done the required access studies. Rather, the Department argues that the State Plan is not a "law" enforceable by mandamus. *CAHSH* flatly rejected this contention. The court held, "whether the state plan is in the nature of a contract[4] or a law, DHS is required by regulation to follow it. (Cal. Code Regs., tit. 22, § 50004(b)(1).) *Thus, if DHS violated the terms of the state plan, it has violated state law as embodied in a regulation*." *CAHSH, supra*, 148 Cal.App.4th at 706 [emphasis and footnote added].

The Department contends that because Welfare and Institutions Code § 14105.19(a) opens with "[n]otwithstanding any other provision of law," it repeals the regulatory requirement that it administer the Medi-Cal program in compliance with the State Plan and applicable federal requirements. However, repeals by implication using such language are highly disfavored. *Prof. Engineers in Cal. Govt. v. Kempton* (2007) 40 Cal.4th 1016, 1038-1039; *Dept. of Personnel Admin. v. Super. Ct.* (1992) 5 Cal.App.4th 155, 191; *In re Marriage of Wilcox* (2004) 124 Cal.App.4th 492, 500 ["the law shuns repeal of statutes by implication"]. This is especially true

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[3] The *Alaska* decision disposes of the Department's suggestion that Boren Amendment's repeal effectively foreclosed all challenges to Medicaid payment rates under any provision of § 1396a.

[4] A federal decision just this month refused to adopt a similar "contract theory" of Medicaid law, holding "[t]he State Plan is the state embodiment of federal law, and DHH officials cannot avoid being held accountable under this law by arguing that Medicaid is merely a contract between DHH and CMS." *Women's Hosp. Found. v. Townsend* (M.D.La., Jul. 10, 2008, Civ. A. No. 07-711-JJB-DLD) 2008 WL 2743284, at 5.

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here, where there is ample indication the Legislature did not intend such a result, as language in the same statute directs the Department to "promptly seek any necessary federal approvals for the implementation of this section." Welf. & Inst. Code § 14105.19(g). Obviously, the Legislature is well aware of the fact that having chosen to participate, it must comply with federal Medicaid laws and regulations, *Harris v. McRae* (1980) 448 U.S. 297, 301, and that any amendment of the State Plan must be submitted by the Department as the "single state agency" (*Doctor's Med. Lab.*, *supra*, 69 Cal.App.4th at 894) to CMS for approval. 42 C.F.R. § 447.256. As discussed at Section III(C), *infra*, the Department may *not* implement changes to the State Plan prior to the Secretary's approval. The Department concedes that it has neither submitted, nor obtained approval for an SPA requesting approval for the Rate Reduction. The mere passage of AB 5 in the absence of a CMS-approved amendment of the existing State Plan does not "cure" the Department's failure to carry out this mandatory duty.

4. The Possibility of CMS Enforcement Does Not Preclude Private Enforcement of federal Medicaid Requirements Under the State Plan.

Notwithstanding *CAHSH* and more than three decades of federal and California appellate decisions enforcing federal Medicaid requirements in connection with the operation of Medi-Cal (see Petitioners' Memorandum of Points and Authorities in Support of Motion for Preliminary Injunction ["Pet. MPA ISO PI"], at 14, n. 4), the Department argues that CMS enforcement is the *exclusive* State Plan enforcement mechanism. The District Court in this case rejected this argument when it remanded this action back to the Superior Court, noting that there could be no serious contention that "the complete preemption doctrine applies in this instance. See *Valles v. Ivy Hill Corp*. (9th Cir. 2005) 410 F.3d 1071, 1075." Supp. RJN Exh. C (Remand Order from *Cal. Med. Assn., et al., v. Shewry* (C.D.Cal, filed Jun. 23, 2008, No. CV 08-3363) at 11. Although it is true that a comprehensive remedial scheme for enforcement may preclude private enforcement, the Supreme Court has held that the Medicaid Act does not provide that type of detailed remedial scheme. *Wilder v. Va. Hosp. Assn.* (1990) 496 U.S. 498, 521-22. "That the Federal Government may withhold federal funds to non-complying States is not inconsistent with private enforcement." *Harris v. Olszewski* (6th Cir. 2006) 442 F.3d 456, 463; *Albiston v. Maine Comm'r of Human*

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Servs. (1st Cir. 1993) 7 F.3d 258, 265

5. Federal Medicaid Requirements Are Mandatory on the Department Pursuant to the Supremacy Clause.

Any concerns this Court may still have about the impact of *Sanchez* on its ability to enforce § 30(A) are alleviated by the recent Ninth Circuit Order finding that AB 5 is inconsistent with § 30(A) and thus preempted under the Supremacy Clause. See *ILCSC*, *supra*.

