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Attorneys for Petitioners

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF LOS ANGELES

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

Petitioners,

vs.

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

Respondents.

CASE NO. BC390126

CLASS ACTION

MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION

[Notice of Motion and Motion for Preliminary Injunction, Declarations and Exhibits in Support Thereof, Request for Judicial Notice, and [Proposed] Order Granting Preliminary Injunction filed concurrently herewith]

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

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I. INTRODUCTION

California's health care system is in an extraordinarily fragile state. During the past 12 years, 70 California hospitals have closed, including 50 in Southern California. We have lost critical emergency rooms and trauma centers, making access to care for all of our citizens increasingly uncertain. Providers frequently cite inadequate payment rates as a reason for closure.

The 10% rate reduction (the "Rate Reduction") will push many providers over the edge. Hospitals will close or reduce services; physicians, dentists, and pharmacies will withdraw from Medi-Cal participation; and those providers most dependent on Medi-Cal, like the Adult Day Health Centers (hereafter "ADHCs"), will be forced out of business.

Perhaps most importantly, Medi-Cal beneficiaries will have nowhere to go to obtain care. Certain types of physician specialists simply will not be available to Medi-Cal patients in vast areas of the State. Access to primary care physicians will become increasingly difficult, if not impossible, leading beneficiaries to forgo care until they are so ill that they flood hospital emergency rooms. Medi-Cal recipients will be unable to obtain needed medications as pharmacies leave Medi-Cal or stop providing those drugs on which they lose the most money. Aged Medi-Cal beneficiaries who rely on ADHCs to sustain their physical and mental well-being will find these facilities shuttered.

Indeed, in the words of Governor Schwarzenegger, these cuts will be "devastating." See Dauner Declaration ("Decl.") ¶ 9, Exh. A-9.[1] They will be devastating to health care providers who cannot survive the payment reductions, to health care workers who will lose their jobs, and to our most needy citizens who will be unable to obtain critical health services. The tragedy that will ensue if the Rate Reduction is not restrained is the epitome of irreparable harm. Petitioners submit concurrently herewith substantial evidence of imminent and concrete harm that will befall health care providers, Medi-Cal recipients, and others if the 10% reduction is not enjoined.

[1] Due to the volume of declarations involved in this case, the declarations located in the simultaneously filed Schedule of Declarations will be identified by the declarant's last name only except in those cases where a first initial is necessary to identify the declarant.

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The threat to the continued vitality of our health care delivery system in general, and to the diminishing efficacy of Medi-Cal more specifically, can be laid squarely at the feet of Respondents. The Medi-Cal program has been substantially and increasingly underfunded for more than 20 years. Today, California ranks dead last in the nation in the amount it spends per Medicaid beneficiary, spending less than 60% of the national average and about one-third of the amount New York spends. This has been accomplished not by limiting eligibility or benefits, but by paying providers at unconscionably low rates.

The Rate Reduction will exacerbate this deteriorating situation to the point where it cannot be credibly contended that beneficiaries will have a reasonable modicum of access to services. As discussed below, the predictable impact that the Rate Reduction will have on beneficiary access leads to the inescapable conclusion that the Rate Reduction is unlawful. It violates the Medi-Cal State Plan, and therefore both state and federal laws mandating compliance with the State Plan, which prohibits implementation of rate reductions enacted by the Legislature unless they comply with federal Medicaid regulations, including the regulation requiring rates to be adequate to ensure access. It violates directly the federal regulation, 42 C.F.R. § 447.204 and the federal statute, 42 U.S.C. § 1396a(a)(30)(A) (hereafter "Section 30(A)"), requiring that Medicaid rates enlist enough providers so that beneficiaries have the same access to services as the general public. It violates state law, Welfare and Institutions Code section 14079, which requires that physician and dentist rates be based on annual studies yielding rates adequate to ensure access. Indeed, the Respondents not only unlawfully failed to consider at all the impact of the Rate Reduction on access prior to its proposed implementation, but also impermissibly adopted the Rate Reduction due solely to budgetary concerns.

The Rate Reduction is unlawful for additional reasons apart from its impact on access. The reduction is not consistent with efficiency, economy, and quality of care, as required by Section 30(A), because the rates are not reasonably related to provider costs, provider costs were not considered in adopting the Rate Reduction, and the Rate Reduction will result is a shift of patients from physician offices to higher cost hospital emergency rooms. The Rate Reduction was adopted without required amendments to the State Plan. The Department will apply the Rate

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Reduction to hospital subacute services, which the Legislature exempted from the Rate Reduction. Finally, the Legislature exceeded the scope of its authority under the California Constitution in enacting the Rate Reduction in the special session. Each of these points is addressed below.

II. BACKGROUND

A. The Federal Medicaid Program

The Medicaid Act, 42 U.S.C. § 1396 et seq., authorizes federal financial support to states for medical assistance provided to low-income persons who are aged, blind, disabled, or members of families with dependent children. The program is jointly financed by the federal and state governments and administered by the states. To receive matching federal financial participation, states must agree to comply with the applicable federal Medicaid law and regulations. See *Alexander v. Choate* (1985) 469 U.S. 287, fn.1; *Harris v. McRae* (1980) 448 U.S. 297, 301; see also *Orthopaedic Hospital v. Belshe* (9th Cir. 1997) 103 F.3d 1491, 1493, cert. den. *Belshe v. Orthopaedic Hosp*. (1998) 522 U.S. 1044 (hereafter "*Orthopaedic II*").

At the state level, Medicaid is administered by a single state agency, which must establish and comply with a State Medicaid Plan that, in turn, must comply with federal Medicaid law. 42 U.S.C. § 1396a(a)(5); 42 C.F.R. §§ 430.10, 431.10. The state Medicaid plan must be submitted to the Secretary of the United States Department of Health and Human Services (the "Secretary") for approval and must describe the policies and methods used to set payment rates. 42 C.F.R. §§ 430.10, 447.201(b). State Plan changes may not be implemented prior to being approved by the Secretary. See *Exeter Memorial Hospital Assn. v. Belshe* (9th Cir. 1998) 145 F.3d 1106, 1108 (hereafter "*Exeter*").

Each state must pay providers at rates "sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population." 42 C.F.R. § 447.204; see also Section 30(A). Moreover, each state's Medicaid plan must "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan … as may be necessary … to assure that payments are consistent with efficiency, economy, and quality of care…." Section 30(A).

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B. California's Medi-Cal Program

California participates in Medicaid through the Medi-Cal program. See Welf. & Inst. Code § 14000 et seq.; Cal. Code Regs., tit. 22 (hereafter "C.C.R."), § 50000 et seq. The Department of Health Care Services ("Department") is the single state agency charged with operating Medi-Cal. This case concerns reimbursement for Medi-Cal services that are not covered by a managed care plan, commonly referred to as the *fee-for-service* Medi-Cal program.

Medi-Cal is governed by the State Plan. See C.C.R., tit. 22, § 50004(b)(1). The State Plan establishes the methodologies the Department must use to determine Medi-Cal rates.

Section 4.19(i) of the State Plan requires that Medi-Cal payments must be "sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population." Petitioners' Request for Judicial Notice in support of Motion for Preliminary Injunction ("RJN") Exh. B (State Plan Section 4.19). The State Plan also prohibits the State from enacting changes in payment rates for non-institutional services unless the "applicable requirements of 42 C.F.R. Part 447 are met." RJN Exh. C (excerpt of State Plan Attachment 4.19-B).

The California Legislature has stressed that all Medi-Cal beneficiaries receive necessary care and that payment rates be adequate to ensure "reasonable access to medical care." Welf & Inst. Code § 14075. To further this intent, Welfare and Institutions Code section 14079 requires that Medi-Cal rates be adopted by regulation and that the Department annually review Medi-Cal rates for physician and dental services, taking into account annual Consumer Price Index cost increases, reimbursement levels under Medicare and other third-party payors, prevailing customary charges and other factors. Section 14079 mandates that the Department revise reimbursement rates based on these reviews "to ensure reasonable access of Medi-Cal beneficiaries."

C. Medi-Cal Payment Rates

Medi-Cal payments per enrollee are the *lowest* in the nation. For years the State has financed Medi-Cal on the backs of providers with infrequent rate increases, and periodic rate decreases.

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1. Rates for Physician Services

Medi-Cal pays physicians for their services pursuant to a fee schedule. C.C.R., tit. 22, § 51503. The Medi-Cal rates for most physician services remained frozen from 1985 until August 1, 2000. See RJN Exh. D at p. 2 (Dept. of Health Services, Notice of Emergency Rulemaking, R-24-01 E, "Initial Statement of Reasons" (July 8, 2000)).

Effective August 1, 2000, the Department increased the rates, with varying increases given for different services. In spite of the rate increases, Medi-Cal rates for physician services remained far below Medicare rates for comparable services. Rates for a large number of services that had been particularly low (1180 procedure codes, including common physician office visits) were increased to 43% of Medicare rates following the 2000-2001 rate increases. No rates were increased to more than 80% of the Medicare rates for comparable services, with most well below that level. *Id.* There have been no subsequent rate adjustments until the current Rate Reduction.

2. Rates for Hospital Services

For hospital inpatient services, a hospital is reimbursed the lowest of (1) its customary charges; (2) its reasonable costs of care determined using Medicare principles; (3) a rate per discharge determined by computing a base year cost per discharge and then limiting annually increases to the base rate; or (4) the 60th percentile rate per discharge of the hospitals in its "peer group." Hospitals in no event receive more than their reasonable costs, and the level of cost reimbursed is controlled both as to the annual rate of growth and by comparison to other peer group hospitals' costs. C.C.R., tit. 22, § 51545 et seq.; RJN Exh. C.

The adequacy of the hospital outpatient rates was subject to a decade of litigation in the *Orthopaedic Hospital* cases. In 1990, the California Hospital Association sued the Department alleging that the rates were so low they violated Section 30(A). At that point, the rates with minor exceptions had remained frozen since 1985. In 1992, the federal District Court entered a judgment holding that the rates had not been properly adopted and remanded the matter to the Department for new rate making. *Orthopaedic Hospital v. Kizer* (C.D.Cal. Oct. 5, 1992, No. CV 90-4209 SVW) 1992 WL 345652 (hereafter "*Orthopaedic I*"). The Department re-adopted the challenged rates, the hospitals sued again, and ultimately the U.S. Ninth Circuit Court of Appeals in 1997

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held that the rates were invalid because they were not reasonably related to hospital costs. *Orthopaedic II*, *supra*, 103 F.3d at p. 1491.

