

1 LLOYD A. BOOKMAN (State Bar No. 89251)
BYRON J. GROSS (State Bar No. 76626)
2 JORDAN B. KEVILLE (State Bar No. 217868)
HOOPER, LUNDY & BOOKMAN, INC.
3 1875 Century Park East, Suite 1600
Los Angeles, California 90067-2517
4 Telephone: (310) 551-8111
Facsimile: (310) 551-8181
5 E-Mail: lbookman@health-law.com

6 CRAIG J. CANNIZZO (State Bar No. 70379)
FELICIA Y SZE (State Bar No. 233441)
7 **HOOPER, LUNDY & BOOKMAN, INC.**
575 Market Street, Suite 2300
8 San Francisco, CA 94105
Telephone: (415) 875-8500
9 Facsimile: (415) 875-8519
E-Mail: ccannizzo@health-law.com

10 Attorneys for Petitioners
11

12 **SUPERIOR COURT OF THE STATE OF CALIFORNIA**
13 **COUNTY OF LOS ANGELES, CENTRAL DISTRICT**
14

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

21 Petitioners,

22 vs.

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

26 Respondents.
27
28

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

1 **I. INTRODUCTION**

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

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

12 Petitioners satisfy the two requirements for a writ of mandate: (1) a ministerial duty on the
13 part of a government official, and (2) a beneficial interest to perform that duty. Petitioners discuss
14 the ministerial duty in Section A, and the beneficial interest in Section B. When these two
15 requirements are met, the petitioner "is entitled as a matter of right to the writ, or, in other words,
16 it would be an abuse of discretion to refuse it." *May v. Bd. of Directors of El Camino Irr. Dist.*
17 (1949) 34 Cal.2d 125, 133-134.

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

19 Mandamus is an appropriate remedy to compel a government official to perform
20 ministerial acts required by law. Code of Civ. Proc. § 1085 ("§ 1085"); see *Jenkins v. Knight*
21 (1956) 46 Cal.2d 220, 222-223. Respondents must comply with federal Medicaid law, including
22 all of the provisions of 42 U.S.C. § 1396a ("§ 1396a"). *Wilder v. Va. Hosp. Assn.* (1990) 496 U.S.
23 498, 502; *Doctor's Medical Laboratory, Inc. v. Connell* (1999) 69 Cal.App.4th 891, 896
24 ("*Doctor's Med. Lab.*"). The State Plan also creates a mandatory duty enforceable by a writ of
25 mandate. See *Cal. Assn. for Health Servs. at Home v. Dept. of Health Servs.* (2007) 148
26 Cal.App.4th 696, 706 ("*CAHSH*"). Lastly, it is undisputed that Respondents have a mandatory
27 duty to comply with the California Constitution and state law. See *Bramberg v. Jones* (1999) 20
28 Cal.4th 1045, 1055, fn. 15 (citing *Wenke v. Hitchcock* (1972) 6 Cal.3d 746, 751).

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

2 The Department spends most of its Opposition arguing that 42 U.S.C. § 1396a(a)(30)(A)
3 ("§ 30(A)") does not impose ministerial duties enforceable under § 1085, relying largely on
4 *Sanchez v. Johnson* (9th Cir. 2005) 416 F.3d 1051. *Sanchez* establishes that providers do not have
5 a private right of action to enforce § 30(A) in federal court through 42 U.S.C. § 1983 ("§ 1983").¹
6 However, the observation in *Sanchez* that § 30(A) is "ill-suited" to judicial remedy cannot extend
7 beyond evaluating the existence of a privately enforceable right under § 1983. Both before and
8 after a change in Supreme Court jurisprudence regarding § 1983 standing, which heavily informed
9 *Sanchez*, numerous federal courts interpreted and applied § 30(A) in reviewing state Medicaid
10 agency rate making decisions. See, e.g., *Orthopaedic Hosp. v. Belshe* (9th Cir. 1997) 103 F.3d
11 1491, cert. den. (1998) 522 U.S. 1044 ("*Orthopaedic*"); *Ark. Med. Soc'y., Inc. v. Reynolds* (8th Cir.
12 1993) 6 F.3d 519; *Visiting Nurse Assn. of North Shore, Inc. v. Bullen* (D.Mass. 1994) 866 F.Supp.
13 1444, affd. and revd. on other grounds (1st Cir. 1996) 93 F.3d 997; *Methodist Hosps., Inc. v.*
14 *Sullivan* (7th Cir. 1996) 91 F.3d 1026; *Ill. Hosp. Assn. v. Ill. Dept. of Pub. Aid* (D.Ill. 1983) 576
15 F.Supp. 360. The fact that multiple courts found § 30(A) definite enough to determine whether
16 state agencies complied with the statute undermines any suggestion in *Sanchez* that § 30(A) is
17 completely unenforceable.