Since the Supreme Court held that § 1983 provides a cause of action for statutory claims regarding welfare benefits that do not involve constitutional violations (*Maine v. Thiboutot* (1980) 448 U.S. 1), almost all federal court litigation to enforce the Medicaid Act and other federal safety net statutes has been under the Civil Rights Act. Federal courts allowed such cases, but then gradually narrowed the ability to bring them, culminating in *Gonzaga University v. Doe* (2002) 536 U.S. 273, which restricted the guidelines for determining that an "enforceable right" exists and led to *Sanchez*, which concluded that no such enforceable right exists under § 30(A). The Ninth Circuit, however, properly recognized that suit may be brought "under the Supremacy Clause to enjoin state law allegedly preempted by federal statute, regardless of whether the federal statute at issue confers an express 'right' or cause of action on the plaintiff." See *ILCSC, supra* (citing, inter alia, *Lankford v. Sherman* (8th Cir. 2006) 451 F.3d 496 [Medicaid case invalidating Missouri regulation under Supremacy Clause because it conflicted with federal law]).[5]

6. A Mandate Will Lie to Compel the Exercise of Discretion or to Correct Abuse of Discretion

Respondents contend that § 30(A) affords them discretion in setting rates, and points out that a mandate may not issue to require an agency to exercise discretion in a particular manner. However, mandate is available to compel an agency to exercise discretion or to curb an abuse of

[5] As the Ninth Circuit has recognized, a state statute need not be inconsistent on its face, but may be inconsistent as applied, to violate the Supremacy Clause. *ILCSC, supra*, at 4 (finding that plaintiffs raised a question "serious enough to require litigation" of their claim that § 30(A) preempts AB 5). See *Livadas v. Bradshaw* (1994) 512 U.S. 107, 119.

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discretion. *Tulare Water Co. v. State Water Commission* (1921) 187 Cal. 533, 537.

Here, there has been no exercise of discretion to which deference might be appropriate, as the Respondents have not performed their mandatory duties to determine, based on a reasonable analysis, whether the rates after the Rate Reduction will ensure equal access or be consistent with efficiency, economy, and quality. Further, to the extent Respondents have exercised discretion, they have abused their discretion because the implementation of the Rate Reduction is arbitrary and capricious. Agency action is arbitrary and capricious, and an abuse of discretion, where the agency has failed to consider the relevant factors or to make a reasonable choice between the factors considered and the agency's decision. See *Cal. Hotel & Motel Assn. v. Industrial Welfare Commission* (1979) 25 Cal.3d 200, 212; see also *Warmington Old Town Associates v. Tustin Unified Sch. Dist.* (2002) 101 Cal.App.4th 840, 861-862. Here, Respondents did not consider the relevant factors of equal access, efficiency, economy, and quality prior to implementing the Rate Reduction, or, at the very least, have not shown that the implementation of the rate reduction would be consistent with these factors and their obligations under state and federal law.

B. Petitioners Have Standing to Bring this Writ of Mandate Action.

1. Petitioners And Members Are Beneficially Interested in the Performance of Respondents' Duties To Comply With Federal Medicaid Law.

Respondents erroneously assert that Petitioners lack a beneficial "right," separate and apart from the “beneficial interest” that C.C.P. § 1086 requires, to enforce state and federal requirements on the Medi-Cal program. Respondents then attempt to graft federal requirements under § 1983 onto California's writ of mandate, despite explicit case law to the contrary.

