2003 WL 24891765 (E.D.Cal.) (Trial Pleading)
United States District Court, E.D. California.

CALIFORNIA MEDICAL ASSOCIATION; American Academy of Pediatrics-California District Ix; American College of Obstetricians and Gynecologists-District Ix; California Chapter, American College of Cardiology; California Chapter, American College of Emergency Physicians; California Dental Association; Long Term Care Pharmacy Alliance; California Foundation for Independent Living Centers; California Pharmacists Association; Aids Healthcare Foundation; Professional Pharmacy Alliance of California, Inc.; Brain Injury Policy Institute; Long Term Care Management Council; Osteopathic Physicians and Surgeons of California, Disabled Rights Union, Plaintiffs,

v.

Diana M. BONTA, Director of the Department of Health Services, State of California, Defendant.

No. CIV-S-03-2336 DFL PAN.
November 19, 2003.

First Amended Complaint for Injunctive and Declaratory Relief

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INTRODUCTION

1. By this action, several groups of Medi-Cal providers (physicians, dentists and pharmacists and beneficiaries seek to enjoin a five percent cutback in Medi-Cal rates that was recently mandated by the California Legislature and is scheduled to take effect on January 1, 2004. This decrease in payments will directly affect Medi-Cal beneficiaries, physicians, dentists, pharmacists and many other non-institutional providers of health services. The rate reduction is being imposed on a system already in crisis, wherein inadequate payment levels have resulted in a scarcity of willing providers, creating serious access hurdles for Medi-Cal beneficiaries. A further reduction in rates will result in additional providers withdrawing from the Medi-Cal program and will exacerbate the current access problems, making it more difficult for Medi-Cal beneficiaries to find physicians, dentists, or other health care providers who are willing to treat them or fill their prescriptions.

2. The Medi-Cal rate reduction has been imposed solely due to the state budget deficit projected for the 2003-04 fiscal year and notwithstanding special efforts passed earlier this year by Congress to augment federal matching payments to avoid further Medicaid cutbacks by the states. Such a reduction is illegal, because federal law does not permit Medicaid rate reductions solely based on budgetary constraints. Pursuant to 42 U.S.C. § 1396a(a)(30)(A) ("Section 30(A)"), states must assure that Medicaid payments are consistent with efficiency, economy, and quality of care, which requires the states to consider the costs of providing quality care when setting rates. Further, Section 30(A) requires that payments be sufficient to enlist a sufficient number of providers so that services are available to Medicaid beneficiaries at least to the extent that such medical services are available to the general public, i.e. to assure sufficient access to services for Medicaid beneficiaries. By imposing the five percent rate reduction, California has failed to consider the costs of the services involved or whether the rate reduction will have an impact on the ability of Medi-Cal beneficiaries to have adequate access to services. Further, the rate reduction violates certain other requirements of federal law and regulations (42 C.F.R. §§ 447, *et seq.* and 42 U.S.C. § 1396b(m)(2)(iii)), California law (Welf. & Inst. Code § 14079) and California's Medicaid State Plan. In fact, by its terms, the rate reduction, which allows for rates to be reduced below the rates set in the California Code of Regulations, is an amendment to the State Plan, which may not be implemented prior to federal approval.

3. For these and other reasons, the five percent rate reduction violates federal Medicaid law, which is binding on the State. The imposition of this rate reduction will cause irreparable injury to Plaintiffs, their members and the populations they serve,

both providers and beneficiaries. Causing providers of services to withdraw from the Medi-Cal program because reimbursement levels will fall so far below the costs of providing services, the rate reduction will threaten the health of beneficiaries by interrupting provider/patient relationships and by resulting in the inability of many beneficiaries to obtain necessary health care. Accordingly, Plaintiffs seek a preliminary and permanent injunction to prevent the rate reduction from taking effect.

JURISDICTION

4. This Court has jurisdiction to resolve the important questions of federal Medicaid law involved in this lawsuit pursuant to 28 U.S.C. §§ 1331 and 1343 and may compel Defendant Diana Bonta, Director of the California Department of Health Services (the "Director") to comply with the mandatory provisions of the federal Medicaid law pursuant to 28 U.S.C. § 1361.

VENUE

5. Venue lies in this judicial district under 28 U.S.C. § 1391, in that the Director has offices within this judicial district and is thus deemed to reside within this judicial district.

THE PARTIES

6. Defendant DIANA M. BONTA is the Director of the California Department of Health Services (the "Department"), the single state agency charged with the administration of California's Medicaid program, known as Medi-Cal. See California Welf. & Inst. Code §§ 14000 et seq. Defendant Bonta's office is located in Sacramento, California.

7. Plaintiff CALIFORNIA MEDICAL ASSOCIATION ("CMA") is a nonprofit, incorporated professional association of more than 30,000 physicians practicing in the State of California, with its principal office in Sacramento, California. CMA's membership includes a large number of California physicians who are engaged in the private practice of medicine, in all specialities. CMA's primary purposes are "to promote the science and art of medicine, the care and well-being of patients, the protection of the public health, and the betterment of the medical profession." CMA brings this action in its representative capacity on behalf of its members, many of whom are providers under California's Medi-Cal program and will be directly and adversely affected by the threatened rate reduction, and on behalf of its members' patients.

8. Plaintiff AMERICAN ACADEMY OF PEDIATRICS, CALIFORNIA DISTRICT DC (AAP-CA), is an organized group of over 5,000 board-certified pediatrician members of all four California regional Chapters. AAP-CA's mission is to attain optimal physical, mental and social health and well-being for all infants, children, adolescents and young adults in California. A top priority for the AAP-CA is to assure for all children living in California access to preventive and comprehensive, cost-effective quality health care, including access for those with special health care needs. AAP-CA brings this action in its representative capacity on behalf of its members, many of whom are providers under California's Medi-Cal program and will be directly and adversely affected by the threatened rate reduction, and on behalf of its members' patients.

