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LOS ANGELES SUPERIOR COURT
JUL 29 2008
JOHN A. CLARKE, CLERK
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8 **SUPERIOR COURT OF CALIFORNIA**
9 **COUNTY OF LOS ANGELES**
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CALIFORNIA MEDICAL ASSOCIATION; CALIFORNIA HOSPITAL ASSOCIATION; CALIFORNIA DENTAL ASSOCIATION; CALIFORNIA ASSOCIATION FOR ADULT DAY SERRVICES; AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, STATE CHAPTER OF CALIFORNIA, INC.; CALIFORNIA PHARMACISTS ASSOCIATION, and CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMEMS, Petitioners, **v.** **SANDRA SHEWRY, Director of the Department of Health Care Services, State of California; CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES,** Respondents.	Case No: BC390126 **ORDER DENYING MOTION FOR PRELIMINARY INJUNCTION** Hearing Date: July 25, 2008

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I.

QUESTION PRESENTED

Have Petitioners made the necessary showing to obtain a Preliminary Injunction to halt the July 1, 2008, ten percent rate reduction for Medi-Cal fee-for-service benefits ordered by the Legislature earlier this year during its emergency session?

II.

EXECUTIVE SUMMARY

To respond to a severe public finance crisis, the California Legislature met in a special session called earlier this year to deal only with the fiscal crisis. Assembly Bill 5, codified as Welfare & Institutions Code §14105.19, provides that "notwithstanding any other provision of law," reimbursements to most Medi-Cal fee-for-service providers are cut by ten percent for services provided after July 1, 2008. AB 5 also concurrently cut reimbursements for various other state-supported programs and services.

Petitioners are several trade groups representing various Medi-Cal service providers who invoke state and federal law provisions referring to "equal access" to Medicaid and Medi-Cal services in support of a request for a preliminary injunction that the state be prevented from implementing such Medi-Cal reimbursement cuts. They also cite various court decisions – virtually all of which precede a key federal court of appeal decision in *Sanchez v. Johnson* (9th Cir. 2005) 416 F.3d 1051 – wherein similar cuts in medical reimbursements were enjoined, at least preliminarily. Petitioners also bring forth an extensive factual showing to support the claim that pre-existing Medi-Cal reimbursement rates are inadequate to provide "equal access" to health services and that such problems will be exacerbated by the July 1, 2008 cuts.

To prevail, Petitioners must show both a likelihood of success on the merits (*i.e.* legal validity to the claim) and irreparable injury. While there are various alternative phrasings of the test, a core requirement is that the Petitioners' claims have a likelihood of success based on intrinsic legal merit. Petitioners' state law theory that the emergency legislation, AB 5, is somehow blocked or overcome by pre-existing state statutes or regulations is makeweight and appears to have been included only to prevent removal of the case to federal district court, where *Sanchez v. Johnson* would have been controlling.

Indeed, it was exactly this argument that the case could be decided in Petitioners' favor on the state law theory and without reference to Petitioners' federal law claim (now multiple federal law theories) which formed the basis for Petitioners' successful effort to get this case remanded back to state court, where Petitioners had chosen to file it. In remanding, United States District Judge Christina Snyder noted "petitioners maintain they can prevail on these claims based solely on the alleged violations of state law. * * * [B]ecause petitioners have stated alternative state law theories for proceeding on each of their claims for relief, under *Rains* [*v. Criterion Sys.* (9th Cir. 1996) 80 F.3d 339], the allegations that the ten percent rate reduction violates federal law are not necessary to any of petitioners' claims for relief."

Insofar as the state law claim is concerned, the legislature has the clear power to amend expressly (as here) or implicitly any prior state statutes and to override any inconsistent pre-existing regulations. The legislature did not purport to amend the state constitution by its emergency legislation, a power which it would normally lack absent some express mandate in the constitution.

The only serious legal question presented then is whether or not the claim based on the "equal access" provision of federal law, 42 U.S.C. §1396a(a)(30)(A) (hereinafter "§(a)(30)(A)") has merit. While similar litigation was successful before the repeal of the "Boren Amendment" in 1997 (former §(a)(13)(A) of the same act) and the 2005 decision in *Sanchez*, the combination of the two changes in the relevant law make it clear to this Court that there is no private right of action available to Petitioners under §(a)(30)(A) and thus no basis for issuance of a writ of mandate under California Code of Civil Procedure §1085 as Petitioners do not have an enforceable "beneficial right" to the continued maintenance of any particular Medi-Cal reimbursement rate. The state legislature saw fit to impose these reimbursement changes expressly "notwithstanding any other provision of law," thereby negating the effectiveness of pre-existing state statutes and state regulations requiring an annual reimbursement adequacy review as a precondition to rate revisions. Having done so, the legislature eliminated all "beneficial right" which the Medi-Cal providers had previously had to a pre-change rate-review process. This makes the otherwise factually similar case of *California Assn. for Health Services at Home v. State Dept. of Health Services* (2007) 148 Cal. App. 4th 696 (hereinafter "*CAHSH*"), inapplicable since the relevant law has changed.

Sanchez articulated some important reasons why the vague and internally inconsistent provisions of §(a)(30)(A) did not support a private right of action, and these comments are highly relevant to this Court's independent conclusion that Petitioners have failed to show that the challenged legislation constitutes a failure to perform a clear ministerial duty or an exercise of discretion which is so obviously unreasonable and arbitrary as to constitute an abuse of discretion:

> Far from focusing on the rights of a specific class of beneficiaries, § 30(A) is concerned with a number of competing interests. It requires a State to "provide such methods and procedures relating to … care and services … as may be necessary to … assure that payments are consistent with efficiency, economy, and

> quality of care." The most efficient and economical system of providing care may be one that benefits taxpayers to the detriment of medical providers and recipients; likewise, the provision of "quality" care – whatever standard may be implied by such a nebulous term – is likely to conflict with the goals of efficiency and economy. The tension between these statutory objectives supports the conclusion that § 30(A) is concerned with overall methodology rather than conferring individually enforceable rights on individual Medicaid recipients.
>
> * * * The language of § 30(A) is similarly ill-suited to judicial remedy; the interpretation and balancing of the statute's indeterminate and competing goals would involve making policy decisions for which this court has little expertise and even less authority.
>
> The text and structure of § 30(A) simply do not focus on an individual recipient's or provider's right to benefits, nor is the "broad and diffuse" language of the statute amenable to judicial remedy. We conclude, therefore, that Congress has not spoken with an unambiguous, clear voice that would put a State on notice that Medicaid recipients or providers are able to compel state action under § 1983.