CAHSH conclusively disposed of this issue. That court rejected the notion that a party needed some sort of beneficial right, akin to the right required under § 1983 for standing. "Unlike section 1983, which requires the violation of a private right, privilege, or immunity to confer standing, [C.C.P. § 1085] confers a broad right to issuance of a traditional writ to those who are beneficially interested within the meaning of [C.C.P. § 1086]." *CAHSH*, *supra*, 148 Cal.App.4th at 706 (citing *Doctor's Med. Lab.*, *supra*, and *Syngenta Crop Protection, Inc. v. Helliker* (2006) 138 Cal.App.4th 1135).

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In order to meet the "beneficial interest" requirement for a writ of mandate, a petitioner need only show a particular interest beyond that of the public at large. *Citizen Assn. for Sensible Dev. of Bishop Area v. County of Inyo* (1985) 172 Cal.App.3d 151, 158. Petitioners and the providers they represent have a particular interest in ensuring that the Department complies with the law in setting Medi-Cal rates. *CAHSH* held that this interest is a sufficient beneficial interest to confer § 1085 standing, ruling that an association of home health providers had standing to bring a writ of mandate case against the Department to enforce compliance with § 30(A), the State Plan, and Cal. Code Regs., title 22, section 50004. *CAHSH*, *supra*, 148 Cal.App.4th at 707.

2. Petitioners Have Third Party Standing to Bring This Suit On Behalf of Their Members' Patients.

Respondents' argument that Petitioners lack third-party standing to assert the interests of Medi-Cal beneficiaries is irrelevant and without merit. Petitioners have standing to bring this writ of mandate on behalf of the public interest to enforce a public right. See *Green v. Obledo* (1981) 29 Cal.3d 126, 144. This theory of standing, uncontested by Respondents, grants Petitioners the authority to assert the interests of Medi-Cal beneficiaries.

Moreover, Petitioners have independent standing to assert the claims of Medi-Cal beneficiaries. Petitioners have met the three elements to establish third-party standing: (1) their members and their patients share a close relationship as is evident from the numerous declarations providers have filed out of concern for their patients' well-being; (2) Petitioners and their members will suffer injury; and (3) Medi-Cal beneficiaries are hindered from bringing suit on their own. See *Novartis Vaccines and Diagnostics, Inc. v. Stop Huntingdon Animal Cruelty USA, Inc.* (2006) 143 Cal.App.4th 1284, 1297. The Ninth Circuit left undisturbed the holding in *Clayworth v. Bonta* (E.D. Cal. 2003) 295 F.Supp.2d 1110, revd. on other grounds (9th Cir. 2005) 140 Fed.Appx. 667 ("*Clayworth*"), which recognized standing of provider organizations to assert interests of Medi-Cal beneficiary patients, and which this court should follow here.

III. Petitioners Have Established A High Likelihood of Success on the Merits.

A. Respondents Have Violated the Equal Access Provision of Section 30(A).

Respondents claim § 30(A) does not apply because the rate reduction was legislatively

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mandated. See Respondents' MPA in Opposition to Motion for Preliminary Injunction ("Opp.") at 18. Respondents' interpretation would render meaningless not only § 30(A), but virtually all of § 1396a, as states could always evade the statute's requirements by changing Medicaid payment rates through legislation. Case authority is to the contrary. See *Minn. Homecare Assn. v. Gomez* (8th Cir. 1997) 108 F.3d 917, 918; *AMISUB, supra*, 879 F.2d at 800-801 (legislative rate reduction invalid under Boren Amendment); *Ala. Nursing Home Assn. v. Harris* (5th Cir. 1980) 617 F.2d 388; *Mo. Childcare Assn. v. Martin* (W.D.Mo. 2003) 241 F.Supp.2d 1032, 1044. Section 30(A) requires that a state plan provide payment methods that assure payments are adequate to afford equal access. State legislation, like AB 5, which would force a state Medicaid agency to violate this provision by implementing a payment method that does not assure access, conflicts with federal law and is therefore invalid. See *AMISUB*, *supra*; *Ala. Nursing Home Assn.*, *supra*.

Respondents contend the 2008 Legislative Analyst Report shows the Legislature adequately considered access, as the report discusses access. See Opp. at 18. The 2008 LAO Report proves little, as the Report states that access would be harmed, yet the statute still was enacted. The only real consideration behind the rate reduction was budgetary concerns. Further, merely considering access is not sufficient. The rate is still invalid if it actually limits access to services. See *Ark. Med. Soc'y. v. Reynolds* (E.D.Ark. 1992) 816 F.Supp. 826, affd. (8th Cir. 1993) 6 F.3d 519. Petitioners have presented ample evidence showing an access problem.