9. Plaintiff AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, DISTRICTED ("ACOG") was founded in 1951. ACOG is the nation's leading group of professionals providing health care for women. Based in Washington, D.C., it is a private, voluntary, nonprofit membership organization with over 43,000 members. California is represented by ACOG, District DC, which counts in excess of 4,300 obstetrician-gynecologists among its membership. District DC's mission is to protect and improve the health and welfare of all California women and to unite qualified physicians practicing obstetrics and gynecology for the improvement of patient care. ACOG brings this action in its representative capacity on behalf of its members, many of whom are providers under California's Medi-Cal program and will be directly and adversely affected by the threatened rate reduction, and on behalf of its members' patients.

10. Plaintiff CALIFORNIA CHAPTER, AMERICAN COLLEGE OF CARDIOLOGY (CA-ACC) is an organization composed of about 1200 cardiologists practicing in California. CA-ACC contributes to the prevention of cardiovascular

diseases, to ensure optimal quality care for the individuals with such diseases, and to foster the highest professional ethical standards. CA-ACC maintains a high level of involvement with socioeconomic issues, which may influence access to high quality cardiovascular health care for all individuals. CA-ACC brings this action in its representative capacity on behalf of its members, many of whom are providers under California's Medi-Cal program and will be directly and adversely affected by the threatened rate reduction, and on behalf of its members' patients.

11. Plaintiff CALIFORNIA CHAPTER OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS (CAL/ACEP) is an organization composed of over 2000 emergency physicians in California. Membership includes emergency physicians who practice in a wide variety of settings including large and small groups, academic centers, and managed care. CAL/ACEP brings this action in its representative capacity on behalf of its members, many of whom are providers under California's Medi-Cal program and will be directly and adversely affected by the threatened rate reduction, and on behalf of its members' patients.

12. Plaintiff CALIFORNIA DENTAL ASSOCIATION is a nonprofit, professional association representing over 19,000 dentists throughout the state of California. This number reflects over two-thirds of all California licensed dentists. Founded in 1870, CDA is the largest constituent member of the American Dental Association. Through public policy, advocacy, education and other means, CDA has promoted the health of the public, the profession and the individuals it serves for over a century. CDA brings this action in its representative capacity on behalf of its members, many of whom are providers under California's Medi-Cal program and will be directly and adversely affected by the threatened rate reduction, and on behalf of its members' patients.

13. Plaintiff LONG TERM CARE PHARMACY ALLIANCE ("LTCPA") is a national trade association organized as a Delaware Limited Liability Corporation. LTCPA members operate "long-term care" pharmacies dedicated to providing services to residents of nursing facilities, most of whom are Medi-Cal eligible beneficiaries. Unlike retail pharmacies, LTCPA's members operate "closed pharmacies," meaning they are not open to the public and do not provide retail services. The vast majority of prescriptions that LTCPA member pharmacies provide are to nursing facility residents. LTCPA brings this action in its representative capacity on behalf of its members who are providers under California's Medi-Cal program and will be directly and adversely affected by the threatened rate reduction, and on behalf of the Medi-Cal patients served by its members.

14. Plaintiff CALIFORNIA FOUNDATION FOR INDEPENDENT LIVING CENTERS ("CFILC") is a statewide, nonprofit organization made up of more than two dozen Independent Living Centers, which arrange for the provision of needed healthcare services for people with disabilities, most of which is funded by the Medi-Cal program. The CFILC's mission is to support independent living centers in their local communities through advocating for systems change and promoting access and integration for people with disabilities. The threatened Medi-Cal rate reduction will adversely affect the CFILC's ability to coordinate and arrange for needed healthcare services for people with disabilities. The increase in difficulty for persons with disabilities served b) CFLIC and its members will frustrate the ability of CFLIC to carry out its mission and will drain its resources. CFILC and its members will be forced to use its limited resources to pay for, obtain or coordinate medical care, rather than other components of its mission.

15. Plaintiff CALIFORNIA PHARMACISTS ASSOCIATION ("CPA") represents over 5,000 pharmacists in California. It is the largest state professional association of pharmacists in the United States. The mission of the Association is to represent pharmacists in all practice settings in the State, and to advocate the role of pharmacy as an essential venue of care for patients. CPA brings this action in its representative capacity on behalf of its members who are providers under California's Medi-Cal program and will be directly and adversely affected by the threatened rate reduction, and on behalf of the Medi-Cal patients served by its members.

16. Plaintiff AIDS HEALTHCARE FOUNDATION ("AHF") is a California nonprofit corporation. It is the largest private provider of AIDS medical care in California. AHF operates licensed community clinics and pharmacies in Los Angeles, San Bernardino, Alameda, and San Francisco counties, and provides direct medical and pharmacy services to approximately 6,000 Californians with HIV/AIDS. AHF and its physicians are providers under California's Medi-Cal program. AHF also operates a Medi-Cal Primary Care Case Management plan known as Positive Healthcare. AHF and the Medi-Cal beneficiaries it serves will be directly and adversely affected by the threatened rate reduction, and on behalf of its members' patients.

17. Plaintiff PROFESSIONAL PHARMACY ALLIANCE OF CALIFORNIA, INC. ("PPA") is a for-profit corporation owned by 63 independent pharmacists residing in the San Joaquin Valley of California. The PPA is also a clearinghouse for information regarding the practice of pharmacy within the State of California. PPA's members are providers under California's Medi-Cal program. A significant number of pharmacies operated by PPA's members will be adversely affected by the threatened rate reduction and may be forced to close if the 5% Medi-Cal rate reduction is implemented. PPA brings this action in its representative capacity on behalf of its members who are providers under California's Medi-Cal program and will be directly and adversely affected by the threatened rate reduction, and on behalf of the Medi-Cal patients served by its members.