416 F.3d at 1059-60

The significance of *Sanchez* has been recognized by the Ninth Circuit in its subsequent 2007 decision *Ball v. Rodgers* (9th Cir. 2007) 492 F.3d 1094, which affirmed *Sanchez'* validity. As Judge Marsha Berzon noted in *Ball*, reversing a trial court decision providing a remedy to private parties under the "equal access" provisions of §(a)(30(A): "Since the district court's judgment was entered, there has been an intervening change in our circuit's case law of critical importance to this case. The district court originally concluded that Arizona violated the Medicaid Act's 'equal access' provisions, §l396a(a)(30(A). We have since held that this provision does not accord Medicaid recipients individual rights enforceable under § 1983. *See Sanchez v. Johnson* [cite]."

The Ninth Circuit's recent unpublished order in *Independent Living Center of Southern California, Inc. v. Shewry*. No. 08-56061, filed July 11, 2008, does not constitute citable authority at this time, and it is based on a supremacy clause claim not presented in the petition in

this case. It is notable that Petitioners argued that their petition could be granted on a state law theory alone in furtherance of their successful argument that the case should be remanded back to this court because it did not present a federal question supporting jurisdiction in the federal District Court. Judge Snyder accepted Petitioners' argument that "the alleged violations of state law do not themselves raise any substantial federal questions because determining whether there has been a violation does not require reference to or interpretation of federal law." Petitioners are now seeking to amend their petition de facto by making a federal "supremacy" clause claim for the first time in their Reply Brief filed a mere three days before this hearing, which is not consistent with due process.

There is one remedy which Petitioners can try to seek if they wish to enforce the equal access provisions of §(a)(30)(A) and that is to encourage the United States Department of Health and Human Services to exercise its power to terminate support for the Medi-Cal program after notice and an opportunity for a hearing if it believes §(a)(30)(A) has been violated. Petitioners may not wish to urge this result but the funds appropriated by Congress come with strings attached. As noted in *Sanchez*, quoting *Pennhurst State School and Hospital v. Halderman* (1981) 451 U.S. 1, 28, "the typical remedy for state noncompliance with federally imposed conditions is not a private cause of action for noncompliance but rather action by the Federal Government to terminate funds to the State." 416 F3d at 1056.

Since Petitioners cannot show any likelihood of success on the ultimate merits, the Court need not weigh the alleged irreparable injury to be suffered by the Petitioners and the various medical service providers they represent (also termed the "balancing of the hardships" as between Petitioners and Respondents). The Respondents have suggested that Petitioners' factual showing is speculative, but the Court does not need to consider whether or not this is so.

Petitioners' factual showing does demonstrate the importance of equal access to health care to all residents of California, including those covered by Medi-Cal as well as the many and increasing number of uninsured California residents whose access problems are presumably even greater than those of Medi-Cal participants. Whether or not these cuts are likely to be cost-effective or prudent from a public health perspective are vitally important questions which the legislature has had to address in its emergency session and which it must continue to address as part of the still open budget process for the current fiscal year. In denying the motion for a preliminary injunction, the Court is not oblivious to the importance of these issues of public policy. The Court has only concluded that the current relevant law leaves the resolution of this question up to the state legislature and the federal executive branch as overseer of federal matching funds.

III.

PROCEDURAL HISTORY

On February 16, 2008, the California Legislature enacted Assembly Bill X3 5 ("AB 5") in a special session; AB 5 adds Welfare & Institutions Code §14105.19, which reduces by ten percent Medi-Cal fee-for-service benefits for dates of service on and after July 1, 2008. The Petitioners filed a class action complaint on May 5, 2008 against the California Department of Health Care Services ("Department") and Sandra Shewry, Director of the Department. The Petitioners are professional and trade associations that represent the interests of California physicians, emergency physicians, dentists, pharmacists, adult day service providers, hospitals, and public hospital systems. The complaint relates to newly enacted Welfare & Institutions Code §14105.19.

In the complaint, the Petitioners assert claims for injunctive relief, declaratory relief, and writ of mandate. They allege that the Respondents have violated both state and federal law. With

respect to the state law violations, the Petitioners claim that the Respondents have violated the State Plan because the rate reduction does not establish equal access to services for Medi-Cal beneficiaries, because the reduction was implemented without any evidentiary basis, and because the reduction fails to meet the requirements of 42 C.F.R. Part 447. The Petitioners claim that the Respondents failed to take the steps necessary to properly amend the State Plan. They further claim that the reduction violates Welfare & Institutions Code §14079 because it does not ensure reasonable access to Medi-Cal beneficiaries. Finally they claim that the Respondents have violated the California Constitution because the reduction exceeded the legislature's authority during the special session called by Governor Schwarzenegger.

With respect to the federal law violations, the Petitioners claim that the reduction violates federal Medicaid law in three ways. First they say that the reduction violates 42 U.S.C. §1396a(a)(30)(A) because it does not ensure that care to Medi-Cal recipients is available at least to the extent that such care is available to the general population. Second, they say that the reduction violates 42 U.S.C. §1396(a)(8) because it fails to ensure that Medi-Cal beneficiaries can access care in a prompt manner. Third, they say that the reduction violates 42 U.S.C. §1396(a)(13) as to hospital services because it was not adopted through a public process.