Respondents assert that declarations from Department employees showing "reimbursement levels for most providers are at or close to the current level" contradict Petitioners' access showing. Opp. at 18. However, this is incomprehensible, because the rates for all services on and after July 1, 2008 are 10% less than before July 1, 2008, and, while the base rates for a few services may increase on August 1, there is no indication that will near make up for the 10% reduction. Further, the fact that Medicaid payment rates for some services, on *average*, may come close to covering provider costs is not, by itself, sufficient to establish those rates are compliant with federal Medicaid law, particularly when some providers are reimbursed

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substantially below their costs. *West Va. Univ. Hosps. v. Casey* (5th Cir. 1989) 885 F.2d 11, 28.[6]

B. The Rate Reduction is Not Consistent with Efficiency, Economy and Quality.

Respondents address only one of several reasons Petitioners present as to why the Rate Reduction is not consistent with efficiency, economy, and quality, i.e., that neither the Legislature nor the Department considered provider costs. See Opp. at 21-22. Respondents make no claim that costs were considered, but assert no such requirement exists because *Orthopaedic*, *supra*, was wrongly decided and no longer is good law. Respondents' assertion is wrong for the reasons explained above. See Section II(A)(2), *supra.*

Respondents do not contest Petitioners' other grounds establishing that the rate reduction is not consistent with efficiency, economy, and quality which separately require its invalidation. See Pet. MPA ISO PI, *supra*, at 28-30. For example, Petitioners have shown that the Rate Reduction will cause patients to forgo treatment until they are very sick, more expensive to treat, and end up in costly emergency rooms, thereby exacerbating overcrowding. This is neither efficient, economical, nor consistent with quality care.

C. Respondents Violated the State Plan by Failing to Amend It.

Respondents do not assert that a SPA has been submitted to CMS, or that a SPA is unnecessary for inpatient hospital, long term care, or ADHC services. Rather, the Department argues that changes to a State Plan may be implemented prior to submission and CMS approval of the amendment, citing 42 C.F.R. §§ 430.20(b), 447.256. The Department attempts to distinguish the contrary holding in *Exeter Mem'l Hosp. Assn. v. Belshe* (9th Cir. 1998) 145 F.3d 1106, arguing that the 1997 amendment of 42 U.S.C. § 1396a(a)(13)(A) somehow negates the Ninth Circuit's express holding. In *Exeter*, the Department had argued that an earlier amendment of that same section allowed it to implement SPAs prior to federal approval. The Ninth Circuit squarely

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[6] Respondents' reference to *Farmacia Remedios Inc. v. Shewry*, (Super. Ct. Sac. County, 2008, No. 34-2008-00012743) is irrelevant whether the rate reduction violates the equal access requirement. While the Sacramento County Superior Court denied an application for a temporary retraining order to stop the rate reduction in *Farmacia*, the only evidence before that court related only to pharmacy services and was nowhere near as complete as the showing made here.

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rejected the Department's effort to distinguish earlier holdings that had precluded pre-approval implementation in *Oregon Assn. of Homes for the Aging, Inc v. Oregon.* (9th Cir. 1993) 5 F.3d 1239, and *Washington State Health Facilities Assn. v. Washington Dept. Soc. & Health Services* (9th Cir. 1982) 698 F.2d 964. The *Exeter* court refused to view its earlier decisions solely through the prism of the language of the so-called Boren amendment as it existed at any point in time, holding instead that: "our opinion in *Washington* was premised on the *overall statutory framework rather than the particular language of the statute relating to amendment to state plans. The framework required then, and at all relevant times since, that all plans receive approval by the federal government before they may be implemented, and that all amendments to plans must also be federally approved*." *Exeter*, 145 F.3d at 1108 (emphasis added).

Respondents argue that Welfare and Institutions Code § 14105.19 does not expressly require the Department to amend the State Plan *before* implementing the rate reduction. This is a straw man, as Petitioners' argument is that federal law prohibits implementation prior to the approval of a SPA. The requirement in § 14105.19(g) that the Department "promptly seek any necessary federal approvals for the implementation of this section" reflects the Legislature's awareness that federal approvals may be required prior to implementation.