3. Rates for Dental Services

Dentists are reimbursed based on rates established by the Department. C.C.R., tit. 22, § 51506 et seq. In 1987, Denti-Cal beneficiaries sued the Department, alleging a significant access problem, and a federal district court ruled in favor of the beneficiaries in a decision affirmed by the Ninth Circuit. See *Clark v. Kizer* (E.D.Cal. 1990) 758 F.Supp.572, affd. in relevant part by *Clark v. Coye* (9th Cir. 1992) 967 F.2d 585.

The Department increased the rates in 1992 following the Ninth Circuit's decision for 56 of the most common dental procedures. However, in 1993, the Department threatened to eliminate Denti-Cal adult benefits. In a negotiated settlement, Denti-Cal rates for the 56 most common procedures were cut by approximately 15 percent in 1994.

The Department has adjusted the fee schedule for dental services, either raising or lowering the rates for all or certain services, at various times during the past 20 years. However, despite significant increases in the costs of services, dental rates for the majority of the 56 most common procedures remain at 1994 levels. See Snow Decl. ¶ 6; see also California Health Care Foundation, Denti-Cal Facts and Figures: A Look at California's Medicaid Dental Program (May 2007) at pp. 2, 8, 18-19, 22, 28 (Mertz Decl., Exh. A) (hereafter "Denti-Cal Facts and Figures").

4. Rates for Adult Day Health Care Centers

Medi-Cal pays ADHCs a bundled per diem of $76.22. Medi-Cal Inpatient/Outpatient Manual, Part 2.

5. Rates for Pharmacy Services

Since 2004, drugs have been reimbursed based on average wholesale price ("AWP") less 17%. Many generic (multi-source) drugs (as opposed to "brand name" or "single-source" drugs) are subject to a federal upper limit (FUL) or a California maximum allowable ingredient cost (MAIC), which reduces reimbursement below AWP minus 17%. In addition to these payments, pharmacies receive a dispensing fee: $7.25 for most prescriptions and $8.00 for drugs dispensed to residents of nursing facilities. Welf. & Inst. Code § 14105.45.

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D. The Ten Percent Rate Reduction

1. Proposition 58

Proposition 58, commonly referred to as the California Balanced Budget Act, grants the Governor the authority to declare a mid-year fiscal emergency if the state is facing substantial revenue shortfalls or spending deficiencies by enacting Article IV, section 10(f) of the California Constitution. The Governor is then required to call the Legislature into special session to take mid-year corrective actions. RJN Exh. E at pp. 11-12 (Legislative Analyst, Analysis of Proposition 58). Pursuant to section 3 of Article IV of the Constitution, the Legislature's authority during a special session is limited to those subjects specified in the Governor's proclamation.

2. Governor Schwarzenegger's Budget and Declaration of Fiscal Emergency

Pursuant to Section 10(f) of Article IV of the California Constitution, on January 10, 2008, Governor Schwarzenegger issued a Fiscal Emergency Proclamation concurrently with the introduction of his 2008-09 budget. RJN Exh. F (Fiscal Emergency Proclamation). The Governor determined that the General Fund revenues for 2007-08 would decline substantially below the estimate of General Fund revenues upon which the 2007 Budget Bill was based. The Governor also noted a $4.8 billion reduction in the General Fund revenue forecast for 2007-08, including a $665 million reduction in the receipt of General Revenue Fund revenues through December 2007. Accordingly, the Governor declared a fiscal emergency. He identified the fiscal emergency to be the "projected budget imbalance and insufficient cash reserves for Fiscal Year 2007-08 and the projected insufficient cash reserves and potential budgetary and cash deficit in Fiscal Year 2008-09." The Governor caused the Legislature to assemble in special session to address the fiscal emergency.

The Governor's budget proposed to save approximately $668 million from the General Fund from reductions to Medi-Cal provider reimbursements for fiscal year 2008-09. The LAO recommended that the Legislature reject the Governor's proposed reductions for nearly all providers. 2008 LAO Report at p. C-39 (Raymond Decl., Exh. B at p. 9) (hereafter "2008 LAO Report"). The LAO described physician rates as not having changed since the Legislature granted rate increases in the 2000-01 budget year, though medical costs continue to increase. *Id.* at p. C-

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37. The LAO further acknowledged evidence that the rates paid to providers can positively affect access to care as well as beneficiaries' perception of quality of care. *Ibid.* The LAO concluded that further rate reductions could limit access to primary care in Medi-Cal and cause a shift to the utilization of costlier sources of care, diminishing the net savings to the state. *Id.* at pp. C-38-39.

3. Ten Percent Rate Reduction

On February 16, 2008, the California Legislature enacted Assembly Bill X3 5 (hereafter "AB 5") in special session. Section 14 of AB 5 added Section 14105.19 to the Welfare and Institutions Code, which provides in relevant part:

> (a) Notwithstanding any other provision of law, in order to implement changes in the level of funding for health care services, the director shall reduce provider payments as specified in this section.
>
> (b)(1) Except as provided in subdivision (c), payments shall be reduced by 10 percent for Medi-Cal fee for service benefits for dates of service on or after July 1, 2008
>
> ….
>
> (e) Notwithstanding Chapter 3.5 (commencing with section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the Department may implement this section by means of provider bulletin, or similar instruction, without taking regulatory action.
>
> ….
>
> (g) The Department shall promptly seek any necessary federal approvals for the implementation of this section.

RJN Exh. A (AB 5). Paragraph (b)(1) reduces Medi-Cal payments for physicians, dentists, pharmacies, ADHCs, and other providers by ten percent for services provided on or after July 1, 2008. The rate reduction will also impact outpatient and distinct-part skilled nursing services furnished by all hospitals.

Pursuant to section 15 of AB 5, the Legislature also enacted Welfare and Institutions Code section 14166.245, which reduces payments for inpatient hospital services furnished on or after July 1, 2008, by ten percent. This is accomplished by reducing interim payments for inpatient hospital services furnished by noncontract hospitals on or after July 1, 2008, by ten percent, and

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by limiting the final reimbursement for each patient day of inpatient hospital services furnished on or after July 1, 2008, to 90% of the hospital's audited allowable cost per day.[2]

The Department has announced its intended implementation of the rate and payment reductions set forth in Welfare and Institutions Code §§ 14105.19(b)(1) and 14166.245, effective for dates of service on or after July 1, 2008 (collectively referred to as the "Rate Reduction"). Cal. Reg. Notice Register 2008, No. 13-Z, p. 492, No. 23-Z, p. 917, No. 26-Z, pp. 1073-1074.

III. STANDING TO BRING A WRIT OF MANDATE

A. Petitioners Are Entitled to a Writ of Mandate to Enforce the Department's Clear and Present Legal Duties in the Administration of Medi-Cal.

California Code of Civil Procedure section 1085 empowers the courts to issue a writ of mandate to compel performance of "an act which the law specially enjoins." The requirements are: (1) a clear, present, and usually ministerial duty on the part of the government official and (2) a clear, present and beneficial interest in the petitioner to the performance of that duty. *Syngenta Crop Protection, Inc. v. Helliker* (2006) 138 Cal.App.4th 1135, 1181. See also *Santa Clara County Counsel Attorneys Assn. v. Woodside* (1994) 7 Cal.4th 525, 540. Where there is not another plain, speedy, and adequate remedy and the petitioner has established the dual requirements of mandate, Code of Civil Procedure section 1086 requires that a writ of mandate issue. When these requirements are met, the petitioner "is entitled *as a matter of right* to the writ, or, in other words, it would be an abuse of discretion to refuse it." *May v. Bd. of Directors of El Camino Irrigation. Dist.* (1949) 34 Cal.2d 125, 133-34 (emphasis added).

B. Petitioners Have A Beneficial Interest

A beneficial interest is established when the petitioner "has some private or particular interest to be subserved, or some particular right to be preserved or protected, independent of that which he holds with the public at large." *Citizen Assn. for Sensible Development of Bishop Area*

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[2] The reduction does not apply to hospitals which have entered into selective provider contracts with the Department for inpatient services, Welf. and Inst. Code § 14081 et seq., or hospitals which are owned by counties or the University of California which are reimbursed based on certified public expenditures.

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v. County of Inyo (1985) 172 Cal.App.3d 151, 158.

Petitioners meet this requirement on at least[3] three independent grounds. First, an association may bring a claim on behalf of its members where (1) its members (or some of them) would have standing to sue in their own right; (2) the interests the association seeks to protect are germane to its purpose; and (3) neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit. *Cal. Assn. for Health Services at Home v. Dept. of Health Services* (2007) 148 Cal.App.4th 696, 707 (hereafter "*CAHSH*"). The members of Petitioners have standing to sue in their own right as they are beneficially interested in ensuring that Medi-Cal rates are established in a lawful manner. See, e.g., Silva Decl. ¶¶ 3-5 (CMA); Snow Decl. ¶¶ 2-5 (CDA); Dauner Decl. ¶¶ 5-6 (CHA); Page Decl. ¶¶ 3-5 (CAL/ACEP); Missaelides Decl. ¶¶ 3-4 (CAADS) Rolston Decl., ¶ 3 (CPhA); see *CAHSH*, *supra*, 148 Cal.App.4th at p. 707 (Medi-Cal providers have a direct pecuniary interest in ensuring that they are paid properly for their services and therefore have an interest over and above the public at large in seeing that Medi-Cal reimbursement rates are adequate and determined in a manner that complies with federal law). The interests Petitioners seek to protect are germane to each organization's purposes. See, e.g., Silva Decl. ¶¶ 3-5 (CMA); Snow Decl. ¶¶ 2-5 (CDA); Dauner Decl. ¶¶ 2-6 (CHA); Page Decl. ¶¶ 3-5 (CAL/ACEP); Missaelides Decl. ¶¶ 3-5 (CAADS); Rolston Decl., ¶ 3 (CPhA). A writ of mandate seeking declaratory and prospective injunctive relief may be adjudicated based on the uniform implementation of an unlawful rate reduction without requiring participation of individual members.

Second, Petitioners have "third-party" standing to represent the interests of Medi-Cal beneficiaries. "In general, a plaintiff may assert a claim on behalf of a third party only when (1) the plaintiff has suffered an injury in fact; (2) the plaintiff has a relationship with the third party so

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[3] Petitioners have also properly alleged a class action on behalf of a class of providers in the Complaint and Petition, and have standing to pursue this matter as class representatives. Petitioners reserve the right to bring a motion to certify the class and sub-classes alleged in the Complaint and Petition, and note that a preliminary injunction may be obtained in a class action prior to class certification. Code of Civ. Proc. § 527(b).