The Respondents removed the action to federal court on May 21, 2008 asserting federal question jurisdiction. On June 23, 2008, the District Court, Hon. Christina Snyder, found that the case had been improperly removed and remanded it back to state court. The Respondents filed an answer to the complaint on July 1, 2008 in which they admitted certain allegations, denied certain allegation, and stated that they could neither admit nor deny other allegations. Additionally, they asserted fifteen affirmative defenses.

The Court has granted amicus curiae AARP and amicus curiae City & County of San Francisco et al.'s requests to file Amicus Briefs in support of Petitioners. In view of the Court's ruling on the legal questions presented, the Court does not need to and thus declines to rule on the parties' extensive evidentiary objections regarding the declarations and exhibits offered on the factual issue of irreparable injury. The Court has taken judicial notice of some but not all of the various items offered by the parties, as more fully noted on the record on July 25, 2008.

IV.

KEY FACTUAL CONTENTIONS OF THE PARTIES

A. Petitioners' Relevant Factual Contentions

The Petitioners contend that they have made a strong showing that the ten percent rate reduction will have a serious negative impact on Medi-Cal recipients with respect to access to medical care. They also assert that the pre-July 1, 2008 Medi-Cal payment rates for fee-for-service providers were already inadequate.

The balance of this portion of the decision is a summary of Petitioners' factual contentions based on the many declarations and supporting exhibits filed with the Court.

Studies have shown that reimbursement rates and doctor participation in the Medi-Cal program are low for both physicians and dentists, even before the implementation of the rate reduction. (See *Where Do Patients Go?*, Exhibit 19 to the declaration of C. Duane Dauner, President and CEO of California Hospital Association, *Unsettling Scores: A Ranking of State Medicaid Programs*, Exhibit E to the declaration of Donald Moulds, Vice President of Medical & Regulatory Policy for the California Medical Association, and *Snapshot: Haves and Have-Notes: A Look at Children's Use of Dental Care in California*, Exhibit B to the declaration of Nadereh Pourat, Director of Research Planning at UCLA's Center for Health Policy Research.)

Petitioners contend that the reduction will make the situation even worse than it is. They maintain that one of the unavoidable consequences of the rate reduction is the spiral effect of the likely decrease in access to primary care physicians, which in turn forces people to seek medical care in community clinics and/or hospital emergency rooms. Amongst the volumes of material submitted by the Petitioners, is the declaration of Dr. Ronald Goldman, a pediatrician in Modesto, who states that while he will continue to treat his current Medi-Cal patients, he will not be able to accept new Medi-Cal patients. (Goldman Dec. ¶11.) Dr. Carla Kakutani, a family physician in Winters, makes the same declaration. (Kakutani Dec. ¶11.) Thus access of Medi-Cal recipients to primary care physicians, usually the first line of defense for basic care and preventative medicine, will be impaired.

Jason Kletter, President of BAART Community Healthcare in San Francisco, declares that while his clinic will continue to see all patients regardless of ability to pay, the volume of patients needing the services of the clinic will increase when other providers are unable to accept or continue seeing Medi-Cal patients. This will increase waiting times at community clinics which will cause people who are in need of immediate medical attention to seek care at an emergency room instead. (Kletter Dec. ¶9.) Adolfo Chanez, CFO of St. Mary Medical Center in Long Beach, declares that a significant portion of patients that are seen in the emergency room of the hospital are Medi-Cal patients. Some are people who come to the hospital for primary care services because they cannot find another source for primary care. This is due to the low reimbursement rates for Medi-Cal, which limits the number of doctors who will see these patients. Others are people who are quite ill but who were initially unable seek treatment from a primary care physician due to lack of access. (Chanez Dec. ¶6.) Similarly, Robert Fuller, Executive Vice President and COO of Downey Regional Medical Center in Downey, notes that Medi-Cal patients are using emergency rooms to meet all of their healthcare needs, even for non-

emergency situations. (Fuller Dec. ¶6.) Mr. Chanez posits that a further reduction in Medi-Cal reimbursement will mean that even more patients will come to the emergency room to get care that they cannot get from local physicians. (Chanez Dec. ¶10.)

Even hospitals that normally do provide non-emergency services to Medi-Cal patients, including crucial outpatients programs such as skilled nursing programs, will be hurt by the rate reduction. These hospitals tend to be situated in rural areas where they are often the primary source of healthcare, as doctors in private practice are limited. They rely heavily on Medi-Cal reimbursement for the services that they provide and the rate reduction would have the effect of seriously jeopardizing these hospitals' ability to continue to provide basic healthcare services to patients in their areas. (See Miller Dec. discussing John C. Freemont Hospital in Mariposa, Scaife Dec. discussing Jerold Phelps Community Hospital in Garberville, and Guenther Dec. discussing the Eastern Plumas Health Care system.) But it is not just rural hospitals that will be affected. Beverly Hospital, located in Montebello in Los Angeles County, will likely have to discontinue all outpatient surgery. (Kiff Dec. ¶5.)

Specialized medicine will also be affected by the reduction. Just as access to primary health care will decrease, so too will access to specialized health care. Dr. Theodore Mazer, the only otolaryngologist in east San Diego County who regularly sees Medi-Cal patients, will also not be able to accept new Medi-Cal patients after the reduction is implemented. (Mazer Dec. ¶9, ¶12.) The Children's Hospital Los Angeles, Center for Diabetes, Endocrinology and Metabolism will lose funding for one physician position and approximately 1,500 patient visit spots for diabetic children will have to be eliminated. (F. Kaufman Dec. ¶11.) Additionally, certain specialists, such as orthopedists and neurologists, have started demanding that hospitals pay them a "stipend" for agreeing to provide on-call services for emergency rooms. Since the Medi-Cal

reimbursement rates are so low, doctors are looking to hospitals as an alternative source of income. (Kiff Dec. ¶7.) However not all hospitals will be able and/or willing to pay such a stipend to a specialist which means that not all emergency rooms will be staffed with a full array of doctors.