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

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

1 Department's failure to comply with the State Plan violated *both* state (Cal. Code Regs., tit. 22, §
2 50004(b)(1)) and federal (§ 30(A)) regulatory requirements that were enforceable through a §
3 1085 mandate. *CAHSH, supra*, 148 Cal.App.4th at 706-708. The *CAHSH* court noted that "(t)he
4 nature of the remedy afforded by section 1983 is more limited than the broader remedy available
5 under [C.C.P. § 1085]," citing *Cal. Homeless & Housing Coal. v. Anderson* (1995) 31 Cal.App.4th
6 450, 458. Thus, *CAHSH* held that the plaintiff providers could enforce by mandamus the
7 Department's duties under the State Plan to assure that payment rates are "sufficient to enlist
8 enough providers so that care and services are available under the plant at least to the extent that
9 such care and services are available to the general population in the geographic area." *Id.* at 707
10 (citing § 30(A) and *Frank v. Kizer* (1989) 213 Cal.App.3d 919, 922, fn. 2).

11 The facts here are remarkably similar. Here, the State Plan imposes a mandatory legal
12 duty on the Department to establish rates adequate to ensure access to services for Medi-Cal
13 beneficiaries at a level at least equal to the general insured population before it may implement the
14 Rate Reduction. Attachment 4.19-B states that the Department may implement rate changes
15 required by state statute only if the it assures that "all applicable requirements of 42 C.F.R. Part
16 447 are met." RJN Ex. C (excerpt of State Plan Attachment 4.19-B). 42 C.F.R. § 447.204 ("§
17 447.204") requires that provider "payments must be sufficient to enlist enough providers so that
18 services under the plan are available to recipients at least to the extent that those services are
19 available to the general public." The Department concedes it has not conducted an analysis to
20 assess whether the proposed Rate Reduction would reduce access below the minimum level the
21 State Plan and § 447.204 establish. Silva Decl. ¶¶ 8-10. Based on the Department's abject failure
22 to perform its ministerial duty to review the adequacy of Medi-Cal beneficiary access to services,
23 a writ of mandate and injunction should issue to compel a review of the adequacy of the proposed
24 (reduced) rates and beneficiary access to services before implementation of the Rate Reduction.

25 2. Valid Federal Authorities Define Respondents' Duties

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

1 whether a state is violating the equal access requirements of § 30(A) and § 477.204 is a
2 comparison of the access of beneficiaries to the access of other individuals in the same geographic
3 areas with public or private insurance coverage. *Clark v. Kizer* (E.D.Cal. 1990) 758 F.Supp. 572,
4 575, affd. in relevant part sub nom. *Clark v. Coye* (9th Cir. 1992) 967 F.2d 585. Congress has
5 clarified its intent that the determination of "whether services are available to Medicaid
6 beneficiaries at least to the extent that services are available to the general population, will
7 compare the access of beneficiaries to the access of other individuals in the same geographic area
8 with private or public insurance coverage" H.R.Rep. No. 101-247, 1st Sess., pp. 390-391
9 (1989); see *id.* This standard is not so imprecise or uncertain as to evade judicial enforcement.