IV. Petitioners Have Demonstrated Irreparable Harm

Petitioners have provided abundant evidence showing that all manner of providers *will* discontinue or limit participation in Medi-Cal if the Rate Reduction goes forward, which *will* immediately decrease access to services for Medi-Cal beneficiaries. This evidence is not speculative. Further, the evidence offered by Respondents, most of which relies on misleading or inconclusive data, does nothing to counteract Petitioners' showing.

Significantly, the concept of irreparable injury, "does not concern itself entirely with injury beyond the possibility of repair or beyond compensation damages.... Rather, by definition, an injunction properly issues … where 'it would be extremely difficult to ascertain the amount of compensation which would afford adequate relief.'…" *Wind v. Herbert* (1960) 185 Cal.App.2d 276, 285. A party seeking injunctive relief does not have to show the injury sought to be prevented is an absolute certainty, but merely "probable." See *Uptown Enters. v. Strand* (1961)

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195 Cal.App.2d 45, 52.

Respondents' characterization of the harm Petitioners show as "the mere loss of monetary" compensation is intellectually dishonest and borders on insulting. See Opp. at 35. This case is not about preventing reduced profit margins, but being able to continue to treat Medi-Cal patients, and, in some cases, basic survival. Petitioners have shown that many providers will not be able to stay in business due to the Rate Reduction, or will be forced to discontinue or decrease services to Medi-Cal patients. See Pet. MPA ISO PI, *supra*, at 32-36. This kind of alleged "irreparable" harm suffices to justify injunctive relief. See, e.g., *Clayworth*, *supra*, at 1127-1128 ; *Exeter Mem'l Hosp. Assn. v. Belshe* (E.D. Cal. 1996) 943 F.Supp. 1239, 1244–1245, affd. 145 F.3d 1106; *Ark. Med. Soc'y v. Reynolds* (E.D.Ark. 1992) 834 F.Supp. 1097, 1101-1102, affd. 6 F.3d 519.

The harm that Petitioners allege is concrete, imminent and, in fact, already occurring. Children's Hospital and Research Center Oakland ("Children's"), which is the only independent hospital serving exclusively children in all of Northern California, already has eliminated two types of outpatient services and scaled back hours for several other outpatient departments in response to the Rate Reduction. See Myers Decl. ¶¶ 7-10. These operational changes required the firing of roughly 65 employees and left the surrounding community wondering where to go for the care that Children's no longer offers. *Id*. at ¶¶ 9-10. The situation at Children's provides vivid proof that the representations of other providers that they will drop out of Medi-Cal, scale back operations, or close altogether due to the Rate Reduction are not mere threats.

Respondents' claims that there is currently and will continue to be sufficient access to physicians by Medi-Cal beneficiaries are fallacious and demonstrate the Department's complete lack of awareness of whether its payments to physicians are sufficient to assure access. Physicians have long endured the brunt of California's budget woes as Medi-Cal payment rates historically have been established without any reasonable basis, have barely been adjusted in almost a quarter century, trail far behind other states' Medicaid and Medicare rates, and now have the dubious honor as being the lowest in the nation. Mould Decl., Exhs. E and I; 2008 LAO Report at C-37; 2001 LAO Report at 1. The Department's estimate that nearly 120,000 physicians are "actively enrolled" in the Medi-Cal program (Machado Decl. ¶ 11) outnumbers the 109,763 physicians with

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active California licenses and the approximately 73,190 physicians actively providing patient care in California, and no longer in residency or fellowship training. (Ford Decl. ¶ 11.) In reality, only approximately 20,000 physicians participate in the Medi-Cal program, drastically fewer than the number of physicians actively practicing in California. (*Id.* at ¶¶ 14-16, 19.) The lack of physicians regularly participating in the Medi-Cal program substantially impairs the ability of Medi-Cal beneficiaries to access needed care, and the Rate Reduction will only aggravate this problem. (*Id.* at ¶¶ 19-20.) Contrary to Respondents' assertions, federally qualified health centers and rural health clinics simply do not have the capacity and are not particularly suited to absorb the additional demands on their services by Medi-Cal recipients created as a result of the Rate Reduction. See, e.g., Supp. Lamp Decl. ¶¶ 6-11 (explaining irreparable impact of influx of Medi-Cal patients on the operations of the Venice Family Clinic and its patients); Senella Decl. ¶¶ 5-7 (same for Tarzana Treatment Center). Nor, to answer the Court's concern, is the existence of Medi-Cal managed care plans in 22 of 58 counties a possible solution for the 3.2 million Medi-Cal beneficiaries in the fee-for-service program. See Thomas Decl. ¶¶ 4, 12.