18. Plaintiff BRAIN INJURY POLICY INSTITUTE ("BET') is a nonprofit corporation representing the interests of survivors of traumatic brain injuries (TBI), their families and caregivers for over twenty-two years in California. Currently, the association has a Board of Directors of fifteen individuals and advisers who are assigned to specific subject matter areas for providing information, technical assistance and referrals on head injury prevention plus home and community-based options for residential and day programs. Medi-Cal is the major payment source of the medical service system for the majority of such survivors. BIPI has made an organizational priority taking action to preserve Medi-Cal provider rates and optional benefits on behalf of such survivors. Since survivors of traumatic brain injuries will be adversely affected by the threatened Medi-Cal rate reduction, BIPI will be frustrated in its ability to carry out its programs and mission.

19. Plaintiff LONG TERM CARE MANAGEMENT COUNCIL ("LTCMC") was established in 1992. Its mission, then and now, is to enhance the effectiveness and efficiency of long term pharmaceutical services in a cost effective manner that will have a positive impact upon patient care. LTCMC voting membership is comprised of long term care pharmacy owners, representing a large portion of California's long term care pharmacies. LTCMC brings this action in its representative capacity on behalf of its members who are providers under California's Medi-Cal program and will be directly and adversely affected by the threatened rate reduction, and on behalf of the Medi-Cal patients served by its members.

20. Plaintiff OSTEOPATHIC PHYSICIANS AND SURGEONS OF CALIFORNIA ("OPSC") serves to advance the practice of osteopathic medicine as an independent, scientific, and complete system of medicine for the restoration and preservation of good health. OPSC presents programs of education and information that contribute to the effective professional practice of osteopathic health care, for the benefit of all members of the profession. OPSC brings this action in its representative capacity on behalf of its members who are providers under California's Medi-Cal program and will be directly and adversely affected by the threatened rate reduction, and on behalf of the Medi-Cal patients served by its members.

21. Plaintiff DISABLED RIGHTS UNION ("DRU") is a nonprofit association registered with the State of California and composed of over 400 members. Its membership consists of poor and disabled individuals, many of them eligible for Supplemental Security Income ("SSF') and Medi-Cal. Through its small staff of volunteers, DRU assists its members in obtaining SSI, Medi-Cal, food stamps, and other government benefits. DRU brings this action in its representative capacity on behalf of its members, most of whom are eligible for benefits under the Medi-Cal program and will be directly and adversely affected by the threatened rate reduction.

PLAINTIFFS' STANDING AND RIGHT TO SEEK ENFORCEMENT OF THE LAW

22. As associations representing the interests of beneficiaries and providers of health care services under the Medi-Cal program, Plaintiffs have a right and an enforceable interest to maintain this action against the Director under the Supremacy Clause of the United States Constitution and under the Civil Rights Act, 42 U.S.C. § 1983, to enjoin the Director's continuing violation of the federal Medicaid law and to compel the Director to comply with the provisions of the applicable federal Medicaid law. Moreover, under 28 U.S.C. § 2201, Plaintiffs are entitled to a declaration of their rights under the federal Medicaid law and state law.

FEDERAL MEDICATD LAW

23. Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 et seq., the Medicaid Act, authorizes federal financial support to states for medical assistance 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, with the federal financial participation level currently ranging between 53 to 80 percent. The states, in accordance with federal law, decide eligible beneficiary groups, types and ranges of services, payment level for services, and administrative and operative procedures. Payment for services is made directly by states to the individuals or entities that furnish the services. 42 C.F.R. § 430.0.

24. In order to receive matching federal financial participation, states must agree to comply with the applicable federal Medicaid law and regulations, 42 U.S.C. §§ 1396 et seq.

25. At the state level, the Medicaid program is administered by a single state agency, which is charged with the responsibility of establishing and complying with a state Medicaid plan (the "State Plan") that, in turn, must comply with the provisions of the applicable federal Medicaid law. 42 U.S.C. § 1396a(a)(5) and 42 C.F.R. §§ 430.10 and 431.10. The State 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 to be used to set payment rates for each type of service included in the state Medicaid plan. 42 C.F.R. §§ 430.10 and 447.201(b). Changes to the State Plan may not be implemented by the state prior to being approved by the Secretary.

26. Each State's Medicaid plan must provide that medical assistance will be furnished with reasonable promptness to all eligible individuals. 42 U.S.C § 1396a(a)(8).

27. 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 which may be necessary *... 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 public in the geographic area*___" 42 U.S.C. § 1396a(a)(30)(A), emphasis added.

28. Historically, Medicaid services have generally been provided through fee-for-service plans under which Medicaid recipients obtain medical services from providers of their choice, who then bill the state agency for these services and are reimbursed for said services in accordance with rates set by the states. As an alternative to a state's providing Medicaid services on a fee-for-service basis, federal law permits states to establish contracts with health plans to provide some or all of the medical services covered by the state's Medicaid plan in return for payment determined under a prepaid capitation basis or other risk basis. 42 U.S.C. § 1396b(m). Under such payment arrangements, health plans receive a predetermined periodic payment for each person for whose medical care they are responsible. Federal law required that prepaid payments to health plans under Medicaid be made on an "actuarially sound basis." 42 § 1396b(m)(2)(A)(iii). Further, for Medicaid managed care plans that have been approved subject to a cost-effectiveness and efficiency waiver -applicable to all of California's Medicaid health plans - reimbursement must be consistent with access, quality, and the efficient and economic provision of covered care and services.