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that it can, and will, effectively present the third party's rights; and (3) obstacles exist preventing the third party from asserting his own rights." *Novartis Vaccines and Diagnostics, Inc. v. Stop Huntingdon Animal Cruelty USA, Inc.* (2006) 143 Cal.App.4th 1284, 1297 (citing *Singleton v. Wulff* (1976) 428 U.S. 106, 113-116). In 2003, the federal district court applied this test to determine that various provider organizations had standing to assert the interests of their Medi-Cal beneficiary patients when it invalidated a threatened Medi-Cal 5% rate reduction. *Clayworth v. Bonta* (E.D.Cal. 2003) 295 F.Supp. 1110, 1117-1118, revd. on other grounds (9th Cir. 2005) 140 Fed.Appx. 677 (hereafter "*Clayworth*"). The same conclusion should be reached here.

Petitioners lastly have standing to bring this action to enforce Respondents' public duty to comply with applicable state and federal laws. An exception to the general rule of standing exists "where the question is one of public right and the object of the mandamus is to procure the enforcement of a public duty … since it is sufficient that [an individual] is interested as a citizen in having the laws executed and the duty in question enforced." *Green v. Obledo* (1981) 29 Cal.3d 126, 144. It is clear that the public has an interest in having Medi-Cal reimbursement rates be established consistent with state and federal law.

C. Respondents Have A Clear, Present and Ministerial Duty To Comply With The State Plan, Federal Regulations, Federal Statutes, The State Constitution And Other State Law.

The second requirement for mandate is a clear, present, and usually ministerial duty on the part of the government official. Mandamus is available to not only correct ministerial duties by a public agency, but it may also "compel a public agency's performance or correct an agency's abuse of discretion whether the action being compelled or corrected can itself be characterized as 'ministerial' or 'legislative'." *Santa Clara County Counsel Attorneys Assn. v. Woodside*, *supra*, 7 Cal.4th at p. 540. Respondents have a mandatory duty to comply with the State Plan (or otherwise to amend the State Plan), California statutes, the California Constitution, and federal regulations statutes. The scope of these duties are discussed throughout this Memorandum.

The State Plan creates a clear, present and ministerial duty on Respondents under state law. *CAHSH*, *supra*, 148 Cal.App.4th at 705-706; see also *Senn Park Nursing Center v. Miller* (Ill.

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1984) 104 Ill.2d 169, 189 (issuing writ of mandate directing director of State Medicaid agency to pay providers as required by the duty established in the State Medicaid Plan). State law independently creates a duty on Respondents to comply with the State Plan. *CAHSH, supra,* 148 Cal.App.4th at p. 706. Moreover, the Department has a mandatory duty to amend the State Plan whenever a material change in California law in the operation of the Medi-Cal program. 42 C.F.R. § 430.12(c).

It is obvious that the Department has a mandatory duty to comply with the statutes and the California Constitution. See *Bramberg v. Jones* (1999) 20 Cal.4th 1045, 1055, fn. 15 (citing *Wenke v. Hitchcock* (1972) 6 Cal.3d 746, 751 [mandamus proper to challenge the constitutionality of statutes]); *Hoffman v. State Bar of Cal.* (2004) 113 Cal.App.4th 630, 639. Mandamus is therefore proper to challenge the validity of AB 5 and its implementation based on California statute and its Constitution.

Once a state has elected to participate in Medicaid and receive federal funds, it is obliged to fully comply with federal statutes and regulations. *Doctor's Medical Laboratory v. Connell* (1999) 69 Cal.App.4th 891, 896. Indeed, "[i]t goes without saying in the public assistance area, California's legislation must not be inconsistent with federal legislation." *Disabled & Blind Action Com. of Cal. v. Jenkins* (1974) 44 Cal.App.3d 74, 78. "[A] writ of mandate is an appropriate method for enforcing a violation of federal law, *even where the law creates no private right of action enforceable under [42 U.S.C.] section 1983*." *CAHSH, supra,* 148 Cal.App.4th at p. 705, fn. 5 (citing *Cal. Homeless & Housing Coalition v. Anderson* (1995) 31 Cal.App.4th 450, 455, 457 [emphasis added]). Because California participates in the Medicaid program and receives federal funds, it has a mandatory duty to comply with the federal statutes and regulations governing that program, including 42 C.F.R. section 447.204 and 42 U.S.C. section (30)(A).

D. <u>Petitioners Have No Other Plain, Speedy and Adequate Remedy In The Course of Law.</u>

Where the dual requirements of mandate are met and the petitioners have no other plain, speedy and adequate remedy, in the ordinary course of law, mandate must issue. Code of Civ. Proc. § 1086; *Harris Transp. Co. v. Air Resources Bd.* (1995) 32 Cal.App.4th 1472, 1481. Where

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another remedy exists, the court retains discretion as to whether to grant the writ. *Harris Transp. Co., supra*, 32 Cal.App.4th at p. 1481.

Here, Petitioners lack any other plain, speedy and adequate remedy in the course of law. The denial or delay of access to health care services by Medi-Cal beneficiaries, the impairment of quality of care provided to beneficiaries or the resulting impact on the well-being of those beneficiaries cannot be remedied in the ordinary course of law, as once these harms have occurred, they cannot be restored with damages. Similarly, the closure of providers or the loss of jobs by healthcare professionals are similarly irremediable in the ordinary course of law. Petitioners further lack any other adequate remedy at law because the ongoing application of the unlawful Rate Reduction will require multiple lawsuits in order to redress under-payments to Petitioners. *Cal. Teachers' Assn. v. Governing Bd.* (1983) 145 Cal.App.3d 735, 747-748 (writ of mandate appropriate despite availability of contract damages in case for reimbursement of health benefits against public agency involving statutory interpretation and to avoid multiplicity of litigation). The availability of declaratory or injunctive relief is insufficient to constitute another plain, speedy, and adequate remedy barring mandate. *County of Los Angeles v. State Dept. of Public Health* (1958) 158 Cal.App.2d 425, 446.

IV. STANDARD FOR INJUNCTIVE RELIEF

"In deciding whether to issue a preliminary injunction, a trial court must evaluate two interrelated factors: (i) the likelihood that the party seeking the injunction will ultimately prevail on the merits of his claim, and (ii) the balance of harm presented, i.e., the comparative consequences of the issuance and nonissuance of the injunction." *Common Cause v. Bd. of Supervisors* (1989) 49 Cal.3d 432, 441-442. The latter factor involves consideration of such things as the inadequacy of other legal remedies, the degree of irreparable harm, the necessity of preserving the status quo and the degree of adverse effect on the public interest or interests of third parties the granting of the injunction will cause. *Vo v. City of Garden Grove* (2004) 115 Cal.App.4th 425, 435 (citing *Cohen v. Bd. of Supervisors* (1985) 40 Cal.3d 277, 286, fn. 5). A trial court's determination is guided by a mix of the likelihood of success and balancing of harm factors. "[T]he greater the Plaintiff's showing on one, the less must be shown on the other to

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support an injunction." *Butt v. State of Cal.* (1992) 4 Cal.4th 668, 677-678.

V. PETITIONERS ARE LIKELY TO PREVAIL ON THE MERITS

This is far from the first time providers or beneficiaries have had to resort to the courts to force the Department to comply with the law in setting Medi-Cal rates. Rather, the Department's practice throughout the forty year history of Medi-Cal has been to ignore the niceties of complying with federal and state law whenever the state faces a fiscal issue. With unsettling frequency, the courts have been required to compel the Department to comply with federal and state requirements concerning provider reimbursement rates. In virtually every case, the courts have found that the Department failed to establish rates that were adequate to achieve adequate beneficiary access to care or sufficient to reimburse providers' cost of care.[4] *Significantly, in the past twenty years, ever since congressional codification of the "equal access" standard through its amendment of the Medicaid Act in 1989,[5] no across-the-board Medi-Cal rate cut such as the Rate Reduction*

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[4] Access Cases: *Cal. Medical Assn., et al. v. Kizer,* Docket No. Civ S 87-0182 LKK (See RJN Exh. G) (Consent Decree permanently enjoining the Department from imposing a 10% reduction in rates to physicians and others); *Clayworth, supra,* 295 F.Supp. at p. 1130 (enjoining a 5% across-the-board rate cut because State failed to consider quality and equal access); *Clark v. Kizer, supra,* 758 F.Supp. at p. 578, affd. in relevant part by *Clark v. Coye, supra,* 967 F.2d 585 (finding Denti-Cal reimbursement rates to be inadequate to ensure equal access); *Sobky v. Smoley,* (E.D.Cal 1994) 855 F.Supp 1123, 1151 (granting injunction based on inconsistent reimbursement levels and availability of Drug/Medi-Cal services); Cost cases: *Cal. Hospital Assn. v. Obledo* (9th Cir. 1979) 602 F.2d 1357, 1361 (enjoining a 10% hospital rate cut); *Cal. Hospital Assn. v. Schweiker,* (C.D.Cal. 1982) 559 F. Supp 110, 117, affd. by *Cal. Hospital Assn. v. Schweiker* (9th Cir. 1983) 705 F.2d 466 (enjoining a 6% hospital rate reduction); *Goleta Valley Community Hospital v. State Dept. of Health Services* (1983) 149 Cal.App.3d 1124, 1133 (upholding trial court order enjoining hospital rate reduction based on low occupancy); *Orthopaedic Hospital v. Belshe, supra,* 103 F.3d 1495 (invalidating hospital outpatient rates where the Department failed to adequately consider hospitals' costs); Failure to follow mandated process: *Cal. Assn. of Nursing Homes v. Williams* (1970) 4 Cal.App.3d 800, 816 (invalidating regulation setting standards for determining Medi-Cal rates for nursing and convalescent homes) (rehg. den. (1970) 4 Cal.App.3d 800; *Cal. Optometric Assn. v. Lackner* (1976) 60 Cal.App.3d 500, 503-504, 511 (largely upholding trial court's award of declaratory relief to providers challenging rates for optometric services); *Cal. Medical Assn. v. Brian* (1973) 30 Cal.App.3d 637, 655 (invalidating two sets of Medi-Cal regulations because of Department's failure to comply with the APA); *CAHSH, supra,* 148 Cal.App.4th at p. 708 (ordering writ of mandate compelling the Department to annually review home health agency reimbursement rates).

[5] The 1989 amendments of the Medicaid Act added the requirement that payment to providers be (footnote continued)

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proposed here has survived legal challenge. Obviously, the Department's lack of past legal success has not deterred the current Administration from attempting once again to bypass all legal requirements and prior case law that unambigously hold that budgetary considerations cannot be the conclusive factor in decisions regarding Medi-Cal reimbursement.