There is also the adverse impact that the reduction will have on adult day health care ("ADHC") providers. These facilities provide significant health and social services to elderly and disabled persons while allowing them to maintain their ability to live independently. According to Lydia Missaelides, Executive Director of California Adult Day Services, approximately 90 percent of the people served by ADHC centers are Medi-Cal patients. (Missaelides Dec. ¶7.) Thus the reduction will be especially harmful to ADHC facilities. Nina Nolcox, CEO of Graceful Senescence Adult Day Health Care Inc. in Los Angeles, declares that the reduction will be so devastating that she will likely be left with no alternative but to close her facility and declare bankruptcy. (Nolcox Dec. ¶5.) Unfortunately, her facility is the primary ADHC in South Los Angeles (¶3), and its closure will force patients into the nursing homes and hospitals that the ADHC system is designed to avoid. Moreover, the United States Centers for Disease Control and Prevention has described the health disparity in South Los Angeles as "comparable to that of a third world country" (¶7), due in significant part to the recent closures of many area hospitals. (See also the declaration of James Lott, Sr., Executive Vice President of Healthcare Policy Development and Communications for the Hospital Association of Southern California and the article *Critical Condition: Examining the Scope of Medical Services in South Los Angeles*, attached as Exhibit B to his declaration discussing the dearth of medical care in South Los Angeles.) Elderly and disabled persons will have to scramble for essential healthcare services in an area that already has limited medical care.

1 Pharmacies and access to needed medications is where the rate reduction may have the
2 most immediate impact. Published reports backup this assertion. Currently Medi-Cal pharmacies
3 are reimbursed $7.25 for dispensing prescriptions. But dispensing actually costs approximately
4 $10.81 per prescription according to a 2007 survey prepared for the California Department of
5 Health Services by Meyers and Stauffer entitled *Survey of Dispensing and Acquisition Costs of*
6 *Pharmaceuticals in the State of California.* (Rolston Dec., Exhibit A.) Moreover, a 2008 report
7 by Dr. Stephen W. Schondelmeyer entitled *Impact of the 10 Percent Fee-for-Service Payment*
8 *Reductions on Medi-Cal Beneficiaries and Pharmacies* demonstrates that of the 278 brand name
9 drugs reimbursed by Medi-Cal, 99 percent of the payments will be below the pharmacies'
10 breakeven costs. Dr. Schondelmeyer concludes that essentially all pharmacies will refuse to
11 dispense certain high cost prescriptions to Medi-Cal patients and some pharmacies will refuse to
12 accommodate some or all Medi-Cal patients. (Schondelmeyer Dec., Exhibit A.) This assertion is
13 supported by the declarations of pharmacists who state that they will not dispense prescriptions
14 to patients where reimbursement is below the drug acquisition costs. (Green Dec. ¶9 and
15 Komoto Dec. ¶9.)
16
17 Petitioners' factual contentions are supplemented by a number of additional citations to
18 websites and publications contained in the two amici curiae's briefs.
19 **B. Respondents' Relevant Factual Contentions**
20 The Respondents contend that the State of California is facing a serious budgetary crisis
21 and that immediate measures must be taken to address this crisis. The rate reduction is simply
22 one way to address the crisis. They further contend that the Petitioners' claim of detriment to the
23 healthcare system is entirely speculative. They say that Medi-Cal beneficiaries will continue to
24 receive sufficient access to care and provider reimbursement rates will continue to remain high.
25

The following is a summary of Respondents' factual contentions.

Pharmacy participation will remain high and Medi-Cal recipients will continue to receive prescription medicine because according to Kevin Gorospe, Chief of the Medi-Cal Pharmacy Policy Branch of the Department, Medi-Cal actually reimburses approximately 99 percent of provider costs. (Gorospse Dec. ¶9.) With respect to ADHC's, there are currently 332 licensed ADHC's in the state and 312 are enrolled in the Medi-Cal program. Sandra Yien, the Department's Chief of the Long-Term Care Reimbursement Unit, says that this because of the generous reimbursement rates that have been made to ADHC's. (Yien Dec. ¶16.) She believes that ADHC participation will remain high and that access to these facilities will not be impacted by the rate reduction. (Yien Dec. ¶16.) According to William Liu, Chief of the Department's Disproportionate Hospital Financing and Non-Contract Hospital Recoupment Section, hospitals that are contracted with Medi-Cal will continue to be reimbursed at extremely high rates: 99.8 to 100 percent of audited costs and 87-88 percent of reported costs. (Liu Dec. ¶3.) Of the hospitals with acute care inpatient services, 90 percent of them are contracted, so the rate reduction will have no impact on them. (Liu Dec. ¶3.)

As to physician services, Linda Machado, Chief of the Professional Provider Unit for the Department, says that there are thousands of different services and Medi-Cal recipients can receive services in physician offices, hospital outpatient departments, federally qualified health care centers, and rural clinics. Federally qualified health care centers and rural clinics are not impacted by the rate reduction. (Machado Dec. ¶12.) Thus there are many options pursuant to which Medi-Cal recipients can, and will continue to, receive adequate access healthcare.

V.

LEGAL STANDARDS FOR A PRELIMINARY INJUNCTION

California Code of Civil Procedure §526 provides the basis for which the Court may issue (or deny issuance of) an injunction. In order to issue an injunction, the legal remedy must be inadequate (CCP §§526(a)(4) and (a)(5)) and it must appear that commission of the act would cause irreparable harm (CCP §526(a)(2)). Irreparable harm and inadequacy of the legal remedy are often related but they separate considerations. (California Practice Guide, Civil Procedure Before Trial, The Rutter Group, ¶ 9:522 (2007 Supp.), referencing *People ex rel. Gow v. Mitchell Brothers' Santa Ana Theater* (1981) 118 Cal.App.3d 863, 870-871.) Additionally, the irreparable harm must be imminent as opposed to a mere possibility of harm sometime in the future. (See *Korean Philadelphia Presbyterian Church v. California Presbytery* (2000) 77 Cal.App.4th 1069, 1084.)