29. In a recent effort to forestall further Medicaid cutbacks by the states faced with difficult budget situations, on May 28, 2003, Congress enacted H.R. 2, the Jobs and Growth Tax Relief Reconciliation Act of 2003 (Pub.LNo. 108-27, Sec. 401,117 Stat. 752,764 (2003), which increased the federal government's matching percentage under Medicaid by $10,000,000,000 over 18 months. California's current federal matching percentage is 53 percent.

CALIFORNIA MEDI-CAL PROGRAM

30. The State of California has elected to participate in the Medicaid program. California has named its program "Medi-Cal". See Cal. Welf. & Inst. Code §§ 14000 *et seq.*; 22 Cal. Code of Regs. §§ 50000 *et seq.*

31. In adopting the Medi-Cal program, the California Legislature has stressed that all eligible Medi-Cal beneficiaries receive necessary care and has established a system designed to ensure that physicians and other health care providers will be available to render this care. To achieve this goal of accessible quality health care for the poor, and to remain eligible for the federal Medicaid subsidies, the California Legislature enacted a statutory scheme designed to enhance the Medicaid program's effectiveness. This system includes provisions ensuring that physicians and other health care providers receive

prompt and adequate payment and ensuring that Medi-Cal beneficiaries have reasonable access to physicians and dental services. Further, state law requires that Medi-Cal fee-for-service rates be adopted pursuant to the regulatory process and requires 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. See generally, 42 U.S.C. 1396a(a)(32), 42 C.F.R. § 447.45, Cal. Welf. & Inst. Code §§ 14075,14079,14105.

MEDI-CAL RATES FOR NON-INSTITUTIONAL SERVICES

32. The Department has adopted regulations under California law establishing payment practices for services reimbursable under Medi-Cal. Relevant to this lawsuit are rates for certain non-institutional services, including physician, dental and pharmacy services. Regulations setting forth the payment rates for said services are found at 22 C.C.R. §§ 51503 (physician services); 51506 (dental services); 51506.1 (maxillofacial dental services); 51506.2 (orthodontic dental services); 51513 (pharmaceutical services and prescribed drugs). The dental rates in Sections 51506, 51506.1 and 51506.2 do not accurately reflect the most recent rate change effective August 1, 2000. The current dental rates can be found in the Denti-Cal Schedule of Maximum Dental Allowances in the Denti-Cal Provider Manual at Section 4, Program Policy, regarding "Denti-Cal Schedule of Maximum Dental Allowances." Further, the pharmacy rates in § 51513 are not current, having been subject to numerous statutory changes in the past 8 years that have not been included in the applicable regulations.

33. The methodology the Department must use to determine Medi-Cal rates for non-institutional services is contained in attachment 4.19-B to the State Plan which has been approved by the Secretary. The State Plan provides that reimbursement for non-institutional services "will be at the lesser of usual charges or the limits specified in the California Code of Regulations (CCR) Title 22, Division 3, Chapter 3, Article 7 (commencing with Section 51501) and CCR, Title 17, Chapter 4, Subchapter 13, Sections 6800-6874, for EPSDT health assessment activities."

34. The State Plan further requires the Department, when setting rates, to 1) develop an evidentiary base or rate study resulting in the determination of a proposed rate, 2) present the proposed rate at a public hearing to gather public input, 3) determine the final rate based on the evidentiary base including the pertinent public input, and 4) establish the payment rate through adoption of regulations specifying such rates.

35. In 1982, the California Legislature mandated that Medi-Cal payment rates for most services be reduced by 10%. The rate reductions were not implemented in accordance with the rate setting methodology in the State Plan. Thus, an amendment to the Plan was submitted by the Department and approved by the Secretary which allowed rate adjustments when required by state statute provided the applicable requirements of 42 C.F.R. Part 447 are met.

HISTORY OF REVISIONS TO RATES FOR PHYSICIAN SERVICES

36. Effective August 1, 1985, the Department revised the Medi-Cal payment rates for non-institutional healthcare services. The net effect of this rate change was an increase of 2% over the rates that were in effect prior to the 1982 rate reduction.

37. In January 1987, the Department proposed a 10% decrease in Medi-Cal rates for physicians (except maternity care services), pharmacists, dentists and most other Medi-Cal providers that would be effective for services provided on or after February 1, 1987 through June 30, 1987. This decrease was enjoined as a result of a lawsuit filed in the Eastern District of California by plaintiff California Medical Association and other provider and beneficiary groups and individuals. California Medical Association. *et al., v.* Kizer, Docket No. Civ S 87-0182 LKK. This case resulted in a Consent Decree, dated October 24, 1989, which permanently enjoined the Department from imposing a 10% reduction in reimbursement rates to physicians and other Medi-Cal providers.

38. With the 1987 proposed change enjoined, the 1985 rate changes were, for 15 years, the only changes that the Department made to all of the non-institutional Medi-Cal rates in an "across-the-board" fashion. For a period of 15 years, between 1985 and 2000, the Department modified only a few selected rates for non-institutional services: physician rates for obstetrical care, office exams of children and portable x-ray transportation services.

39. For fiscal year 2000-2001, effective August 1, 2000, the Department granted the first Medi-Cal general across-the-board rate increase in fifteen years for physician and allied health providers. Rather than increase all rates by a uniform percentage, the Department implemented a realignment of rates, with varying increases given for different services. The total amount of the increase was driven by the funds appropriated by the Budget Act of 2000, with the Department determining how to allocate the rate increases among the various services.

40. In spite of the rate increases that were made in 2000-2001, 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. Many other rates were increased by 13.26%. No rates were increased to be more than 80% of the Medicare rates for comparable services, with most well below that level.

41. The Department failed to consider efficiency, economy, quality of care, and patient access in setting rates prior to 1982 and in making each of the rate changes described above. The Department failed to demonstrate a reasonable connection between the factors of efficiency, economy, quality of care, and patient access and the rates it established pursuant to the rate modifications described above.