A. The Threatened Ten Percent Rate Reduction is Void Because the Rates After Reduction are Insufficient to Establish Equal Access to Services

To comply with both state and federal law, the Department is required to establish rates adequate to ensure access to services for Medi-Cal beneficiaries at least equal to the general insured population in the geographic area. The Department has made no effort to comply with this "equal access" standard in its intended implementation of the Rate Reduction, notwithstanding clear ministerial duty to do so contained in applicable provisions of both state and federal law. On the basis of this failure alone, the Rate Reduction must be enjoined.

1. The Rate Reduction Violates The Express Terms of the State Plan

The California State Plan is a comprehensive written statement by the Department describing the nature and scope of the Medi-Cal program and giving assurance that it will be administered in conformity with title XIX of the Social Security Act, the regulations of the Secretary, and the other applicable official issuances of the U.S. Department of Health and Human Services. 42 C.F.R. § 430.10. By both statute and regulation, the Department must "administer the Medi-Cal program in accordance with … [t]he State Plan under Title XIX of the Social Security Act." C.C.R., tit. 22, § 50004(b)(1); see also Welf. & Inst. Code § 14100.1. "Thus, if

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"sufficient to enlist enough providers so that the care and services are available under the plan at least to the extent such services are available to the general population in the geographic area," essentially codifying the "equal access" regulatory standard at 42 C.F.R. § 447.204. Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6402(a) (codified at 42 U.S.C. § 1396a(a)(30)(A)). Congress explained that, "without adequate payment levels, it is simply unrealistic to expect physicians to participate in the program...." H.R. Rep. No. 101-247, at pp. 389-390, reprinted in 1989 U.S.C.C.A.N. at pp. 2115-16. Congress was forced to act in 1989 based on concerns that physician participation in the Medicaid programs was approaching alarmingly inadequate levels because states had not maintained adequate provider reimbursement levels. *Id.*

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DHS violates the terms of the state plan, it has violated state law as embodied in a regulation." *CAHSH*, *supra*, 148 Cal.App.4th at p. 706.

A writ of mandate will issue in a petition brought by Medi-Cal providers to compel the Department to follow the rate setting requirements of the State Plan. *CAHSH*, *supra*, 148 Cal.App.4th at p. 706. State Plan Attachment 4.19-B mandates that rate changes required by state statute may be implemented only if the Department assures that "all applicable requirements of 42 C.F.R. Part 447 are met."[6] Part 447 requires that provider "payments must be sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general public." 42 C.F.R. § 447.204. Thus, the Department may implement the Rate Reduction only if the resulting rates are adequate to assure access.

The Department has conducted no study or analysis to determine whether the Rate Reduction would reduce access below the prescribed minimum level established by the State Plan and federal regulations (42 C.F.R. § 447.204). Silva Decl. ¶¶ 8-10. A writ of mandate should issue, therefore, to compel a review of the adequacy of the proposed (reduced) rates before implementation of the Rate Reduction.

Similar relief was granted in *CAHSH*. An association of home health care providers brought a petition for writ of mandate challenging the state's failure to review Medi-Cal rates over several years for home health care services in violation of both state and federal law. The petitioners challenged the Department's failure to comply with the State Plan which required the Department to conduct an annual review of rates to ensure compliance with federal regulations,

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[6] Attachment 4.19-B applies to non-institutional services, such as services of physicians, dentists, and hospital outpatient departments. The failure to assure access violates the State Plan with respect to these services only, although this failure separately violates federal law with respect to all of the services at issue. Further, as discussed below, the Rate Reduction is inconsistent with the portions of the State Plan which apply to institutional services, such as inpatient hospital services, DP/NF services, and ADHC services, and therefore may not be implemented for those services unless and until the State Plan is amended and the amendment is approved by CMS.

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including the "equal access" regulation.[7] The court held that the Department's failure to comply with the State Plan violated both state (C.C.R., tit. 22, § 50004(b)(1)) and federal (42 U.S.C. § 1396a(a)(30)(A)) regulatory requirements that were enforceable by way of mandate under Code of Civil Procedure section 1085. *CAHSH*, *supra*, 148 Cal.App.4th at 706-708.

2. AB 5 Did Not Supersede the State Plan

Respondents have asserted in other filings that AB 5 had the effect of "superseding" the requirements of the State Plan. This is plainly wrong. A state may not simply legislate a change in a State Plan. Rather, the single state agency (here, the Department) must submit an amendment to CMS. 42 C.F.R. § 447.256. In fact, California's State Plan requires the Department to submit an amendment to the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services ("CMS") whenever payment rates for various classes of providers are changed.[8] See Section V.C, *infra***.** It is well-settled law that changes to the State Plan may *not* be implemented by the Department prior to being approved by CMS. *Exeter*, *supra*, 145 F.3d 1106; *Oregon Assn. of Homes for the Aging, Inc. v. Oregon* (9th Cir. 1993) 5 F.3d 1239; *Washington State Health Facilities Assn. v. Washington Dept. Soc. & Health Services* (9th Cir. 1982) 698 F.2d 964. The evidence is undisputed that *the Department has neither submitted nor obtained approval for a State Plan amendment implementing the Rate Reduction.* Silva Decl. ¶¶ 8-10.

Accordingly, since the Department has neither sought to comply with the current State Plan by conducting an analysis of the impact of the Rate Reduction on beneficiary access, nor sought to amend the State Plan to eliminate the requirement that it assure compliance with 42 C.F.R. Part 405, an injunction should issue prohibiting implementation of the Rate Reduction until the Department has complied with its ministerial duty under the Plan to assure that provider

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[7] A similar statutory requirement is applicable here: "The Director annually shall review the reimbursement levels for physician and dental services under Medi-Cal, and shall revise periodically the rates of reimbursement to physicians and dentists to ensure the reasonable access of Medi-Cal beneficiaries to physician and dental services." Welf. & Inst. Code § 14079.

[8] AB 5 specifically charges the Department to "promptly seek any necessary federal approvals for the implementation of this section, including any necessary amendments to the state plan." Welf. & Inst. Code §§ 14105.19(g), 14166.245(f). Inexplicably, it has refused to do so.

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reimbursements rates are—and will be—sufficient to assure access to care under Medi-Cal at least equal to the general insured population.

3. The 10% Rate Reduction Violates the "Equal Access" Requirement in 42 U.S.C. § 1396a(a)(30)(A)

The Medicaid Act "requires that the state maintain both a procedurally sound methodology as well as achieve the mandated results of efficiency, economy, quality of care and equal access." Provider reimbursement rates cannot be based solely on budgetary considerations. *Arkansas Medical Society, Inc. v. Reynolds* (E.D.Ark. 1993) 819 F.Supp. 816, 826 affd. (8th Cir. 1993) 6 F.3d 519 (citing Section 30(A)).[9]

Nevertheless, the Legislature has specifically declared that the Rate Reduction was based solely on budgetary considerations: "The Legislature finds and declares that the state faces a fiscal crisis that requires unprecedented measures to be taken to reduce General Fund expenditures to avoid reducing vital government services necessary for the protection of the health, safety, and welfare of the citizens of the State of California."[10] Welf. & Inst. Code § 14166.245(a).

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[9]While federal decisional law raises doubt as to whether a federal court could grant relief to Petitioners by enforcing the requirements of Section 30(A), *Sanchez v. Johnson* (9th Cir. 2005) 416 F.3d 1051, state courts do not face the same obstacle and have expressly upheld the enforceability of the "equal access" requirements of the Medicaid Act on behalf of Medi-Cal providers even after *Sanchez* through the court's writ of mandate jurisdiction under Code of Civil Procedure section 1085. *CAHSH, supra*, 148 Cal.App.4th at p.706 ("absence of a privately enforceable right under section 1983 does not render mandamus relief under Code of Civil Procedure section 1085 unavailable"). See also *Doctor's Medical Laboratory, Inc., supra*, 69 Cal.App.4th at p. 896 (citing *Cal. Homeless & Housing Coalition, supra*, 31 Cal.App.4th at p. 458 [while section 1983 of 42 United States Code requires violation of a private right, privilege, or immunity to confer standing, section 1085 of the California Code of Civil Procedure creates a broad right to issuance of a writ of mandate "to compel performance of an act which the law specifically enjoins"]); *RJC Medical Services, Inc. v. Bonta* (2001) 91 Cal.App.4th 986, 1003 (distinguishing federal decisional law limiting the rights of providers in federal court from state decisional law and statutory authority that permit a private party to enforce federal Medicaid law under California's writ of mandate statute).

[10] Along these lines, Petitioners also engaged Legislative Intent Service to locate the documents which would constitute the legislative history of AB 5. Nothing in these documents demonstrates any consideration of any factors other than purely budgetary pressures. See Raymond Decl. ¶ 9, Exh. B. If anything, the relevant documents indicate that the legislature turned a blind eye to what information it was provided that was relevant to the Section 30(A) factors. Specifically, the LAO (footnote continued)

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Case law is very clear that although budgetary realities may properly be taken into account, and states may promote efficiency by any legitimate means consistent with adequacy of rates and quality of care, federal statutory standards and their attendant regulations, as well as their legislative history, require that the conclusive factor in rate determinations must not be the amount of money appropriated by the state's legislature. Rather, the state Medicaid agency must make an objective, principled decision with regard to what rates are reasonable and adequate considering the applicable statutory criteria. See Section 30(A); *Arkansas Medical Society, Inc.*, *supra*, 6 F.3d at p. 530; *Amisub v. State of Colorado Dept. of Social Services* (10th Cir. 1989) 879 F.2d 789, 800-801; *Alabama Nursing Assn. v. Harris* (5th Cir. 1980) 617 F.2d 388, 396; *Long Term Care Pharmacy Alliance v. Ferguson* (D.Mass. 2003) 260 F.Supp.2d 282, 292-293; *Friedman v. Perales* (S.D.N.Y 1987) 668 F.Supp. 216, 221, affd. (2d Cir. 1988) 841 F.2d 47; *Michigan Hosp. Assn. v. Babcock* (W.D.Mich. 1990) 736 F.Supp. 759, 764; *Visiting Nurse Assn. of N. Shore, Inc. v. Bullen* (D.Mass. 1994) 866 F.Supp. 1444, 1446-1447, affd. and revd. on other grounds (1st Cir. 1996) 93 F.3d 997; *Illinois Hosp. Assn. v. Illinois Dept. of Pub. Aid* (N.D.Ill. 1983) 576 F.Supp. 360, 368 ("By tieing [sic] payment rates solely to state budgetary needs, [the state] has totally ignored the federal mandate that rates must be adequate to assure Medicaid beneficiaries reasonable access to hospital services of adequate quality, Section 1396a(a)(30)").