California Code of Civil Procedure §527(a) authorizes issuance of an injunction before trial if the papers "show satisfactorily that sufficient grounds exist therefor." While the court has broad discretion when deciding whether to issue a preliminary injunction, the discretion must be exercised in light of two interrelated questions: 1) is there a reasonable probability that the plaintiff will prevail on the merits and 2) is the plaintiff likely to suffer greater injury from the denial of the preliminary injunction than the defendant is likely to suffer if it is granted? "The trial court's determination must be guided by a 'mix' of the potential-merit and interim-harm factors; the greater the plaintiff's showing on one, the less must be shown on the other to support an injunction." (*Butt v. State of California* (1992) 4 Cal. 4th 668, 678.) Nevertheless, even if a plaintiff shows a great inadequacy of a legal remedy and/or irreparable harm, a preliminary injunction must not be issued "unless it is reasonably probable that the moving party will prevail

on the merits." (*San Francisco Newspaper Printing Co. v. Superior Court* (1985) 170 Cal. App. 3d 438, 442.)

VI.

MERITS OF THE REQUEST FOR A PRELIMINARY INJUNCTION

A. Probability of Success on the Merits

i. The Petitioner's Have Standing

In order to main an action in court, the Petitioners must have standing. As articulated by the U.S. Supreme Court in *Lujan v. Defenders of Wildlife* (1992) 504 U.S. 555, 560-561, standing contains three elements. Those elements are:

> First, the plaintiff must have suffered an injury in fact -- an invasion of a legally protected interest which is (a) concrete and particularized and (b) actual or imminent, not conjectural or hypothetical. Second, there must be a causal connection between the injury and the conduct complained of -- the injury has to be fairly traceable to the challenged action of the defendant, and not the result of the independent action of some third party not before the court. Third, it must be likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision. (Internal citations omitted.)

The Petitioners argue that they have standing to pursue this action on three independent grounds: 1) associational standing, 2) third party standing, and 3) public duty.

With respect to associational standing, to establish this type of standing, the Petitioners "must demonstrate that their members would have standing to sue in their own right." *California Assn. for Health Services at Home v. State Dept. of Health Services* ("*CAHSH*") (2007) 148 Cal. App. 4th 696, 707.) Moreover, the nature of the claim and of the relief sought must not make individual participation of each injured member indispensable to proper resolution of the cause. (*Warth v. Seldin* (1975) 422 U.S. 490, 511.) Here, the members of the Petitioners' organizations do have standing to sue in their own right because just as Medi-Cal recipients have an interest in ensuring that the Respondents carry out their mandated obligation to provide proper care and services, providers have "a direct monetary interest in ensuring that they are paid for their

services." (*CAHSH, supra,* 148 Cal.App.4th at 707) The rate reduction will decrease the amounts that the Petitioners' members are compensated (*i.e.*, the injury), the injury is caused by the implementation of the reduction by the Respondents (*i.e.*, causation), and a finding that the reduction is illegal would require the reduction to be overridden (*i.e.*, redressability). Finally, since the rate reduction will be uniformly applied to all Medi-Cal fee-for-service providers, there is no obvious reason why the Petitioners' members must be individually involved in the lawsuit. Thus all of the elements of standing are satisfied.

With respect to the two other bases for standing, they need not be reached but it should be noted that these bases would fail. To demonstrate third party standing, the Petitioners must demonstrate that 1) they have suffered an injury in fact; 2) they have a relationship with the third parties so that they can, and will, effectively present the third parties' rights; and 3) obstacles exist preventing the third parties from asserting their own rights. (*Novartis Vaccines & Diagnostics, Inc. v. Stop Huntingdon Animal Cruelty USA, Inc.* (2006) 43 Cal. App. 4th 1284, 1297.) Here, the second two elements are not satisfied. The Petitioners cannot effectively represent Medi-Cal recipients' rights. The Petitioners' interest is solely pecuniary as they are concerned that they will no longer be properly paid for their services. Conversely, the interest of Medi-Cal recipients is in receiving equal access to healthcare. Healthcare providers who are threatening to no longer treat Medi-Cal recipients cannot adequately represent the interest of these recipients. Additionally there is no apparent reason why obstacles exist to prevent Medi-Cal recipients from suing on their own. In fact, the case of *Independent Living Center of Southern California v. Sandra Shewry* (C.D. Cal.) 08-CV-03315 demonstrates that Medi-Cal recipients can sue the Respondents regarding AB 5 on their own behalf.

Finally with respect to the public duty exception, the Court in *Green v. Obledo*, (1981) 29 Cal. 3d 126, 144, articulated this exception by stating:

> It is true that ordinarily the writ of mandate will be issued only to persons who are "beneficially interested." [Citation]. Yet in Bd. of Soc. Welfare v. County of L.A. (1945) 27 Cal.2d 98 [162 P.2d 627], this court recognized an exception to the general rule "'where the question is one of public right and the object of the mandamus is to procure the enforcement of a public duty, the [petitioner] need not show that he has any legal or special interest in the result, since it is sufficient that he is interested as a citizen in having the laws executed and the duty in question enforced.'"

However as will be discussed below, the request for writ of mandate fails as there is no ministerial duty at issue that is capable of being compelled. Thus the public duty exception to the standing requirement cannot be used as no writ relief is available in the first place.

ii. The State Law Claims

a. The State Plan

Title XIX of the Social Security Act, 42 U.S.C. §1396 *et seq* ("the Medicaid Act") authorizes the federal government to distribute funds to participating states for the purpose of providing medical assistance to low income persons who are aged, blind, disabled, or members of families with dependent children. Because California has elected to participate in the Medicaid program, it must administer its state Medicaid program, Medi-Cal, in compliance with a State Plan that has been preapproved by the Secretary of the U.S. Department of Health and Human Services and which complies with the requirements set forth in 42 U.S.C. §1396a(a)(1)-(70). Cal. Code Regs. tit. 22, §50004(b) requires the California Department of Health Care Services to administer the Medi-Cal program in accordance with the State Plan.