42. Despite the few rate increases that have been made during the past 21 years, including the large set of increases made effective August 1, 2000, the disparity between the costs of providing physician services and the Medi-Cal payment rates for such services has grown tremendously.

43. Despite the 2000-01 rate increases, nearly half of all physicians in urban counties in California are unwilling to treat Medi-Cal beneficiaries. According to one recent study of Medi-Cal access in urban counties published by the Medi-Cal Policy Institute, an independent source of information on the Medi-Cal program that is funded by the California HealthCare Foundation, only 50% of primary care physicians, 55% of medical specialists and 52% of surgical specialists accepted Medi-Cal patients in their practices.

44. A recent study published by the Medi-Cal Policy Institute determined that the percentage of physicians who are willing to accept new Medi-Cal patients into their practice is low. Among physicians accepting new patients into their practices, only 55% of primary care physicians, 48% of medical specialists and 43% of surgical specialists were willing to accept any Medi-Cal patients.

45. A recent study published by the Medi-Cal Policy Institute shows that physician services are not available to Medi-Cal beneficiaries to the same degree that they are available to the general population. The number of available primary care physicians per capita for Medi-Cal beneficiaries in 2001 was one-third *less* than for the general population. The number of medical specialists available per capita for Medi-Cal beneficiaries in 2001 was one-half *less* than for the general population. The number of surgical specialists available per capita for Medi-Cal beneficiaries in 2001 was two-thirds *less* than for the general population.

46. Overall, the ratio of primary care physicians available for Medi-Cal beneficiaries in 2001 (46 per 100,000) was well below the workforce standards established by the Health Resources Services Administration (which recommends 60 to 80 per 100,000) according to a recent study published by the Medi-Cal Policy Institute.

47. The level of participation by physicians in the Medi-Cal program is significantly lower than the level of participation by physicians in the Medicaid programs of most other states. Despite the rate increases in 2000-01, Medi-Cal rates for physician services still lag significantly behind payment rates of other California payors. Further, Medi-Cal payment rates are low compared to the payment rates for physician services in the Medicaid programs of most other states.

HISTORY OF RATES FOR DENTAL SERVICES

48. In most California counties, the Department contracts with a private insurance company, Delta Dental, to administer the provision of dental services to Medi-Cal beneficiaries. The dental Medi-Cal program is known as “Denti-Cal.”

49. As with other non-institutional rates, dental rates were reduced in 1982. However, unlike other non-institutional rates, dental rates were not increased in 1985. See supra paragraph 34.

50. In 1987, Denti-Cal beneficiaries filed a class action lawsuit against the Department because of alleged federal violations that resulted in a significant access problem. A federal district court held that the Department violated 42 U.S.C. Section 1396a(a)(30)(A), that there was a significant dental services access problem, and that the Department's Denti-Cal rates were insufficient to result in the requisite access under federal law. This decision was affirmed by the Ninth Circuit.

51. In 1992, as a result of the aforementioned class action lawsuit, the Department was forced to increase the rates for 56 of the most common dental procedures. However, in 1993, the Department threatened to eliminate Denti-Cal benefits to all adults; in a negotiated settlement, Denti-Cal rates for the 56 most common procedures were cut by approximately 15 percent in 1994.

52. Until the August 1, 2000 general rate increase mentioned above, dental rates for all services other than the 56 most common procedures remained at 1982 levels. The August 1, 2000 dental rate increase was spread mostly to the less common procedures, since they had been frozen for 18 years. Thus, dental rates for the overwhelming majority of the 56 most common procedures have remained at 1994 levels to this day.

53. In recent years, California legislative committees, the Department of Health Services and provider groups all have had hearings and/or meetings focused on the lack of sufficient access to Denti-Cal services. A study in 2000 published by Center for California Health Workforce of the University of California at San Francisco Center for the Health Professions focused on the availability of Denti-Cal providers throughout Medical Service Study Areas" ("MSSAs") in California. An MSSA is a rational services area used by state agencies such as the Office of Statewide Health Planning and Development ("OSHPD") for the administration of various programs. According to the study, 22 % of MSSAs in California have no active Denti-Cal dentists. Half of the MSSAs in California have fewer than one Denti-Cal dentist for every 1,000 Medi-Cal beneficiaries eligible for Denti-Cal services.

54. Despite the two dental rate increases that have been made during the past 21 years, the disparity between the costs of providing dental services and the Denti-Cal payment rates for such services has grown tremendously.

HISTORY OF REVISIONS TO RATES FOR PHARMACY SERVICES

55. Pursuant to 42 C.F.R. § 447.331, State Medicaid programs must provide reimbursement for drugs by providing payment for two separate items: the estimated acquisition cost of the drug, plus a reasonable dispensing fee. In accordance with federal regulations, California provides reimbursement under its Medi-Cal program under two different methodologies, depending on whether the item is a brand-named drug or a generic drug. Reimbursement for brand-name drugs is equal to average wholesale price ("AWP") (less a specified percentage), plus a dispensing fee. AWP is the price for a drug product or a medical supply listed in certain reference sources used by the Department, as set forth in 22 C.C.R. § 51513(a)(7). Generic drugs are paid subject to two upper-limit price systems: federal upper limit ("FUL") and California maximum allowed ingredient cost ("MAIC")- Pharmacy providers are reimbursed the acquisition price of the generic drug pursuant to the lesser of these fee screens, plus the same dispensing fee paid for brand-name drugs. Some generic drugs, for which an FUL or MAIC limit has not been established, are paid based on AWP.

56. Prior to 1995, brand-name drugs were reimbursed based on the AWP minus five percent (5%), plus a dispensing fee of $4.05. Generic drugs are reimbursed as described above, plus the $4.05 dispensing fee. This dispensing fee applied to both retail pharmacies and long term care (institutional) pharmacies. The rates paid prior to 1995 are still reflected in the most recent version of the applicable regulation, 22 C.C.R. § 51513.