10 Likewise, the "efficiency, economy and quality of care" standards are equally proper for
11 judicial enforcement. As established in *Orthopaedic*, the only way that a state can satisfy this
12 mandate is to perform studies and/or analyze relevant data, including information about provider
13 costs, before setting rates. See *Orthopaedic, supra*, 103 F.3d at 1495-1500.² *Sanchez* did not
14 mention *Orthopaedic*, let alone overrule it. *Orthopaedic* focused only on the substantive
15 requirements of § 30(A), while *Sanchez* was concerned only with whether § 30(A) is enforceable
16 under § 1983. The observation in *Sanchez* that § 30(A) is "ill-suited" to judicial remedy does not
17 extend beyond the § 1983 standing analysis.

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

23 ² This court should afford no deference to a stale litigation position of the U.S. Department of
24 Health and Human Services ("HHS") in an *amicus* brief, purportedly showing HHS's earlier
25 disagreement with the Ninth Circuit's ruling in *Orthopaedic*. HHS' opinions about § 30(A)'s
26 requirements—whatever they are—are not determinative of whether the Department complied with
27 the law in this case. *AMISUB v. Colo. Dept. of Soc. Servs* (10th Cir. 1989) 879 F.2d 789, cert.
28 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.

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

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

5 Respondents concede they have not complied with Attachment 4.19-B of the State Plan,
6 which precludes implementation of the legislatively-mandated rate reduction until they review the
7 impact on access, or submitted a State Plan Amendment ("SPA") for certain services (e.g.,
8 hospital) for which the Department cannot change rates at all without an SPA, even if they had
9 done the required access studies. Rather, the Department argues that the State Plan is not a "law"
10 enforceable by mandamus. *CAHSH* flatly rejected this contention. The court held, "whether the
11 state plan is in the nature of a contract⁴ or a law, DHS is required by regulation to follow it. (Cal.
12 Code Regs., tit. 22, § 50004(b)(1).) *Thus, if DHS violated the terms of the state plan, it has*
13 *violated state law as embodied in a regulation."* *CAHSH, supra*, 148 Cal.App.4th at 706
14 [emphasis and footnote added].

15 The Department contends that because Welfare and Institutions Code § 14105.19(a) opens
16 with "[n]otwithstanding any other provision of law," it repeals the regulatory requirement that it
17 administer the Medi-Cal program in compliance with the State Plan and applicable federal
18 requirements. However, repeals by implication using such language are highly disfavored. *Prof.*
19 *Engineers in Cal. Govt. v. Kempton* (2007) 40 Cal.4th 1016, 1038-1039; *Dept. of Personnel*
20 *Admin. v. Super. Ct.* (1992) 5 Cal.App.4th 155, 191; *In re Marriage of Wilcox* (2004) 124
21 Cal.App.4th 492, 500 ["the law shuns repeal of statutes by implication"]. This is especially true
22

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

25 ⁴ A federal decision just this month refused to adopt a similar "contract theory" of Medicaid law,
26 holding "[t]he State Plan is the state embodiment of federal law, and DHH officials cannot avoid
27 being held accountable under this law by arguing that Medicaid is merely a contract between DHH
28 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.

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

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

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

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

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

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

7 Since the Supreme Court held that § 1983 provides a cause of action for statutory claims
8 regarding welfare benefits that do not involve constitutional violations (*Maine v. Thiboutot* (1980)
9 448 U.S. 1), almost all federal court litigation to enforce the Medicaid Act and other federal safety
10 net statutes has been under the Civil Rights Act. Federal courts allowed such cases, but then
11 gradually narrowed the ability to bring them, culminating in *Gonzaga University v. Doe* (2002)
12 536 U.S. 273, which restricted the guidelines for determining that an "enforceable right" exists and
13 led to *Sanchez*, which concluded that no such enforceable right exists under § 30(A). The Ninth
14 Circuit, however, properly recognized that suit may be brought "under the Supremacy Clause to
15 enjoin state law allegedly preempted by federal statute, regardless of whether the federal statute at
16 issue confers an express 'right' or cause of action on the plaintiff." See *ILCSC, supra* (citing, inter
17 alia, *Lankford v. Sherman* (8th Cir. 2006) 451 F.3d 496 [Medicaid case invalidating Missouri
18 regulation under Supremacy Clause because it conflicted with federal law]).⁵