Access to hospital care will likewise be reduced and cause irreparable harm. Respondents' evidentiary presentation focuses entirely on inpatient services provided by non-contract hospitals (Opp. at 37); petitioners have not alleged a significant access problem with respect to inpatient hospital services. Petitioners have shown that a number of hospitals, including several in very rural areas, will eliminate certain outpatient services or skilled nursing care in the wake of the Rate Reduction. See Pet. MPA ISO PI, *supra,* at 34, 36; see also Myers Decl. ¶ 9. Respondents make no effort to rebut this evidence. The purported adequacy of inpatient rates does nothing to disprove, e.g., that the Rate Reduction will leave 30 skilled nursing patients of Loyalton Hospital in Eastern Plumas County without a reasonable alternative source of care. Guenther Decl. ¶ 8.A.

The Department's claim that the 10% reduction will have no impact on pharmacy access is based on misleading data. The Myers & Stauffer studies on which DHCS so heavily relies provide aggregate averages that are essentially meaningless because they ignore the impact of the rate reduction on high cost drugs. Supp. Schondelmeyer Decl., ¶ 20. It defies logic that pharmacies will dispense drugs for reimbursement significantly below acquisition cost. The

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DHCS assertion that there is a "range of reasonableness" under federal law that allows for reimbursement at 85% to 95% of costs, or as low as 70% to 80% for pharmacies, is based on questionable case law pertaining to hospitals and nursing homes, inapplicable to pharmacies for which 81% of costs are attributable to product cost, which, contrary to Gorospe's unfounded assertion, cannot be reduced by measures of efficiency. Supp. Schondelmeyer Decl. at ¶ 7-13; 21.

Contrary to DHCS' assertions, pharmacies already have begun refusing to dispense drugs for which the reduced payment is below their cost of purchasing the drug, including at least one pharmacy in a rural area with no other pharmacies nearby. Peeler and Supp. Cronin Decls. Further, the statement that pharmacies complained about the 2004 rate reduction but remained in the program (Gorospe Decl. ¶ 7) is misleading. The reimbursement change in 2004 was the result of a negotiation and replaced a more draconian 5% reduction that had been enjoined, but was on appeal. The change almost doubled the dispensing fee, which benefited greatly most pharmacies that do not dispense a lot of high cost drugs. It did not have nearly the same impact as the across-the-board 10% reduction in AB 5. Cronin Decl. ¶ 6.

In regard to ADHCs, which AB 5 will hit hard, Sandra Yien's assertion that ADHCs will still be receiving 110% of their costs is *completely unfounded*. Her statement that ADHCs have fewer responsibilities than NF-As, on which their rate is based, is contrary to fact. Further, her statement that the current rates must be generous because 94% of ADHCs participate in Medi-Cal is misleading: 94% of ADHCs participate in Medi-Cal because, until recently, they *were required* to do so as a condition of licensure. See Supp. Missaelides Decl. ¶ 9.

As for dental care, John Chin's suggestion that a few large dental providers will be able to make up for other dentists dropping out of Medi-Cal is baseless. These few providers do not have the capacity to care for all the patients who are going to lose their dentists because of the rate reduction. Supp. Snow Dec. ¶ 5. Further, Mr. Chin's statement that patients in rural areas may have "registered hygienists" available to them disregards the patients' actual medical needs. Most Denti-Cal patients require more than primary teeth cleaning, which is what hygienists provide. Supp. Snow Delc. ¶ 6. Having access to a hygienist is not the same as having access to a dentist. To suggest otherwise simply illustrates the Department's callous attitude toward access.

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DATED: July ___, 2008

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