State Plan Attachment 4.19-B, which applies to non-institutional services, provides that rate changes can only be implemented if the Respondents ensure that "all applicable requirements of 42 C.F.R. Part 447 are met." Part 447 requires that provider "payments must be

1 sufficient to enlist enough providers so that services under the plan are available to recipients at
2 least to the extent that those services are available to the general public." The Petitioners say that
3 the Respondents failed to conduct any study or analysis to determine whether the reduction
4 would reduce access to Medi-Cal below the acceptable minimum level (see Silva Dec. ¶¶8-10),
5 and therefore it is necessary to compel a review of the adequacy of the reduction before it is
6 actual implemented. The Petitioners further say that AB 5 did not have the effect of superseding
7 the requirements of the State Plan because the State Plan can only be amended upon approval of
8 the federal Department of Health and Human Services, Centers for Medicare and Medicaid
9 Services. (See *Exeter Mem'l Hosp. Ass'n v. Belshe* (9th Cir. 1998) 145 F.3d 1106, 1108 stating,
10 "all [state] plans receive approval by the federal government before they may be implemented,
11 and that all amendments to plans must also be federally approved.") The Respondents did not
12 seek federal approval for the reduction. Thus the Petitioners argue that since the Respondents
13 did not conduct an analysis of the impact of the reduction on access and since the State Plan was
14 not properly amended, the reduction is invalid.
15
16 The Petitioners' arguments lack merit. The emergency legislation necessarily amended
17 any and all regulations giving the existing State Plan the force of law insofar as the State Plan
18 was inconsistent with AB 5. Thus, as a legal proposition, it cannot be held that the State Plan has
19 been violated or breached by the superseding legislation. Simply put, any substantive right to
20 enforce the State Plan that was embodied in Cal. Code Regs. tit. 22, §50004(b) is trumped by the
21 express language of Welfare & Institutions. Code §14105.19. While the Court in *CAHSH, supra*,
22 at 706 rationalized that a violation of the State Plan could be remedied pursuant to a writ a
23 mandate because a violation of the terms of the State Plan was a violation of state law as
24 embodied in the regulation, §14105.19(a) specifically says that "[n]otwithstanding any other
25 provision of law" the rate reduction is to be implemented. An act of the legislature prevails over

any conflicting regulation. (See *American Airlines, Inc. v. County of Los Angeles* (1976) 65 Cal. App. 3d 325, 332 stating, "an administrative rule in conflict with an act of the Legislature is void.") Thus Cal. Code Regs. tit. 22, §50004(b) cannot be used to force the Respondents to comply with the State Plan.

With respect to the Respondents' failure to obtain federal approval of the rate reduction before its implementation, such approval was not necessary. Welfare & Institutions Code §14105.19(g) says that the department shall promptly seek any necessary federal approvals for the implementation of the rate reduction but it does not say when said approvals shall be sought nor does it say that the reduction cannot be implemented until approvals are obtained. *Exeter* merely says that State Plan amendments require federal approval but does not say when that approval is to be granted. (145 F.3d 1106 at 1108.) To the extent that the reduction does require federal approval (and it is not even clear that such approval is necessary), the Respondents still have time to seek such approval. 42 C.F.R §§ 430.20(b)(2) and 447.256 provide that states have until the last day of the quarter in which a change in reimbursement methods and standards is implemented to submit any necessary State Plan amendment. The end of the quarter is not until September 30, 2008. (Matsumoto Dec. ¶6.)

b. *The California Constitution*

The Petitioners contend that the reduction violates the California Constitution because Art. IV, §10(f), which is the section that authorized Governor Schwarzenegger to declare a fiscal emergency and to assemble a special session, limits legislation to the fiscal year in which the legislation was enacted. They claim that because the reduction is to be applicable to the 2008-2009 fiscal year in addition to the 2007-2008 fiscal year, it is invalid.

This argument too lacks merit. Cal. Const. Art. IV, §10(f)(1) states that if the Governor believes that there is a fiscal emergency for the fiscal year, he "may issue a proclamation declaring a fiscal emergency and shall thereupon cause the Legislature to assemble in special session for this purpose. The proclamation shall identify the nature of the fiscal emergency," and it shall be presented to the legislature along with the proposed legislation to address the fiscal emergency. In the proclamation under which Governor Schwarzenegger proclaimed the fiscal emergency that led to the enactment of AB 5, it notes, "the Department of Finance projected shortfall between revenues and expenditures in Fiscal Year 2008-09 would be $6.1 billion", a "cumulative budget shortfall in Fiscal Year 2008-09 of $14.5 billion", and "insufficient cash to make currently anticipated payments in Fiscal Year 2008-09." (Petitioners' Request for Judicial Notice, Exhibit F.) While Art. IV, §3(b) limits the legislature's power during a special session to legislate "only on subjects specified in the proclamation," there can be no doubt that the 2008-09 fiscal year emergency was part of the Governor's proclamation. Therefore, the legislature acted within the scope of its authority during the special session and AB 5 does not violate the California Constitution.

iii. *The Federal Law Claim*

a. *42 U.S.C. §1396a(a)(30)(A)*

The Petitioners claim that the Defendants have violated the equal access to care and efficient, economic, and quality care requirements set forth in 42 U.S.C. §1396a(a)(30)(A). This section requires that a State Plan:

> 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.

b. ***No Private Right of Action Under the Federal Law***

Previously, courts did require states administering Medicaid programs to comply with state and federal requirements concerning provider reimbursement rates. The courts found that such state agencies had failed to establish rates that were sufficient to achieve adequate access to care or adequate to reimburse providers' cost of care. (See cases cited in footnote 4 of Petitioner's moving papers.) However the majority of the cases cited by Petitioners were decided under 42 U.S.C §1396a(a)(13)(A), which was the so-called Boren Amendment. The cases were not brought under §(a)(30)(A). The Boren Amendment required the State Plan to provide payment for services through the use of rates that were reasonably adequate to meet the costs incurred for the services. Importantly, the Boren Amendment was repealed in 1997 and Congress stated: "It is this Committee's intention, that, following enactment of the Balanced Budget Act of 1997, neither this nor any other provision of §1396 will be interpreted as establishing a cause of action for hospitals and nursing facilities relative to the adequacy of the rates that they receive. (H.R. REP. NO. 105-149 at 1230 (1997).) Therefore the cases that were decided pursuant to the no longer operative Boren Amendment are not persuasive.