In *Arkansas Medical Society, Inc.*, the state had announced a 20% cut in provider payments to address a projected Medicaid budget shortfall without, by its own admission, considering whether its action had any relevance to the requirements of Section 30(A). The District Court enjoined the threatened cuts as failing to comply with federal "equal access" requirements. In affirming the lower court order, the Eighth Circuit Court of Appeals held:

> We agree with the trial court's conclusion that the relevant factors that DHS is obliged to consider in its rate-making decisions are the factors outlined in 42 U.S.C. § 1396a(a)(30)(A). As already discussed, the equal access provision

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recommended that the Legislature reject broad Medi-Cal payment cuts because of data indicating that such cuts would decrease beneficiary access to services as well as overall quality of care and result in beneficiaries seeking care in more expensive settings. 2008 LAO Report, *supra*, at p. C-39.

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> provides an unambiguous and compulsory framework to guide substantive agency decisions regarding reimbursement rates for noninstitutional providers. The statute requires that the reimbursement rates are sufficient to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. 42 U.S.C. § 1396a(a)(30)(A).
>
> Abundant persuasive precedent supports the proposition that budgetary considerations cannot be the conclusive factor in decisions regarding Medicaid. (Citations) DHS may take state budget factors into consideration when setting its reimbursement methodology. (Citations) However, the state may not ignore the Medicaid Act's requirements in order to suit budgetary needs. (Citations) Given all the evidence, we must agree with the district court's conclusion that budgetary reasons were the guiding force and the relevant factors did not in any way form the basis for DHS's rate-making decision. Because it failed to consider the rate reduction's impact on equality of access, efficiency, economy, and quality of care, DHS's decision violated the requirements of 42 U.S.C. §1396a(a)(30)(A).

Arkansas Medical Society, Inc., *supra*, 6 F.3d at p. 530.

The recent decision in *Oklahoma Chapter of American Academy of Pediatrics v. Fogarty* (N.D.Okla. 2005) 366 F.Supp.2d 1050 (hereafter "*OKAAP*"), finding that Oklahoma provider reimbursement rates violated the "equal access'' provisions of Section 30(A), bears considerable relevance to the situation presented here in California. In that case, the court found that provider reimbursement rates under Oklahoma's Medicaid fee schedule never exceeded 72% of Medicare's payment for comparable medical services under that federal program and were "significantly less than rates paid to physicians by private insurance plans." *Id.* at pp. 1074-1076. By setting reimbursement rates for physician specialists and sub-specialists so low, less than two-thirds of specialists in the state were "fully participating" in the programs, "causing excessive delays in service availability." *Id.* at p. 1106. Relying on the earlier California decision in *Clark v. Kizer*, the *OKAAP* court held that such performance by the state failed to meet minimum federal standards assuring reasonable and timely access to medical care.

In the present case, the situation is even bleaker than the circumstances reviewed in *OKAAP*, justifying the issuance of a preliminary injunction. See Section V.A.4, *infra*.

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4. Respondents Have Systematically Failed to Ensure that Medi-Cal Payment Rates are Sufficient to Ensure Equal Access for Medi-Cal Beneficiaries

a. *Medi-Cal Rates Are Egregiously Low*

Medi-Cal payment rates have historically been and continue to be shockingly low. California's Medicaid payments per enrollee are already the lowest in the nation, and not by just a small margin. California's Medi-Cal payments per enrollee in 2005 were less than 60% of the national average payments per enrollee and represented less than 35% of the per enrollee annual payments per enrollee of larger states, such as New York. Moulds Decl., Exh. E. Indeed, while estimates vary, Medi-Cal rates trail far behind the Medicare program. Moulds Decl., Exh. I at p. 51 (Medi-Cal physician payment rates are 57% of Medicare); 2008 LAO Report, *supra*, at p. C-37 (Medi-Cal physician payment rates 61% of Medicare).

In 2001, the Legislative Analyst Office ("LAO") assessing Medi-Cal physician rates concluded that "there is not a rational basis for Medi-Cal rates." RJN Exh. H at p. 1 (2001 LAO Report). The LAO reported that "[d]espite state and federal requirements, [the Department] has not conducted annual rate reviews or made periodic adjustments to Medi-Cal rates to ensure reasonable access to health care services." *Ibid.* At that time, the LAO recommended that the Legislature establish a more rational process for reviewing and adjusting Medi-Cal rates, suggesting that in the short term, the Legislature use 80% of Medicare rates as a benchmark. *Id.* at pp. 1, 5.

The LAO again in its report on the California Medical Assistance Program for the 2002-2003 Budget Bill, which included a proposed 15% reduction in certain provider payments, specifically commented on the absence of a rational basis in the Department's Medi-Cal rate setting system. RJN Exh. I at pp. 14-17 (2002 LAO Report). The report echoed the findings of the 2001 LAO report that the Department had no regular process for the periodic evaluation of the adequacy of rates before adjusting them. *Id*. at p. 16. Most importantly, the report concludes:

> Our analysis indicated that the lack of a rational system for physician rate setting has significant potential ramifications for the provision of health care for Medi-Cal beneficiaries and the administration of the program: (1) the state will not ensure reasonable access to quality health care services; (2) physician services will be used less efficiently, with overpayments for some medical procedures and

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> underpayments for others, providing an incentive for the overuse of some services and the underuse of others; (3) some medical providers may not be fairly compensated for certain medical procedures; and (4) the Medi-Cal rate system will remain complex and difficult to administer for DHS and participating physicians.

Id. at p. 16.

> The Legislative Analyst's recommendation include the following observations:
>
> The Governor's rate reduction proposal to help balance the budget does not consider how cuts in provider rates might affect access or quality of care. The evidence suggests that the rate reduction could negatively affect access to care and quality of care….
>
> Accordingly, we recommend that the Legislature not adopt the Governor's proposal to reduce provider rates and consider alternative approaches to achieving savings in the Medi-Cal Program such as those we have discussed above. We further recommend that the Legislature enact legislation to require the department to establish a rational rate-setting process for fee-for-service providers….

Id. at p. 17.

Predictably, when the Legislature considered the Rate Reduction in special session in early 2008, the LAO again cautioned against such rate reductions. 2008 LAO Report, *supra*, at p. C-37. The LAO described the inadequacy of payments to physicians, noting that Medi-Cal fee-for-service payment rates were, on average, about 61% of what Medicare pays to its service providers. *Ibid.* The application of the Rate Reduction would decrease the payment rates to approximately 57% of Medicare levels. *Ibid.* The LAO cited to studies that higher rates positively affect access to care, patient satisfaction, and patient outcomes. *Ibid.*

b. *The Current, Low Medi-Cal Payment Rates Have Impaired Access*

The Rate Reduction will, without question, worsen California's already inadequate and insufficient health care service system by further reducing access to physicians for Medi-Cal beneficiaries. California Medi-Cal beneficiaries have for many years been deprived of equal access to physician services in the State. This egregiously low level of Medi-Cal payments over time has had a predictable result on beneficiary access to care. The low participation rates of providers in California are related to the low reimbursement rates. Berman Decl., Exh. A at p. 247. Medi-Cal rates are inadequate, often not even covering a provider's costs of providing the service. Blustein Decl. ¶ 7; Carnevali Decl. ¶ 8; Goldman Decl. ¶ 8; Hawthorne Decl. ¶¶ 7, 10; Kakutani Decl. ¶ 8; Mazer Decl. ¶¶ 9, 14; Messinger Decl. ¶ 7; Nager Decl. ¶ 5; Polansky Decl. ¶

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7; Ring Decl. ¶ 8; Roache Decl. ¶ 6; Siegel Decl. ¶ 7; Simon Decl. ¶ 10; Sprau Decl. ¶ 8.

Studies have conclusively shown that the supply of physicians available to Medi-Cal beneficiaries is significantly less than that available to the general population. In 2001, a survey conducted by the University of California, San Francisco, showed an alarmingly low level of participation rate in the Medi-Cal program by physicians, especially specialists. Moulds Decl., Exh. C; see also Berman Decl. ¶ 8 (physician participation rates in California "substantially lower" than U.S. average). The report, which analyzes the availability of services in 2001, after the 2000 Medi-Cal physician rate increases, demonstrated that the number of available primary care physicians per capita for Medi-Cal beneficiaries was one-third less, the number of medical specialists more than one-half less, and the number of surgical specialists an astounding two-thirds less than those providing such services to the general population. Overall, the ratio of primary care physicians available to Medi-Cal patients in urban counties in 2001 (46 per 100,000) was well below the 60 to 80 physicians per 100,000 recommended as the proper workforce standards by the Health Resources Services Administration. Moulds Decl., Exh. C at p. 2. Whereas 85.4% of physicians nationwide provide services to Medicaid patients, only just over one half of physicians in California do so. *Id*., Exh. C at pp. 2, 39. In urban areas, nearly half of the primary care physicians are unwilling to treat Medi-Cal patients. *Id*., Exh. C at p. 1. Furthermore, only a small percentage of physicians (25%) was found to be responsible for 80% of the primary care patient visits by Medi-Cal beneficiaries.

Access to specialists is substantially impaired for Medi-Cal beneficiaries. For example, a survey of otolaryngologists in Southern California found that only 27% responding physicians would accept appointments with children enrolled in fee for service Medi-Cal. Wang Study (Moulds Declaration) at pp. 585-586. Only 19% of these physicians would offer to perform surgery. *Ibid.* Of the physicians who would not accept new appointments, 90 percent cited low reimbursement rates as a reason. *Ibid.*

The actual experience of physicians participating in Medi-Cal confirms the lack of availability of specialists for Medi-Cal beneficiaries. Many providers are aware of a shortage of specialists participating in the program due to low reimbursement rates, often from having

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difficulties finding specialists to whom they can refer patients. See, e.g., Farmer Decl. ¶ 6; Goldman Decl. ¶ 6; Kletter Decl. ¶ 6; Lievre Decl. ¶ 7; Mazer Decl. ¶¶ 9-10; Senella Decl. ¶ 5; Siegel Decl. ¶¶ 8, 14; Simon Decl. ¶¶ 16-17. Specifically, access to otolaryngologists, orthopaedists, neurosurgeons, dermatologists, gastroenterologists, urologists, radiation therapists, oncologists, rheumatologists and endocrinologists are problematic in different areas of the state. *Ibid.* As a result, patients either have to travel far distances or experience unnecessary delays in getting specialty care. For example, virtually no rheumatology specialists and very few gastroenterologists, urologists, dermatologists and adult orthopaedic specialists in the Sacramento area participate in the Medi-Cal program, forcing at least one physician to sometimes send patients as far as San Francisco to receive care. Simon Decl. ¶¶ 14-17. Similarly, Dr. Theodore Mazer, the only otolaryngologist in east San Diego County regularly accepting Medi-Cal patients, sometimes sees patients referred to him from as far as 30 miles away (from Riverside County, southern Orange County, as far south as the Mexican border). Mazer Decl. ¶ 9. Even in urban Los Angeles County, patients sometimes have to wait 3-5 months to see a specialist. F. Kaufman Decl. ¶ 9; Siegel Decl. ¶ 14. For Medi-Cal beneficiary Theodora Johnson, the lack of specialists means that she has had problems finding a cardiac specialist, despite her primary care physician's advice that she needs to see one "immediately." Johnson Decl. ¶ 3.