57. In 1995, based on budgetary restraints, California reduced the dispensing fee paid for each prescription by $.50, to $3.55 per prescription, effective January 1, 1995. Calif. Welf. & Inst. Code § 14105.336.

58. In 1999, the California legislature passed legislation increasing the dispensing fee that had been reduced in 1995.

Effective January 1, 2000, the dispensing fee was increased by $.25, to $3.80, for each prescription reimbursed through the Medi-Cal program. Effective July 1, 2002, the reimbursement for each prescription claim was increased by another $.15 per prescription, to $3.95. Calif. Welf. & Inst. Code § 14105.337(a) and (b).

59. This latter increase was short-lived. Effective September 30, 2002, the $.25 and $.15 increases that had been implemented were eliminated, but only as applied to retail pharmacies. Since September 30, 2002, retail pharmacies are entitled to a dispensing fee of $3.55 per prescription, while long term care pharmacies are entitled to dispensing fees of $3.95 per prescription. Calif. Welf. & Inst. Code § 14105.337(c).

60. In addition to the decrease in the dispensing fee, the reimbursement rate for the acquisition cost of drugs was decreased from AWP less 5% to the AWP less 10%, effective September 30, 2002. Calif. Welf. & Inst. Code § 14105.46(b)(2).

61. In June 2002, the Department published a study of Medi-Cal pharmacy reimbursement that had been conducted pursuant to a directive from the California legislature that the Department perform a study of the adequacy of Medi-Cal pharmacy rates, including the cost of providing prescription drugs and services. Calif. Bus. & Prof. Code § 4426. The major component of the study was a survey of pharmacy dispensing costs. Pursuant to this study, it was determined that the average dispensing cost, weighted by Medi-Cal volume, was $7.21 per prescription.

62. Because the dispensing fee paid by Medi-Cal is only about half of the average dispensing cost to pharmacies, pharmacists must recoup this cost from the difference between their purchase price for the drugs and the acquisition cost paid by Medi-Cal. To the extent such a cushion exists for some drugs, any further rate reductions will eliminate this cushion, which allows pharmacists to recoup their costs on some drugs reimbursed through the Medi-Cal program.

63. Increasing the financial pressure on pharmacists already subject to low Medi-Cal rates, since 1999 the California legislature has required that, as a condition of participation in the Medi-Cal program, pharmacies must charge Medicare beneficiaries a price for prescription medications that does not exceed the Medi-Cal reimbursement rate. Calif. Bus. & Prof. Code

§ 4425. Any further decrease in Medi-Cal reimbursement rates to pharmacists will thus also impact rates that can be charged to Medicare beneficiaries, thus multiplying the impact of the rate reduction.

64. Due to the already existing low reimbursement rates for drugs, some retail pharmacists have ceased participating as Medi-Cal providers. The five percent rate reduction will likely result in additional pharmacists withdrawing from Medi-Cal, thus making it more difficult for Medi-Cal beneficiaries to access needed medications.

THE FIVE PERCENT RATE REDUCTION

65. On August 11, 2003, the California Legislature enacted AB1762 for the 2003-2004 budget year. Section 62.5 of said act added Welfare and Institutions Code § 14105.19, which provides, in relevant part, as follows:
(a) Due to the significant state budget deficit projected for the 2003-04 fiscal year, and in order to implement changes in the level of funding for health care services, the Director of Health Services shall reduce provider payments as specified in this section.

(b) (1) Payments shall be reduced by 5 percent for Medi-Cal program services for dates of services on and after January 1, 2004.

(2) Payments shall be reduced by 5 percent for non-Medi-Cal programs described in Section 14105.18, for dates of service on and after January 1, 2004.

(3) The payments made to managed health care plans shall be reduced by the actuarial equivalent amount of 5 percent at the time of the plan's next rate determination.

(e) Notwithstanding Chapter 3.4 (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.

(f) The department shall promptly seek all necessary federal approvals in order to implement this section, including necessary amendments to the state plan.

66. Pursuant to paragraph (b)(l) of Welfare and Institutions Code § 14105.19, payments under the Medi-Cal fee-for-service program for physicians, pharmacists, dentists and other non-institutional providers will be reduced by 5 percent for services provided on or after January 1, 2004.

67. Pursuant to paragraph (b)(3) of Welfare and Institutions Code § 14105.19, the Department has determined the actuarial equivalent of the 5 percent reduction and is informing Medi-Cal managed care plans that their capitation rates will be reduced by this actuarially equivalent percentage upon their contract renewal date. On information and belief, Plaintiffs allege that the actuarially equivalent amount by which managed care capitation rates are being reduced will vary from plan to plan, but is approximately 1.8%. These reductions will be passed down in varying amounts to physicians, dentists, and pharmacists. In many cases, contractual arrangements between managed care plans and physicians and dentists are based on the Medi-Cal fee-for-service rates, so the rates paid by the managed care plans to the physicians and dentists are being reduced by 5%.

68. Prior to enacting or implementing this statute, no studies or other analyses were conducted by the Legislature or by the Department to determine whether the Medi-Cal rates resulting from the five percent reduction would be consistent with efficiency, economy and quality of care or with the costs of providing the services affected by the rate reduction.

69. Prior to enacting or implementing this statute, no studies or other analyses were conducted by the Legislature or the Department to determine what impact the rate reduction would have on the ability of Medi-Cal beneficiaries to have access to health care services to the same degree as the general public in the geographic areas where beneficiaries are located.