Moreover, the recent case of *Sanchez v. Johnson* (9th Cir. 2005) 416 F.3d 1051, made it clear that there is no private right to enforce the requirements of §(a)(30)(A), the operative code section. In that case, the plaintiffs, both developmentally disabled individuals and providers who assist these individuals and receive Medi-Cal reimbursement, attempted to remedy perceived violations of the equal access provision by claiming that §(a)(30)(A) creates an individual right enforceable by them under 42 U.S.C. §1983. The *Sanchez* court looked to guidance from the U.S. Supreme Court case of *Gonzaga Univ. v. Doe*, (2002) 536 U.S. 273, where the court made clear what was necessary to create an individual cause of action under §1983. The *Gonzaga* court said:

> We now reject the notion that our cases permit anything short of an unambiguously conferred right to support a cause of action brought under § 1983. Section 1983 provides a remedy only for the deprivation of "rights, privileges, or immunities secured by the Constitution and laws" of the United States. Accordingly, it is rights, not the broader or vaguer "benefits" or "interests," that may be enforced under the authority of that section. (Id. at 283.)

The court went on to note that a private right of action may also be implied from a particular statute, but it rejected "the notion that our implied right of action cases are separate and distinct from our § 1983 cases." (*Ibid.*) The court concluded that the first inquiry for both use of §1983 and for determining the existence of an implied right of action is "whether Congress intended to create a federal right." (*Ibid.*) Congress does not intend to create a private right "where a statute by its terms grants no private rights to any identifiable class." (*Id.* at 284, citing *Touche Ross & Co. v. Redington* (1979) 442 U.S. 560, 576.)

Applying these guidelines, the *Sanchez* court found that there was nothing in §(a)(30)(A) which unmistakably focuses on recipients or providers as individuals. In analyzing the statute, the court noted that it mentioned a State's obligation to develop "methods and procedures" for providing services generally and it only mentioned Medi-Cal recipients as members of the larger "general population in the geographic area." According to the court, "a statutory provision that refers to the individual only in the context of describing the necessity of developing state-wide policies and procedures does not reflect a clear Congressional intent to create a private right of action." (416 F.3d 1051 at 1059.) Thus the court ultimately held:

> a plaintiff seeking redress under § 1983 must assert the violation of an individually enforceable right conferred specifically upon him, not merely a violation of federal law or the denial of a benefit or interest, no matter how unambiguously conferred. The text and structure of § 30(A) do not persuade us that Congress has, with a clear voice, intended to create an individual right that either Medicaid recipients or providers would be able to enforce under § 1983. (*Id.* at 1062.)

Importantly, in finding that §(a)(30)(A) could not be enforced under §1983, the *Sanchez* court found that §(a)(30)(A) did not create any individual federal rights. Thus not only is relief under §1983 not available, but there is no implied private right of action under §(a)(30)(A) either.

The July 11, 2008 order in *Independent Living Center of Southern California, supra,* where the Ninth Circuit vacated the District Court's denial of the motion for preliminary injunction and temporarily enjoined the rate reduction with respect to prescription drugs, does not alter this conclusion. (On July 16, 2006, that court sua sponte vacated the temporary injunction. (Respondents' Supp. Req. Jud. Notice, Exhibit L.)) In this not yet citable order, the court held that a plaintiff may bring a lawsuit under the supremacy clause of the United States Constitution to "enjoin implementation of a state law allegedly preempted by a federal statute, regardless of whether the federal statute at issue confers an express 'right' or cause of action on plaintiff." (Respondents' Req. Jud. Notice, Exhibit G.) However that situation is distinguishable from the instant case because the Petitioners did not allege any violation of the supremacy clause in their Petition and they only raised the argument in connection with their Reply Brief. Moreover, the Petitioners successfully argued to the District Court that this matter could be resolved solely on state law grounds such that remand was appropriate. For them to now argue that the supremacy clause necessarily preempts AB 5 would be inconsistent with their prior argument which was based on the alleged independent validity of state law provisions even in the face of the passage of AB 5. As the Court in *Valles v. Ivy Hill Corp.* (9th Cir. Cal. 2005) 410 F.3d 1071, 1075, said, "when the preemptive force of a statute is so strong that it completely preempts an area of state law…federal law displaces a plaintiff's state-law claim, no matter how carefully pleaded." (Internal citations omitted.) Here the preemptive force of the supremacy clause would surely be so strong that it would preempt any state law claims for violation of AB 5 meaning this case would properly belong in federal court, not the state court.

1 While the holding of *Sanchez* is not binding on this Court, but rather merely persuasive,
2 this Court declines to find that there is a private right of action for violations of 42 U.S.C.
3 §1396a(a)(30)(A). Federal courts are in better position to interpret federal laws than state courts
4 and for this reason this Court chooses to follow the holding of *Sanchez*. Moreover, the *Sanchez*
5 court noted that "the typical remedy for state noncompliance with federally imposed conditions
6 is not a private cause of action for noncompliance but rather action by the Federal Government to
7 terminate funds to the State." (*Id.* at 1056.) Thus the more legally appropriate type of relief is
8 not to sue the Respondents for failing to comply with §(a)(30)(A) but rather to have the federal
9 government rescind its funding to the Medi-Cal program, if in fact §30(A) is being violated.
10 Neither party is advocating that this is a viable option.