Similarly, access to dental services is woefully inadequate. At present, less than half of dentists in California accept Medi-Cal patients. Of those dentists who do accept Medi-Cal patients, many restrict the number they will treat. See Denti-Cal Facts and Figures, *supra*, at pp. 2, 18, 19. Access to specialized dental care, like that furnished by orthodontists, oral surgeons and pediatric dentists, is even harder to come by for Denti-Cal patients. See *ibid.* A striking illustration of the access problem is a finding as part of the 2008 California Health Care Foundation study that Denti-Cal beneficiaries were far more likely to have never seen a dentist as compared to patients with other types of insurance. Pourat Decl., Exh. A at p. 11.

c. *The Implementation of the Rate Reduction Will Gravely Erode Access to Services for Medi-Cal Beneficiaries*

The implementation of the Rate Reduction will only further irreparably erode the already

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insufficient access by Medi-Cal beneficiaries to health care services. The evidence discussed herein relating to the impact of the threatened Rate Reduction on access to services for Medi-Cal beneficiaries also demonstrates the degree of irreparable injury the denial of the injunction will cause to those same beneficiaries. See Sec. VI, *infra*.

The Rate Reduction will impair access, forcing beneficiaries to utilize emergency rooms instead of primary and preventive care services and create overcrowding at community health clinics. See, e.g., Andrews Decl. ¶ 10; Blustein Decl. ¶ 10; Carnevali Decl. ¶ 10; Farmer Decl. ¶ 9; Goldman Decl. ¶ 10. Many providers may cease accepting new Medi-Cal patients due to the Rate Reduction. See, e.g., Goldman Decl. ¶ 11; Hawthorne Decl. ¶ 10; Kakutani Decl. ¶ 11; Messinger Decl. ¶ 10. Dr. Gilbert Simon in Sacramento, whose practice focuses almost entirely on Medi-Cal patients, will consider closing one of his clinics, resulting in the lack of access for his patients. Simon Decl. ¶ 13. Dr. Theodore Mazer, the only otolaryngologist in east San Diego County regularly accepting Medi-Cal patients, will not accept patients for whom he will receive less than the current Medi-Cal rate, which will decimate Medi-Cal patients' access. Mazer Decl. ¶ 12. The Center for Diabetes, Endocrinology and Metabolism at the Children's Hospital Los Angeles will eliminate 1500 patient slots, decreasing access for diabetic children. F. Kaufman Decl. ¶ 11. Similarly, the Center for Cancer and Blood Diseases at Children's Hospital Los Angeles will eliminate one physician position, reducing access for children with cancer and blood diseases. Siegel Decl. ¶¶ 11, 15.

Similarly, the abysmal access Medi-Cal beneficiaries have to dental services will get even worse. Even more providers will drop out of the program after the rate reduction takes effect, thus pushing access to services toward non-existent. See Snow Decl. ¶ 8; Burg Decl. ¶ 10; Gottschalk Decl. ¶ 11; Mead Decl. ¶ 11.

Access to hospitals also will be immediately affected, particularly those servicing isolated communities. Hospitals in rural areas all over the state will discontinue or significantly reduce services. See Scaife Decl. ¶¶ 9-11; Mendoza Decl. ¶¶ 8-10; Guenther Decl. ¶¶ 8-9; Miller Decl. ¶¶ 7-9. Even some urban area hospitals will discontinue some lines of service. See Kiff Decl. ¶ 5. The residents of the areas these facilities service will be without reasonable alternative sources of

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care. See Scaife Decl. ¶¶ 9-11; Mendoza Decl. ¶¶ 8-10; Guenther Decl. ¶¶ 8-9; Miller Decl. ¶ 8; Kiff Decl. ¶ 5.

The impairment of access to ADHC services will have serious consequences. ADHCs provide intensive day services through a multi-disciplinary team of health and social services professionals to frail elderly and disabled persons, in order to maintain their ability to reside in the community.[11] Because ADHC services are not covered under Medicare or most private insurance, ADHCs almost exclusively serve Medi-Cal participants. Missaelides Decl. ¶ 7. ADHCs are highly regulated and are thus unable to cut costs. Further, they cannot shift costs to other payers, since Medi-Cal covers 90% of ADHC participants, and they are already stretched to the breaking point due to the significant deferrals in payments which the State is imposing. *Id*. at ¶¶ 14, 15, 17. There have been some recent ADHC closures already due to significant operational expenses. Programs are currently facing financial deficits, and it is clear that many more will be forced to close their doors as a result of the Rate Reduction. Missaelides Decl. ¶¶ 19, 22; Cooper-Puckett Decl. ¶¶ 5-10; C. Kauffman Decl. ¶¶ 6-8; Nolcox Decl. ¶¶ 5-6; Vega Decl. ¶¶ 5-10.

Of all services, the Rate Reduction may have the most immediate impact on pharmacies and the ability of Medi-Cal beneficiaries to obtain needed medications. A recent study commissioned by the State showed that the $7.25 payment for dispensing is significantly below the actual cost of dispensing. See Myers and Stauffer, *Survey of Dispensing and Acquisition Costs of Pharmaceuticals in the State of California* (Dec. 2007), Prepared for the Cal. Dept. of Health Services (attached to Rolston Decl.) (hereafter "Myers Survey"). According to the Myers Survey, the weighted mean dispensing cost is $10.81, so pharmacies are on average being reimbursed only 67% of their dispensing costs (which will be reduced to 60% after the Rate Reduction). Myers Survey, *supra*, at p. 30. This means that pharmacies must make up for their loss on dispensing costs, as well as any profit, from the spread between their actual acquisition cost for the drugs and

[11] ADHCs are licensed pursuant to the California Adult Day Health Care Act, Health and Safety Code section 1570 et seq., and are a benefit under the Medi-Cal Program pursuant to the Adult Day Health Medi-Cal Law, Welfare and Institutions Code section 14520 et seq.

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the price paid by Medi-Cal for acquisition (i.e., AWP minus 17%).

Dr. Stephen W. Schondelmeyer, a noted academic expert in pharmaceutical economics, with 30 years of experience, including appointment by Congress to the Prescription Drug Payment Review Commission, has prepared an extensive, 50-page report entitled *Impact of the 10 Percent Fee-for-Service Payment Reductions on Medi-Cal Beneficiaries and Pharmacies,* (Jun. 3, 2008), attached to his declaration (hereafter "Schondelmeyer Report"). Results of his analysis of rates after the Rate Reduction show that of the top 278 brand name drugs reimbursed by Medi-Cal, which accounted for more than half of total Medi-Cal drug expenditures in 2006, 99 percent of prescription payments will be below the pharmacy's breakeven cost (i.e., acquisition plus dispensing cost, but no profit) and 32 percent will be below the pharmacy's actual drug ingredient cost. Schondelmeyer Report, *supra*, at pp. 38-39. In this latter category of drugs to be reimbursed below acquisition cost are several key classes of drugs, including antipsychotic drugs, anti-convulsants and antiretroviral drugs, making it likely that many mentally ill and HIV-positive patients, and those suffering from seizure disorders, will have no access to critical medications. *Id*. at p. 40. Pharmacists will not be able to reduce their acquisition costs, because community pharmacies have little ability to negotiate better drug ingredient costs from manufacturers or wholesalers. *Id*. at p. 44. Nor are they in a position to easily reduce other costs, such as labor costs; a relative shortage of pharmacists makes it difficult, if not impossible, to cut wages to a significant degree. *Id.* at p. 45. Dr. Schondelmeyer concluded the following would occur as a result of the Rate Reduction: "Virtually all pharmacies will refuse a few high cost Medi-Cal prescriptions. Some pharmacies will refuse some Medi-Cal prescriptions and some patients. Other pharmacies will refuse all Medi-Cal prescriptions and all patients." *Id.* at p. ix.

Dr. Schondelmeyer's predictions are supported by statements made by pharmacy owners contemplating the Rate Reduction. See Rolston Decl. ¶ 8. Many pharmacists have already decided that they will not dispense drugs that are reimbursed below acquisition cost. See, e.g., Cronin Decl. ¶ 9; Mistry Decl. ¶ 9; Witherwax Decl. ¶ 9; Green Decl. ¶ 9; Komoto Decl. ¶ 9; Nelson Decl. ¶ 9; Gunner Decl. ¶ 9; Vermillion Decl. ¶ 9; B. Patel Decl. ¶ 9. While other pharmacies, though contemplating such drastic action, are not willing right now to assert that they

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will definitely stop dispensing drugs at below acquisition cost (see various pharmacist declarations included herewith), it is only a matter of logic and time before they would stop doing so. Even worse, some pharmacies are indicating they may close altogether. For example, Pharmkee, Inc. owns and operates nine pharmacies in predominately rural communities, covering many areas where there are no other pharmacies. Their business is about 75% Medi-Cal, and for some of their pharmacies the Medi-Cal share exceeds 90%. Because of the Rate Reduction, they may not be able to continue to operate their pharmacy business, and patients will have no other source for drugs. Wilcox Decl. See also Lumpkin Decl. ¶ 10 (Horton & Converse may close 3 or more pharmacies). Some pharmacies will curtail services. Tilley Decl. ¶ 10 (only pharmacy in Downey that delivers to Medi-Cal patients and provides special packaging for SNF patients will stop these extra services). Others will not accept new Medi-Cal patients. Lofholm Decl. ¶ 10; Cable Decl. ¶ 10; Vasoya Decl. ¶ 10. There is no question that access to pharmacy services for Medi-Cal beneficiaries is going to be severely curtailed if the Rate Reduction is allowed to go into effect.