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

21 Respondents contend that § 30(A) affords them discretion in setting rates, and points out
22 that a mandate may not issue to require an agency to exercise discretion in a particular manner.
23 However, mandate is available to compel an agency to exercise discretion or to curb an abuse of
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25 _____
26 ⁵ As the Ninth Circuit has recognized, a state statute need not be inconsistent on its face, but may
27 be inconsistent as applied, to violate the Supremacy Clause. *ILCSC, supra*, at 4 (finding that
28 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.

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

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

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

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

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

22 CAHSH conclusively disposed of this issue. That court rejected the notion that a party
23 needed some sort of beneficial right, akin to the right required under § 1983 for standing. "Unlike
24 section 1983, which requires the violation of a private right, privilege, or immunity to confer
25 standing, [C.C.P. § 1085] confers a broad right to issuance of a traditional writ to those who are
26 beneficially interested within the meaning of [C.C.P. § 1086]." *CAHSH, supra*, 148 Cal.App.4th
27 at 706 (citing *Doctor's Med. Lab., supra*, and *Syngenta Crop Protection, Inc. v. Helliker* (2006)
28 138 Cal.App.4th 1135).

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

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

11 Respondents' argument that Petitioners lack third-party standing to assert the interests of
12 Medi-Cal beneficiaries is irrelevant and without merit. Petitioners have standing to bring this writ
13 of mandate on behalf of the public interest to enforce a public right. See *Green v. Obledo* (1981)
14 29 Cal.3d 126, 144. This theory of standing, uncontested by Respondents, grants Petitioners the
15 authority to assert the interests of Medi-Cal beneficiaries.

16 Moreover, Petitioners have independent standing to assert the claims of Medi-Cal
17 beneficiaries. Petitioners have met the three elements to establish third-party standing: (1) their
18 members and their patients share a close relationship as is evident from the numerous declarations
19 providers have filed out of concern for their patients' well-being; (2) Petitioners and their members
20 will suffer injury; and (3) Medi-Cal beneficiaries are hindered from bringing suit on their own.
21 See *Novartis Vaccines and Diagnostics, Inc. v. Stop Huntingdon Animal Cruelty USA, Inc.* (2006)
22 143 Cal.App.4th 1284, 1297. The Ninth Circuit left undisturbed the holding in *Clayworth v.*
23 *Bonta* (E.D. Cal. 2003) 295 F.Supp.2d 1110, revd. on other grounds (9th Cir. 2005) 140
24 Fed.Appx. 667 ("*Clayworth*"), which recognized standing of provider organizations to assert
25 interests of Medi-Cal beneficiary patients, and which this court should follow here.

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

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

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

1 mandated. See Respondents' MPA in Opposition to Motion for Preliminary Injunction ("Opp.") at
2 18. Respondents' interpretation would render meaningless not only § 30(A), but virtually all of §
3 1396a, as states could always evade the statute's requirements by changing Medicaid payment
4 rates through legislation. Case authority is to the contrary. See *Minn. Homecare Assn. v. Gomez*
5 (8th Cir. 1997) 108 F.3d 917, 918; *AMISUB, supra*, 879 F.2d at 800-801 (legislative rate reduction
6 invalid under Boren Amendment); *Ala. Nursing Home Assn. v. Harris* (5th Cir. 1980) 617 F.2d
7 388; *Mo. Childcare Assn. v. Martin* (W.D.Mo. 2003) 241 F.Supp.2d 1032, 1044. Section 30(A)
8 requires that a state plan provide payment methods that assure payments are adequate to afford
9 equal access. State legislation, like AB 5, which would force a state Medicaid agency to violate
10 this provision by implementing a payment method that does not assure access, conflicts with
11 federal law and is therefore invalid. See *AMISUB, supra*; *Ala. Nursing Home Assn., supra*.