11 c. ***Mandate Does Not Provide a Remedy in the Absence of a Private Right of Action***

12 Despite the fact that there is no private right of action under federal law for violations of
13 42 U.S.C. §1396a(a)(30)(A), the Petitioners attempt to circumvent the holding of *Sanchez* by
14 seeking relief pursuant to the state writ of mandate procedure. California Code of Civil §1085
15 states in relevant part, "A writ of mandate may be issued by any court…to compel the
16 performance of an act which the law specially enjoins, as a duty resulting from an office, trust, or
17 station…" The Court in *CAHSH* suggested in a footnote that "a writ of mandate is an
18 appropriate method for enforcing a violation of federal law, even where the law creates no
19 private right of action enforceable under section 1983." (148 Cal. App. 4th 696 at 705, fn. 5.)
20 Thus while a writ of mandate may theoretically be a proper procedural tool to use in this
21 situation, the Petitioners still have to demonstrate that the requirements for mandamus are met
22 before they can receive relief.
23
24 The two required elements for a writ of mandate are: (1) a clear, present and usually
25 ministerial duty on the part of the respondent and (2) a clear, present and beneficial right in the

petitioner to the performance of that duty. (*Santa Clara County Counsel Attys. Ass'n v. Woodside* (1994) 7 Cal. 4th 525, 539-540.) With respect to the first element of the existence of a ministerial duty, the court in *Carrancho v. California Air Resources Board* (2003) 111 Cal. App. 4th 1255, 1267, provided some discussion regarding what a ministerial duty is. The court said:

> A ministerial act is an act that a public officer is required to perform in a prescribed manner in obedience to the mandate of legal authority and without regard to his own judgment or opinion concerning such act's propriety or impropriety, when a given state of facts exists. Discretion, on the other hand, is the power conferred on public functionaries to act officially according to the dictates of their own judgment. Thus, where a statute or ordinance clearly defines the specific duties or course of conduct that a governing body must take, that course of conduct becomes mandatory and eliminates any element of discretion. (Internal citations omitted.)

The *Sanchez* court's interpretation of §(a)(30)(A) shows that it does not create a ministerial duty on the part of the Respondents. It said that §(a)(30)(A) contains a number of competing interests because:

> It requires a State to "provide such methods and procedures relating to . . . care and services . . . as may be necessary to . . . assure that payments are consistent with efficiency, economy, and quality of care." The most efficient and economical system of providing care may be one that benefits taxpayers to the detriment of medical providers and recipients; likewise, the provision of "quality" care -- whatever standard may be implied by such a nebulous term -- is likely to conflict with the goals of efficiency and economy. (416 F.3d 1051 at 1059.)

The court further said: "The language of § 30(A) is similarly ill-suited to judicial remedy; the interpretation and balancing of the statute's indeterminate and competing goals would involve making policy decisions for which this court has little expertise and even less authority." (*Id.* at 1060; *see also Ball v. Rodgers* (9th Cir. 2007) 492 F.3d 1094, 1115 (affirming this finding by *Sanchez* and stating "§ 1396a(a)(30)(A) would require a court to account for numerous, largely unquantifiable variables."))

According to the *Sanchez* court, interpreting the statute would require making policy decisions, which can be more appropriately described as an exercise of discretion rather than a ministerial act that must be performed in a proscribed manner. The court also noted that the statute is not clear because it has competing goals, *i.e.*, providing quality care versus economic and efficient care, and this suggests that there is no specific duty or course of conduct that must be taken. The *Sanchez* court believed that it (a judicial body charged with interpreting federal law) lacked the expertise and authority to interpret the way §(a)(30)(A) should be implemented. There is no reason to think that this Court is any better position to do so than the Ninth Circuit. As such, there is no ministerial duty encompassed by §(a)(30)(A).

With respect to the second element of a clear, present, and beneficial right in the performance of a duty, the right must be "substantial" (*Parker v. Bowron* (1953) 40 Cal. 2d 344, 351) and it must be "specific" (*People ex rel. Smith v. Olds* (1853) 3 Cal. 167, 171). Based on the *Sanchez* case, the Petitioners, who represent the interests of healthcare providers, do not have such a right. The *Sanchez* court noted that pursuant to the terms of §(a)(30)(A), "[t]he State is directed to 'provide methods and procedures . . . 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.'" (16 F.3d 1051 at 1059.) It further noted that "providers are to be 'enlisted' as subordinate partners in the administration of Medicaid services." (*Ibid.*) The court held that while medical providers "may certainly benefit from their relationship with the State, but they are, at best, indirect beneficiaries and it would strain common sense to read § 30(A) as creating a 'right' enforceable by them." (*Ibid.*) Moreover, with respect to beneficiaries of Medicaid/Medi-Cal services, the court recognized that the tension between the statutory objectives, *i.e.*, providing quality care versus economic and efficient care, shows that §(a)(30)(A) "is concerned with overall methodology rather than

conferring individually enforceable rights on individual Medicaid recipients." (*Id.* at 1059-1060.) Since neither the Petitioners nor the beneficiaries of Medi-Cal have an enforceable right under §(a)(30)(A), they have no clear, present, and beneficial right to compel the Respondents to perform any duties regarding the statute.

B. Inadequacy of a Legal Remedy/Irreparable Harm

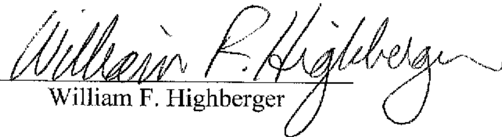
Despite the Respondents' contentions that the Petitioners' have made merely a speculative showing that the rate reduction will cause irreparable harm, the Court does not adopt this interpretation of Petitioner's evidence. Petitioners have presented a substantial showing of actual harm which will likely occur as a consequence of the reimbursement reductions. However since the Petitioners have failed to show any probability of success on the legal merits, the Court need not resolve the ultimate question of whether sufficient irreparable harm has been shown or whether, to state the same question in another formulation, the balance of hardships clearly tips in Petitioners' favor.

VII.

CONCLUSION

The Petitioners' motion for preliminary injunction is denied.

Dated: July 29, 2008



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