B. The Rate Reduction Was Enacted Without Consideration of, and Will Not Be Consistent With, Efficiency, Economy and Quality of Care

Section 30(A) requires that rates be consistent with efficiency, economy, and quality of care in addition to ensuring access. States must reasonably consider these factors when adopting rates, and must produce rates consistent with them. See *Orthopaedic II*, *supra*, 103 F.3d at p. 1497; *Arkansas Med. Soc.*, *supra*, 6 F.3d at pp. 529-530; *OKAAP*, *supra*, 366 F.Supp.2d at p. 1105.

The Ninth Circuit in *Orthopaedic II*, *supra*, 103 F.3d at page 1496 held that Section 30(A) requires that rates be related to costs:

> We conclude that the Director must set … reimbursement rates that bear a reasonable relationship to efficient and economical hospitals' costs of providing quality services, unless the Department shows some justification for rates that substantially deviate from such costs. To do this, the Department must rely on responsible cost studies, its own or others', that provide reliable data as a basis for its rate setting ….
>
> The Department cannot know that it is setting rates that are consistent with efficiency, economy, quality of care and access without considering the costs of providing such services.

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The Rate Reduction violates the efficiency, economy, and quality of care prong for several reasons, each of which is a separate and independent basis for invalidating the reduction. First, there is no evidence that the Department or the Legislature considered efficiency, economy, and quality of care prior to enacting the Rate reduction. Rather, as discussed above, the Rate Reduction was impermissibly based solely on budgetary factors.

Second, there is no evidence that the Legislature or the Department considered whether the reduced rates are reasonably related to provider costs. Without at least considering costs, the State could not have reasonably concluded that the rates are consistent with quality of care.

Third, the rates after the Rate Reduction will not be reasonably related to costs. Hospitals will be paid on average less than 40% of cost for outpatient services and no more than 90% of costs for inpatient services. Zaretsky Decl. ¶¶ 7-8. Hospitals will be paid, on average, only 78% of their costs for DP/NF services, with most receiving a much smaller percentage. Zaretsky Decl. ¶¶ 9-10; Scaife Decl. ¶ 10. Medi-Cal payment rates for physicians, dentists, pharmacies and ADHCs will come well short of covering the costs incurred by these providers. See, e.g., Burg Decl. ¶ 8 (inadequacy of dental payment rates); Mead Decl. ¶ 9 (dental rates); Gottschalk Decl. ¶ 11 (dental rates). The Department has offered no valid basis for deviating so substantially from provider costs.

Fourth, the Rate Reduction will cause patients to receive care in higher cost settings, which is wholly inconsistent with efficiency and economy. As beneficiaries will be unable to obtain access to community physicians, they will turn increasingly to hospital emergency rooms for services. See Chanez Decl. ¶ 6; Dauner Decl. ¶ 8; Kiff Decl. ¶ 6; Fuller Decl. ¶ 6; Mazer Decl. ¶ 14; F. Kaufman Decl. ¶ 14; Kozai Decl. ¶¶ 7 – 8, 12. It is of course much more expensive to render care and emergency room than in a physician's office. Zaretsky Decl. ¶¶ 12-13. Indeed, the LAO cited the fact that the Rate Reduction will force beneficiaries into costly emergency rooms as a primary reason for recommending against the Rate Reduction for most providers. 2008 LAO Report, *supra*, at p. C-38.

Similarly, the forced closure of ADHCs due to low rates will ultimately cost the State more as beneficiaries who previously received services at ADHCs will end up in nursing homes. 2008

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LAO Report, *supra*, at p. C-39. The closure of pediatric subacute hospitals will force their patients to find intensive care placements in hospitals at a much higher cost. Zarcone Decl. ¶ 7. Reduced access to prenatal care will result in more childbirth complications and use of neonatal intensive care units, at a higher cost to the state. Polansky Decl. ¶ 9.

Fifth, the Rate reduction will be inconsistent with quality of care. Beneficiaries who cannot obtain access to physicians will delay care, and as a result will be much sicker when they finally seek care at hospital emergency rooms. See, e.g., Fuller Decl. ¶ 4; Chanez Decl. ¶ 6; Kozai Decl. ¶ 9. Further, the influx of more patients into already crowded emergency rooms necessarily impacts quality of care as patients will have to wait longer for treatment and the hospitals' medical professionals will have less time get to devote to them each patient. Chanez Decl. ¶ 6; Dauner Decl. ¶ 8; Kiff Decl. ¶ 6; Fuller Decl. ¶ 6; Kozai Decl. ¶¶ 7 – 12.

Finally, the Rate Reduction is not efficient or economical because it will increase the costs to non-Medi-Cal patients. The Medi-Cal underpayments are subsidized by payments by insured individuals and employers offering coverage. RJN Exh. J at pp. 2-3 (Governor's Health Care Proposal); Lavarreda Decl. ¶ 9. The Rate Reduction will necessarily increase this "hidden tax." See, e.g., Goldman Decl. ¶ 11; Kakutani Decl. ¶ 11.

C. The Rate Reduction is Invalid As to Hospital Services Because the Respondents Failed to Amend the State Plan

In regard specifically to inpatient services of hospitals that are not operating under contracts with the Department, DP/NF and subacute services provided by all hospitals, nursing facility-Level A (NF-A) services and ADHC services, the Department has violated California's State Medicaid Plan by failing to amend the Plan, and obtain federal approval, for the Rate Reduction. Therefore, the Rate Reduction is invalid as to these services.

While Attachment 4.19-B to the State Plan (at p. 2, paragraph (e)) allows for state statutory changes in rates for many services without amending the State Plan (as long as the requirements of 42 C.F.R. Part 447 are met), there is no such provision applicable to services for which reimbursement is not covered by Attachment 4.19-B. Hospital inpatient services are covered under Attachment 4.19-A. Section II.A of 4.19-A provides that hospitals not covered by a

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contract shall be reimbursed the lowest of four items, one of which is their allowable costs; it does not allow for payment at 10% below allowable costs, as required by AB 5 (Welf. & Inst. Code § 14166.245(c)(3)). Rate methodologies for long-term care services, including DP/NF services, NF-A services and subacute services, are covered under Attachment 4.19-D. Rates for ADHC services, though not specifically mentioned in any of the Attachments to the State Plan that cover reimbursement methodologies, are tied to NF-A rates as a result of a lawsuit settlement entered into by the Department, and thus fall within the ambit of 4.19-D. (The Settlement Agreement in *Cal. Assn. of Adult Day Services v. Dept. of Health Services* is attached to the Missaelides Decl.) No provision allowing for rate changes without a State Plan amendment exists in 4.19-A or 4.19-D. See Gross Decl.

This Court should determine the Rate Reduction invalid as applied to these services, until such time as the Department submits an appropriate State Plan amendment and the federal government approves it. *Exeter, supra*, 145 F.3d 1106; *Oregon Assn. of Homes for the Aging, Inc., supra*, 5 F.3d 1239.

D. Hospital Subacute Units Are Exempt From the Rate Reduction

The Department has recently announced it will apply the Rate Reduction to hospital subacute units, which treat patients who are too acute for a DP/NF but who do not need hospital care. However, these services are exempt from the Rate Reduction pursuant to express terms of the implementing statute. Welf. & Inst. Code § 14105.19(c)(4)(C).

E. The Passage of the Rate Reduction Violates the California Constitution.

The Legislature acted outside its Constitutional authority by enacting the Rate Reduction for fiscal year 2008-09. The Legislature enacted AB 5 in special session to address the fiscal emergency proclaimed by Governor Schwarzenegger pursuant to Article IV, section 10(f) ("Section 10(f)") of the California Constitution. Section 10(f) authorizes the Governor to declare a fiscal emergency and to call the Legislature into special session only with respect to the current fiscal year. Here the Governor's proclamation of a fiscal emergency occurred on January 10, 2008. RJN Exh. F. It was therefore unconstitutional for the Governor to have included fiscal year 2008-09 in his proclamation of emergency and for the Legislature to have taken action with

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respect to 2008-09. Cal. Const., art. IV, § 3 (limiting Legislature's authority to act in special session to those subjects set forth by gubernatorial proclamation).

Section 10(f) was added in 2004 pursuant to Proposition 58 ("Prop. 58"). Prop. 58 required the enactment of a balanced budget for 2004-05 and subsequent fiscal years and created a mechanism for mid-year budget adjustments in Section 10(f). These provisions were intended to act together to prevent the State from having budget deficits at the end of any given fiscal year. RJN Exh. E at pp. 14-15.

The Analysis by the Legislative Analyst presented to the voters describes Section 10(f) as creating a formal process and requirement for the Legislature to take "mid-year corrective actions … when the budget falls out of balance." RJN Exh. E at p. 11. The Rebuttal to the Argument Against Prop. 58 further states that "Proposition 58 requires the Legislature to enact a balanced budget and if circumstances change after they pass the budget, the Governor is required to call them into special session to make mid-year changes to the budget, so that we end the year with A BALANCED BUDGET." *Ibid.* Accordingly, Section 10(f) does not authorize the Legislature to enact any legislation in special session outside the fiscal emergency in fiscal year 2007-08. On this basis, the Rate Reduction, applicable only after the end of the 2007-08 fiscal year, is invalid.

VI. PETITIONERS' MEMBERS, MEDI-CAL BENEFICIARIES AND OTHERS FACE IMMINENT IRREPARABLE INJURY FROM THE RATE REDUCTION

An evaluation of the relative harm to the parties upon the granting or denial of a preliminary injunction requires consideration of: "(1) the inadequacy of any other remedy; (2) the degree of irreparable injury the denial of the injunction will cause; (3) the necessity to preserve the status quo; [and] (4) the degree of adverse effect on the public interest or interests of third parties the granting of the injunction will cause."[12] *Vo*, *supra*, 115 Cal.App.4th at p. 435. Failure to

[12] The court should take into account the impact of the cuts on Medi-Cal beneficiaries and the public as a whole in addition to the impact on providers. The Petitioners have third-party standing to bring claims on behalf of their patients, Medi-Cal beneficiaries, and have brought this suit to enforce public duties. See *Common Cause, supra*, 49 Cal.3d at p. 439 (a party has standing to seek a preliminary injunction to enforce performance of a public duty).

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enjoin the implementation of the Rate Reduction will result in irreparable harm, described below.

A. Medi-Cal Beneficiaries Will Suffer Irreparable Harm by the Impairment of Access to All Manner of Health Care Services.

As discussed above, any further rate cut will drastically reduce the number of providers willing to furnish services and, consequently, will further limit already limited access for Medi-Cal patients. Berman Decl. ¶ 9 (less likely that children enrolled in Medi-Cal will have access to care and services to the same extent as other children in the same geographic area).