FIRST CLAIM

(Violation of 42 U.S.C. § 1396a(a)(8), § 1396a(a)(30)(A), § 1396b(m)(2)(A)(iii) and § 1396n(b))

70. The five percent Medi-Cal fee-for-service rate reduction for physicians, pharmacy, dental and other noninstitutional services, and the actuarially equivalent reduction for Medi-Cal managed care providers of the same services, violate the requirements of 42 U.S.C. § 1396a(a)(30)(A), in that the rate reduction was imposed for purely budgetary reasons, without any consideration as to whether the resulting rates 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 State Plan at least to the extent that such care and services are available to the general public in the geographic area. The 5% rate reduction also violates the terms of 42 U.S.C. § 1396a(a)(8), in that the decrease in available providers that will be a direct result of the rate reduction will cause harmful delays in the ability of Medi-Cal beneficiaries to access services. Further, the rate reduction to managed care plans violates the requirements of 42 U.S.C. § 1396b(m)(2)(A)(iii) that Medicaid managed care notes be actuarially sound, and of § 1396n(b) that reimbursement be consistent with access, quality and efficient and economic provision of covered care and services. In imposing this rate reduction, the Department has not considered the relevant factors to determine whether the requirements of 42 U.S.C. § 1396a(a)(8), 42 U.S.C. § 1396a(a)(30)(A), 42 U.S.C. § 1396b(m)(2)(A)(iii) or 42 U.S.C. § 1396n(b) have been met. The Department has failed to set the rates after relying on responsible cost studies to determine whether the rates have some relationship to the costs of providing services to Medi-Cal beneficiaries, and, to the extent such rates deviate from those determined costs, failed to provide a justification for that deviation. Further, the rates resulting after the five percent rate reduction is imposed will not be consistent with efficiency, economy, and quality of care, nor will the resulting rates be sufficient to enlist enough providers so that care and services are available under the State Plan at least to the extent that such care and services are available to the general public in the geographic area.

SECOND CLAIM

(Violation of 42 C.F.R. §§ 447 et seq.)

71. The five percent Medi-Cal rate reduction for physicians, pharmacy, dental and other noninstitutional services, and the actuarially equivalent reduction for Medi-Cal managed care, violate the requirements of 42 C.F.R. §§ 447 et seq., which are applicable by law and are also specifically made applicable by the State Plan, in that:
a. The reduced rates will not be sufficient to enlist enough providers so that services under the State Plan are available to recipients at least to the extent that those services are available to the general population, in violation of 42 C.F.R. § 447.204.

b. The Department has failed to provide public notice of the reduction in rates and provide an opportunity for public comment, in violation of 42 C.F. R. § 447.205.

THIRD CLAIM

(Violation of State Plan)

72. The five percent Medi-Cal rate reduction for physicians, pharmacy, dental and other noninstitutional services, and the actuarially equivalent reduction for Medi-Cal managed care, violates the requirements of the State Plan in that:
a. The State Plan requires that rates be set at the lesser of usual charges or the limits specified in the California Code of Regulations, but Welfare and Institutions Code § 14105.19 provides for a five percent rate reduction that is to be implemented without any regulatory action. Thus, the resulting rates will not be consistent with rates established in the California Code of Regulations, as required by the State Plan.

b. The State Plan requires the Department to follow certain procedures before setting rates, but the five percent rate reduction is being imposed without regard to these required procedures. The State Plan requires the Department to 1) develop an evidentiary base or rate study resulting in the determination of a proposed rate, 2) present the proposed rate at a public hearing to gather public input, 3) determine the final rate based on the evidentiary base including the pertinent public input, and 4) establish the payment rate through adoption of regulations specifying such rates. None of these procedures have been followed by the Department, and therefore the rates resulting from the five percent reduction are illegal and invalid.

FOURTH CLAIM

(Implementation of State Plan Amendment Prior to Federal Approval)

73. As set forth above, the five percent rate reduction violates the requirements of the State Plan, because the Department is establishing rates that will not be set forth in the California Code of Regulations and because the required procedures for development of a rate study, public hearings and the consideration of public input are not being followed. By adopting rates in this manner, the Department is, in effect, amending the State Plan. However, pursuant to the Medicaid Act and its implementing regulations, including 42 U.S.C. § 1396n(f) and 42 C.F.R. § 430.12(c), amendments to the State Plan may not be implemented prior to federal approval. Since the federal government has not approved the *de facto* amendments to the State Plan, the threatened rate reduction is invalid.

FIFTH CLAIM

(Violation of Consent Decree)

74. The five percent Medi-Cal rate reduction for physicians, pharmacy, dental and other noninstitutional services, and the

actuarially equivalent reduction for Medi-Cal managed care, violates the permanent injunction ordered in California Medical Association, et al. v. Kizer. United States District Court, Eastern District of California, Case No. Civ S 87-0182 LKK.

SIXTH CLAIM

(Violation of Calif. Welf. & Inst. Code § 14079)

75. The five percent Medi-Cal rate reduction for physicians, pharmacy, dental and other noninstitutional services, and the actuarially equivalent reduction for Medi-Cal managed care, violates Calif. Welf. & Inst. Code § 14079, in that the rate reduction was implemented in such a way as to not ensure reasonable access by Medi-Cal beneficiaries to physician and dental services and without consideration of Consumer Price Index increases, reimbursement levels under Medicare and other third party payors, prevailing customary charges and other factors required by the statute to be considered.

DECLARATORY RELIEF

76. An actual and justiciable controversy exists between Plaintiffs and the Defendant regarding the validity of the five percent rate reduction in Medi-Cal payment rates for non-institutional services that is scheduled to take effect on January 1, 2004. Plaintiffs contend that the rate reduction is invalid and unlawful in violation of federal law, federal regulations, State law and the State Plan, while the Defendant contends that the rate reduction is valid in all respects. Accordingly, pursuant to 28 U.S.C. § 2201, Plaintiffs request this Court to declare that the rate reduction is invalid and unlawful.