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

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

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28

1 substantially below their costs. *West Va. Univ. Hosps. v. Casey* (5th Cir. 1989) 885 F.2d 11, 28.⁶

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

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

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

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

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

24 _____

25 ⁶ Respondents' reference to *Farmacia Remedios Inc. v. Shewry*, (Super. Ct. Sac. County, 2008,
26 No. 34-2008-00012743) is irrelevant whether the rate reduction violates the equal access
27 requirement. While the Sacramento County Superior Court denied an application for a temporary
28 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.

1 rejected the Department's effort to distinguish earlier holdings that had precluded pre-approval
2 implementation in *Oregon Assn. of Homes for the Aging, Inc v. Oregon*. (9th Cir. 1993) 5 F.3d
3 1239, and *Washington State Health Facilities Assn. v. Washington Dept. Soc. & Health Services*
4 (9th Cir. 1982) 698 F.2d 964. The *Exeter* court refused to view its earlier decisions solely through
5 the prism of the language of the so-called Boren amendment as it existed at any point in time,
6 holding instead that: "our opinion in *Washington* was premised on the *overall statutory framework*
7 *rather than the particular language of the statute relating to amendment to state plans. The*
8 *framework required then, and at all relevant times since, that all plans receive approval by the*
9 *federal government before they may be implemented, and that all amendments to plans must also*
10 *be federally approved."* *Exeter*, 145 F.3d at 1108 (emphasis added).

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

17 **IV. Petitioners Have Demonstrated Irreparable Harm**

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

23 Significantly, the concept of irreparable injury, "does not concern itself entirely with injury
24 beyond the possibility of repair or beyond compensation damages.... Rather, by definition, an
25 injunction properly issues ... where 'it would be extremely difficult to ascertain the amount of
26 compensation which would afford adequate relief.'..." *Wind v. Herbert* (1960) 185 Cal.App.2d
27 276, 285. A party seeking injunctive relief does not have to show the injury sought to be
28 prevented is an absolute certainty, but merely "probable." See *Uptown Enters. v. Strand* (1961)

1 195 Cal.App.2d 45, 52.

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

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

20 Respondents' claims that there is currently and will continue to be sufficient access to
21 physicians by Medi-Cal beneficiaries are fallacious and demonstrate the Department's complete
22 lack of awareness of whether its payments to physicians are sufficient to assure access. Physicians
23 have long endured the brunt of California's budget woes as Medi-Cal payment rates historically
24 have been established without any reasonable basis, have barely been adjusted in almost a quarter
25 century, trail far behind other states' Medicaid and Medicare rates, and now have the dubious
26 honor as being the lowest in the nation. Mould Decl., Exhs. E and I; 2008 LAO Report at C-37;
27 2001 LAO Report at 1. The Department's estimate that nearly 120,000 physicians are "actively
28 enrolled" in the Medi-Cal program (Machado Decl. ¶ 11) outnumbers the 109,763 physicians with

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

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

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

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

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

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

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

HOOPER, LUNDY & BOOKMAN, INC.
1875 CENTURY PARK EAST, SUITE 1600
LOS ANGELES, CALIFORNIA 90067-2517
TEL: (310) 551-8111 • FAX: (310) 551-8181

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DATED: July ____, 2008

HOOPER, LUNDY & BOOKMAN, INC.