The impairment of access is irreparable because once a delay has occurred, it cannot be restored. These delays in access negatively affect the care received and the health of Medi-Cal beneficiaries. Ring Decl. ¶ 11 (inability to obtain specialty consults forces primary care doctors to practice beyond their area of expertise); F. Kaufman Decl. ¶¶ 11-13; Siegel Decl. ¶¶ 12, 15; see also Lavarreda Decl. ¶ 9 (lack of access to health care services results in the inability to see a doctor regularly or have a well-child visit, not taking necessary medications for diseases such as asthma, diabetes and high blood pressure and not receiving preventive health care services). Absent access to primary care, patients will be forced to seek care at emergency rooms. Sugarman Decl. ¶ 11 (if Rate Reduction implemented, Medi-Cal beneficiaries will be unable to find private doctors willing to treat them and will begin to rely almost exclusively on emergency care); Kivela Decl. ¶ 12 (same); Nager Decl. ¶ 6 (50% of emergency admissions could have been prevented if children had appropriate access to care); Simon Decl. ¶ 13. As a result, wait times in emergency rooms will become even longer. Sugarman Decl. ¶ 11; Kivela Decl. ¶ 11; Nager Decl. ¶ 11.

The elimination of Medi-Cal participating dentists will be particularly traumatic for some patients. For example, Dr. H. William Gottschalk specializes in dental care for patients who suffer from disabilities, such as Down Syndrome, cerebral palsy, autism and other types of mental retardation. Gottschalk Decl. ¶ 5. These patients cannot obtain dental care in a traditional setting because they require anesthesia before any procedure. *Id.* Dr. Gottschalk very likely will discontinue seeing Medi-Cal patients once the rate reduction becomes effective. Gottschalk Decl. ¶ 11. His Medi-Cal patients will have no other dentists to turn to for regular care. *Id.* The displacement of these patients and others is unlikely to be remedied quickly because once dentists

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like Dr. Gottschalk discontinue participation in Denti-Cal, they rarely return. See Snow Decl. ¶ 9.

The hospital closures and reduction in services also will be particularly traumatic for some patients. In particular, frail and elderly patients receiving skilled nursing care in rural areas will have their lives significantly disrupted. Scaife Decl. ¶ 11; Guenther Decl. ¶¶ 8-9. For example, in Eastern Plumas County, the likely closure of Loyalton Hospital because of the rate reduction will displace 30 skilled nursing patients who need 24 hour care that cannot be provided in a home or residential care environment. See Guenther Decl. ¶ 8.A; see also Scaife Decl. ¶ 11. Assuming these patients can even find other facilities to take them, it would only be in facilities far away from their homes. Putting frail, sometimes elderly, patients like this in a position where they may be without adequate care is not just harmful, but borders on cruel.

Here in Los Angeles County, the patients of Children's Hospital Los Angeles will be irreparably injured by the Rate Reduction. The children who are patients at the Center for Diabetes, Endocrinology and Metabolism ("CDEM") and the Center for Cancer and Blood Diseases ("CCBD") are very ill. Both centers see over 70% Medi-Cal patients. F. Kaufman Decl. ¶ 6; Siegel Decl. ¶ 6. The Rate Reduction will require each Center to eliminate one physician position, reducing access for ill children on Medi-Cal. F. Kaufman Decl. ¶11; Siegel Decl. ¶15. As a result, all of the patients seen by the centers will have to wait longer for appointments. F. Kaufman Decl. ¶ 11; Siegel Decl. ¶11. Without appropriate management of diabetes, the patients of CDEM face frequent hospitalizations, increased absences from school, permanent health consequences and lower quality of life. F. Kaufman Decl. ¶ 13. The Rate Reduction will cause the quality of care of children with cancer to diminish. Siegel Decl. ¶ 12. If these children cannot be seen by centers approved by the Children's Oncology Group and by providers using national protocols, they face a lower chance of survival. *Ibid.* The 3-5 month wait for a consultation with a pediatric subspecialist is particularly harmful to children with cancer, "delaying key decision-making in [the CCBD's] patient's cancer treatment and its complications … [and] reducing the quality of care for … patients." *Id.* at ¶ 14.

Likewise, with some pharmacies ceasing to service Medi-Cal patients altogether, or refusing to take on new Medi-Cal customers, beneficiaries in small towns and rural areas, or other

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underserved areas, may not be able to find a pharmacy willing to serve them. Schondelmeyer Report, *supra*, at p. 49; Wilcox Decl. Other pharmacies, as cited to above, have made it clear that they will not continue to dispense medications where the reimbursement falls below the actual cost of purchasing the drugs. Unable to fill their prescriptions, the health and well-being of Medi-Cal beneficiaries, especially those dependent on anti-psychotic, anti-convulsant and HIV-related medications, will deteriorate almost immediately, and they will suffer unnecessary harm. Besides the pain and suffering, these patients will end up in emergency rooms seeking treatment, costing the State more money than if the medications had been properly provided and taxing our emergency care system. Further, depending on how different pharmacies react to the Rate Reduction, beneficiaries may have to obtain various drugs at different pharmacies, creating coordination of care issues, which could lead to more severe medical problems. Schondelmeyer Report, *supra*, at p. 49.

As discussed above, many ADHCs are threatened with closure due to the Rate Reduction and their inability to meet all their regulatory requirements with reduced reimbursement. This will have an almost immediate and severe impact on the participants who have been able to remain in their homes due to the medical support they receive at their ADHCs. It is estimated that 20-30% of current ADHC participants would be forced into nursing facilities, in anywhere from 30 days to 6 months. Missaelides Decl. ¶ 19; Kauffman Decl. ¶ 9. Due to shortages of SNF beds in certain counties, some participants would be forced into institutions far from their families. Cooper-Puckett Decl. ¶ 10. The individual impacts on disabled individuals and their families will be devastating. La Mar Decl.; Traylor Decl.; Simmons Decl.

There will be impacts for other services as well, in addition to those that could be covered in this brief. For example, Philip Jenkins became totally disabled at age 47 due to a massive stroke (as explained in his wife's moving declaration), and he depends on home health care to remain at home. But now, he has been informed by his home health agency that, due to the Rate Reduction, they will no longer service Medi-Cal patients. See McCurley-Jenkins Decl. Similarly, the children who are either tracheostomy- or ventilator-dependent who are current or future patients at Saratoga Children's Hospital and Children's Recovery Center, two pediatric subacute

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care facilities, will be forced to find intensive care placement in acute hospitals when these two facilities will be forced to close due to the Rate Reduction. Zarcone Decl. ¶¶ 2, 7. This harm will be multiplied by the unavailability of intensive care beds. *Id.* at ¶¶ 7-8.

B. The Rate Reduction Will Force Some Providers Out of Business and Cost People Their Jobs.

Many providers will close if the Rate Reduction is not enjoined. See, e.g., Roache Decl. ¶ 10 (provider of critical pharmacy and life support services in home unable to remain in business); Zarcone Decl. ¶ 7 (closure of two pediatric subacute hospitals); Lumpkin Decl. ¶ 10 (closure of 3 or more pharmacies); Tilley Decl. ¶ 10 (pharmacy closure); see also Cooper-Puckett Decl. ¶¶ 5-10 (potential ADHC closure); Kauffman Decl. ¶¶ 6-8 (same). For the owners of for-profit facilities, this will be the total loss of businesses developed over many years. Other facilities will be overwhelmed by the demand. Lamp Decl. ¶ 10. Several providers will scale back on services, which will eliminate jobs. See Mendoza Decl. ¶¶ 8-10 (rural hospital); Guenther Decl. ¶¶ 6, 8 (rural hospital); Miller Decl. ¶¶ 7-9 (rural hospital); F. Kaufman Decl. ¶ 11 (Center for Diabetes, Endocrinology and Metabolism); Siegel Decl. ¶¶ 8, 10 (Center for Cancer and Blood Diseases). See also Kiff Decl. ¶ 5. Lay offs take on a heightened significance in rural areas because other work is especially difficult to come by. See Mendoza Decl. ¶ 8. Moreover, once some of these qualified individuals go elsewhere, e.g., out of state, they are not likely to return. Siegel Decl. ¶ 8.

In light of the foregoing, the rate reduction threatens to take away the livelihood of many health care providers, as well as many more provider employees. A preliminary injunction is necessary to prevent this irreparable harm.

C. The Rate Reduction Will Cause Irreparable Harm to the Public.

The public fisc will be irreparably injured by spending more on care than would be necessary for care. As discussed above, because the Rate Reduction will reduce access to primary care services and less expensive forms of care, such as ADHCs and pediatric subacute facilities, patients will be forced to utilize more expensive forms of care, such as emergency rooms or nursing homes. And, with seriously ill patients not being able to obtain certain drugs, such as anti-psychotic drugs and anti-convulsants (Schondelmeyer Report, *supra*, at p. vii), there will certainly

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be an increase in admissions to hospital emergency rooms, putting strain on our overtaxed system.

The additional patient care demands that are going to be placed on hospitals due to the rate reduction threaten to rip a gaping hole in California's health care safety net, particularly in Los Angeles County. As mentioned above, hospitals in Los Angeles have been closing at an alarming rate for the last decade. See Lott Decl. ¶ 6; Zaretsky Decl. ¶ 14. The hospitals that remain have difficulties meeting the needs of the communities they service. Lott Decl. ¶¶ 6-10; Fuller Decl. ¶¶ 4-7; Chanez Decl. ¶¶ 6-7; Kozai Decl. ¶¶ 7 – 12. Emergency department wait times have stretched to the point of being untenable at some facilities and inpatient bed availability is sometimes scarce. Lott Decl. ¶¶ 6-10; Fuller Decl. ¶¶ 4-7; Chanez Decl. ¶¶ 6-7; Kozai Decl. ¶¶ 7, 12. Now these already overtaxed hospitals are going to be forced to shoulder more of the burden of caring for Medi-Cal beneficiaries, but will have less resources with which to do it because of the Rate Reduction. Consequently, Los Angeles County is threatened with an imminent full-blown crisis with respect to available health care services.

Also, as discussed above, the non-Medi-Cal public will face irreparable harm by having an increase in the "hidden tax" they are required to pay to compensate for increased underpayments by the Medi-Cal program.

VII. CONCLUSION

For the foregoing reasons, the Court should find that Petitioners have shown that they will likely succeed on the merits of this action and that irreparable harm will likely occur if the ten percent Medi-Cal rate reduction goes forward. Accordingly, the Court should grant Petitioners' request for a preliminary injunction.

DATED: July 1, 2008

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