PRELIMINARY AND PERMANENT INJUNCTIVE RELIEF

77. Unless and until Defendant is enjoined from reducing Medi-Cal rates for noninstitutional services, as set forth in Welfare and Institutions Code § 14105.19, Plaintiffs will be irreparably harmed because of the invalid and illegal reduction in Medi-Cal rates in violation of federal law, federal regulations and the State Plan, in that:
a. Because the reduction in rates will result in a large number of physicians and other non-institutional providers of health care services to either withdraw from or reduce their participation the Medi-Cal program due to the inadequacy of the Medi-Cal rates to meet the costs of providing services, Medi-Cal beneficiaries in need of health care services will have increasing difficulty gaining access to needed services. This will result in delays in the receipt of necessary health care services or the inability of Medi-Cal beneficiaries to receive needed services at all.

b. The relationships between patients and providers will be permanently and irreparably disrupted, because many Medi-Cal beneficiaries will be forced to interrupt current courses of treatment with their providers, as those providers are forced to withdraw from or reduce their participation in the Medi-Cal program due to the decrease in Medi-Cal rates.

c. The reduction in Medi-Cal rates below the levels necessary to be consistent with efficiency, economy and quality of care will make it increasingly difficult for providers who do remain in the Medi-Cal program to provide services consistent with community standards of quality care since they will incur costs in providing those services greater than the applicable Medi-Cal payments, thus endangering the health and well-being of Medi-Cal beneficiaries and the financial solvency of the Medi-Cal providers.

78. No administrative appeal process or other administrative remedy is available to Plaintiffs to challenge the five percent Medi-Cal rate reduction for noninstitutional services.

79. All of the said injuries are great, immediate, and irreparable, for which damages at law are inadequate, and for which plaintiffs have no plain, adequate or speedy relief at law or otherwise.

WHEREFORE, Plaintiffs pray for judgment as follows:

1. For an Order declaring that the Medi-Cal rate reduction imposed by Welfare and Institutions Code § 14105.19 violates the provisions of 42 U.S.C. § 1396a(a)(8), 42 U.S.C. § 1396a(a)(30)(A), 42 U.S.C. § 1396b(m)(2)(A)(iii), 42 U.S.C. § 1396n(b), 42 C.F.R. § § 447, *et seq.*, Calif. Welf. & Inst. Code § 14079, the California State Medi-Cal Plan, and the permanent injunction in California Medical Ass'n. *et al.* v. Kizer. and is therefore illegal and invalid;

2. For an Order declaring that the Medi-Cal rate reduction imposed by Calif. Welf. & Inst. Code § 14105.19 represents a *de facto* amendment to the California State Medi-Cal Plan and, therefore, said rate reduction cannot be imposed without prior federal approval;

3. For an Order declaring that, when setting rates in the future, the Department must rely upon reliable cost studies to determine whether the rates have some relationship to the costs of providing services to Medi-Cal beneficiaries, and, to the extent that rates deviate from such costs, must provide a justification for the deviation;

4. For an Order preliminarily and permanently enjoining Defendant from effectuating the Medi-Cal rate reduction imposed by Welfare and Institutions Code § 14105.19 or reducing to any degree the Medi-Cal rates for noninstitutional services that are affected by Calif. Welf. & Inst. Code § 14105.19;

5. For an Order requiring the Department to perform the annual review of rates mandated by Calif. Welf. & Inst. Code § 14079 in order to ensure reasonable access of Medi-Cal beneficiaries to physician and dental services;

6. For the costs of this suit, including reasonable attorneys' fees incurred by Plaintiffs; and

7. For such other relief as this Court may deem just and proper

DATED: November 19,2003
HOOPER, LUNDY & BOOKMAN, INC.

CRAIG J. CANNIZZO

BYRON J. GROSS

<<signature>>

Craig J. Cannizzo

<<signature>>

Byron J. Gross

Attorneys for Plaintiffs

PROOF OF SERVICE

I declare as follows:

I am employed in the County of San Francisco, State of California. I am over the age of eighteen and not a party to the within action. My business address is First Legal Support Services, 1814 "I" Street, Sacramento, California

On November 19, 2003, I served a true copy of the foregoing document(s) described as **FIRST AMENDED COMPLAINT FOR INJUNCTIVE AND DECLARATORY RELIEF** in this action as follows:

Irene K. Tamura, Esq.

Deputy Attorney General

Office of the Attorney General

P.O. Box 944255

1300 “I” Street

Sacramento, CA 94244

Attorneys in Related Case

Telephone: (916) 322-2587

Fax: (916) 324-5567

SQU **BY MAIL**: By placing a true copy thereof enclosed in a sealed envelope addressed as above, with postage thereon fully prepaid in the United States mail, at San Francisco, California. I am readily familiar with the firm’s practice of collection and processing correspondence for mailing. Under that practice it would be deposited with U.S. Postal service on the same day with postage thereon fully prepaid at San Francisco, California, in the ordinary course of business. I am aware that on motion of the party served, service is presumed invalid if postal cancellation date or postage meter date is more than one day after date of deposit for mailing in affidavit.

SQU **BY OVERNIGHT COURIER**: I caused the above-referenced document(s) to be delivered to_____for delivery to the above address(es).

X BY FAX: I transmitted a copy of the foregoing document(s) this date via telecopier to the facsimile numbers shown above.

SQU BY **PERSONAL SERVICE**: I caused such envelope to be delivered by hand to the offices of the addressee(s).

SQU [State] I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

X [Federal] I declare under penalty of perjury that I am employed by the office of a member of the bar of this Court, at whose direction this service was made.

Executed on November 19, 2003, at San Francisco, California.

First Legal Support Services