By: _____
CRAIG J CANNIZZO
Attorneys for Petitioners

TABLE OF CONTENTS

Page

1 I. INTRODUCTION.....1

2 II. THIS COURT HAS THE AUTHORITY TO GRANT A PRELIMINARY

3 INJUNCTION BASED ON CODE OF CIVIL PROCEDURE SECTION 1085.....1

4 A. A Writ of Mandate Lies To Compel the Performance of a Ministerial Duty.1

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

6 Mandamus.2

7 2. Valid Federal Authorities Define Respondents' Duties.....3

8 3. The Department's Failure to Adhere to Its State Plan Obligations

9 Violates State Law, Which AB 5 Neither "Superseded" nor

10 "Repealed."5

11 4. The Possibility of CMS Enforcement Does Not Preclude Private

12 Enforcement of federal Medicaid Requirements Under the State

13 Plan.....6

14 5. Federal Medicaid Requirements Are Mandatory on the Department

15 Pursuant to the Supremacy Clause.7

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

17 Correct Abuse of Discretion.....7

18 B. Petitioners Have Standing to Bring this Writ of Mandate Action.....8

19 1. Petitioners And Members Are Beneficially Interested in the

20 Performance of Respondents' Duties To Comply With Federal

21 Medicaid Law.....8

22 2. Petitioners Have Third Party Standing to Bring This Suit On Behalf

23 of Their Members' Patients.9

24 III. Petitioners Have Established A High Likelihood of Success on the Merits.9

25 A. Respondents Have Violated the Equal Access Provision of Section 30(A).9

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

27 Quality.....11

28 C. Respondents Violated the State Plan by Failing to Amend It.11

IV. Petitioners Have Demonstrated Irreparable Harm12

TABLE OF AUTHORITIES

Page

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

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cert. den. (1990) 496 U.S. 9354, 10

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424 F.3d 9314, 5

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6 F.3d 519.....2, 10

Ark. Med. Soc'y. v. Reynolds (E.D.Ark. 1992) 834 F. Supp. 1097, affd. (8th Cir. 1993)
6 F.3d 519.....13

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Clark v. Coye (9th Cir. 1992) 967 F.2d 585.....4

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revd. on other grounds (9th Cir. 2005) 140 Fed.Appx. 6679, 13

Exeter Mem'l Hosp. Assn. v. Belshe (9th Cir. 1998) 145 F.3d 1106..... 11-13

Gonzaga University v. Doe (2002) 536 U.S. 273.....7

Harris v. McRae (1980) 448 U.S. 2976

Harris v. Olszewski (6th Cir. 2006) 442 F.3d 4566

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Livadas v. Bradshaw (1994) 512 U.S. 1077

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Oregon Assn. of Homes for the Aging, Inc. v. Oregon (9th Cir. 1993) 5 F.3d 1239.....12

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cert. den. (1998) 522 U.S. 10442, 4, 5, 11

Sanchez v. Johnson (9th Cir. 2005) 416 F.3d 1051.....2, 4, 7

HOOPER, LUNDY & BOOKMAN, INC.
1875 CENTURY PARK EAST, SUITE 1600
LOS ANGELES, CALIFORNIA 90067-2517
TEL: (310) 551-8111 • FAX: (310) 551-8181

HOOPER, LUNDY & BOOKMAN, INC.
 1875 CENTURY PARK EAST, SUITE 1600
 LOS ANGELES, CALIFORNIA 90067-2517
 TEL: (310) 551-8111 • FAX: (310) 551-8181

TABLE OF AUTHORITIES

Page

1 *Tulare Water Co. v. State Water Commission* (1921) 187 Cal. 5338
 2 *Uptown Enters. v. Strand* (1961) 195 Cal. App. 2d 4512
 3 *Warmington Old Town Associates v. Tustin Unified Sch. Dist.* (2002) 101 Cal. App. 4th 840.....8
 4 *Wenke v. Hitchcock* (1972) 6 Cal. 3d 7461
 5 *Wind v. Herbert* (1960) 185 Cal. App. 2d 27612

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6
 7
 8 42 U.S.C.
 § 1396 *passim*
 § 19832
 9

Federal Regulations

10
 11 42 C.F.R.
 § 430.2011
 12 § 447.2043
 § 447.2566, 11
 13

State Statutes

14
 15 Code of Civil Procedure
 § 10858
 16 § 10868
 § 19838
 17 Welfare and Institutions Code § 14105.1912
 18

State Regulations

19
 20 Cal. Code Regs., tit. 22, § 50004(b)(1)3, 5
 21
 22
 23
 24
 25
 26
 27
 28