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IN THE UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

WESTERN DIVISION

INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, a nonprofit corporation; GRAY PANTHERS OF SACRAMENTO, a nonprofit corporation; GRAY PANTHERS OF SAN FRANCISCO, a nonprofit corporation; GERALD SHAPIRO, Pharm.D. doing business as Uptown Pharmacy and Gift Shoppe; SHARON STEEN, doing business as Central Pharmacy; MARK BECKWITH; and MARGARET DOWLING, TRAN PHARMACY, INC., AND JASON YOUNG,

Petitioners,

v.

SANDRA SHEWRY, Director of the Department of Health Care Services, State of California; CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES,

Respondents.

Case No. CV08-03315 CAS (MANx)

(Los Angeles Superior Court Case No. BS114459)

RESPONDENTS' NOTICE OF REMOVAL OF ACTION UNDER 42 U.S.C. § 1441(b)

TO THE CLERK OF THE ABOVE-ENTITLED COURT:

PLEASE TAKE NOTICE that Respondents Sandra Shewry, Director of the California Department of Health Care Services, and the California Department of Health Care Services, hereby remove to this Court the state court action described below:

1. On April 22, 2008, Petitioners filed a Verified Petition for Writ of Mandamus in the Superior Court of California, in and for the County of Los Angeles, entitled "Independent Living Center of Southern California, a nonprofit corporation; Gray Panthers of Sacramento, a nonprofit corporation; Gray Panthers of San Francisco, a nonprofit corporation; Gerald Shapiro, Pharm.D. doing business as Uptown Pharmacy and Gift Shoppe; Sharon Steen, doing business as Central Pharmacy; Mark Beckwith; and Margaret Dowling, Petitioners, vs. Sandra Shewry, Director of the Department of Health Care Services, State of California; California Department of Health Care Services, Respondents" as case number BS114459.

2. In their Verified Petition for Writ of Mandamus, Petitioners, who are health care advocates and Medi-Cal providers and recipients, seek to enjoin Respondents from implementing a 10% reduction in Medi-Cal payments to Medi-Cal providers. Petitioners allege that the proposed reduction, which is planned to go into effect on July 1, 2008, violates the Medicaid Act, namely 42 U.S.C. § 1396a subd. (a)(30)(a), the Americans with Disabilities Act of 1990, and the Social Security Act, among other things.

3. Respondents Sandra Shewry, Director of the California Department of Health Care Services, and the California Department of Health Care Services were served with copies of the Verified Petition for Writ of Mandamus on April 22, 2008.

4. On May 12, 2008, Petitioners filed a Verified First Amended Petition for Writ of Mandamus and a Memorandum in Support of Writ of Mandamus,

or in the Alternative, For Permanent or Preliminary Injunction. The Amended Petition added Petitioners Tran Pharmacy, Inc. and Jason Young. Respondents were served on May 12, 2008 with the Verified First Amended Petition for Writ of Mandamus and the Memorandum in Support of Writ of Mandamus, or in the Alternative, For Permanent or Preliminary Injunction. Petitioners again allege that Respondents violated the Medicaid Act, namely 42 U.S.C. § 1396a subd. (a)(30)(a), the Americans with Disabilities Act of 1990, and the Social Security Act, among other things.

5. On or around May 15, 2008, Petitioners filed an Ex Parte Application for Alternative Writ of Mandamus under California Code of Civil Procedure section 1085 to immediately enjoin Respondents from implementing the 10% reduction in Medi-Cal payments to Medi-Cal providers. The hearing on this application is set for May 20, 2008 at 8:30 a.m. at the Los Angeles Superior Court before the Honorable James C. Chalfant in Department 85.

6. Under 28 U.S.C. § 1331, this civil action is within the original jurisdiction of this Court. Respondents may remove this case to this Court under 28 U.S.C. § 1441(b) because Plaintiff alleges that Respondents violated federal laws, namely the Medicaid Act, the Americans with Disabilities Act, and the Social Security Act.

7. Under 28 U.S.C. § 1446(a), attached are true and correct copies of the state-court file in this case, as served on Respondents:

a. Exhibit A: Verified Petition for Writ of Mandamus.

b. Exhibit B: Civil Case Cover Sheet.

c. Exhibit C: Civil Case Cover Sheet Addendum and Statement of Location.

d. Exhibit D: Verified First Amended Petition for Writ of Mandamus.

e. Exhibit E: Petitioners' Memorandum in Support of Writ of Mandamus, or in the Alternative, For Permanent or Preliminary Injunction.

f. Exhibit F: Petitioners' Notice of Ex Parte Application and Ex Parte Application for Alternative Writ of Mandamus Under § 1085 Cal. Code of Civil Procedure with supporting documentation

Dated: May 19, 2008

Respectfully submitted,

EDMUND G. BROWN JR.
Attorney General of the State of California
RICHARD T. WALDOW
Supervising Deputy Attorney General
JENNIFER M. KIM
Supervising Deputy Attorney General
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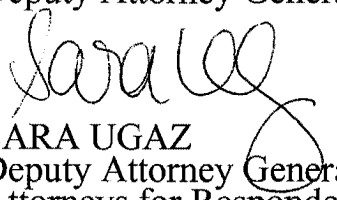

SARA UGAZ
Deputy Attorney General
Attorneys for Respondents Sandra Shewry, Director of the California Department of Health Care Services, and the California Department of Health Care Services

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-CA DOJ/LA B&T HEW SECTION-

***** UF-8000 v2 ********** -9TH FLOOR NORTH - ***** - 2138972672- *********

EDMUND G. BROWN JR.
Attorney General

State of California
DEPARTMENT OF JUSTICE

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DATE: May 19, 2008 **TIME:** 1:24 PM **NO. OF PAGES:** 5
(Including Fax Cover Sheet)

TO:

NAME: **Lynn S. Carman**
OFFICE: Medicare Defense Fund
LOCATION: 28 Newport Landing Drive
FAX NO.: (415) 499-1687 PHONE NO.:

FROM:

NAME: **Jin S. Nam, Legal Secretary** to SARA UGAZ, Deputy Attorney General
OFFICE:
LOCATION: **Los Angeles**
FAX NO.: **(213) 897-2805** PHONE NO.: **(213) 897-2461**

MESSAGE/INSTRUCTIONS

Re: Independent Living Ctr. of So. Cal., et al. v. DHCS; USDC Case No. TBD

Please see attached document:

RESPONDENTS' NOTICE OF REMOVAL OF ACTION UNDER 42 U.S.C. § 1441(b) w/out Exhibits

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UNITED STATES DISTRICT COURT, CENTRAL DISTRICT OF CALIFORNIA
CIVIL COVER SHEET

AFTER COMPLETING THE FRONT SIDE OF FORM CV-71, COMPLETE THE INFORMATION REQUESTED BELOW.

VIII(b). RELATED CASES: Have any cases been previously filed that are related to the present case? ☑ No ☐ Yes

If yes, list case number(s): _____

Civil cases are deemed related if a previously filed case and the present case:

(Check all boxes that apply) ☐ A. Arise from the same or closely related transactions, happenings, or events; or
☐ B. Call for determination of the same or substantially related or similar questions of law and fact; or
☐ C. For other reasons would entail substantial duplication of labor if heard by different judges; or
☐ D. Involve the same patent, trademark or copyright, and one of the factors identified above in a, b or c also is present.

IX. VENUE: List the California County, or State if other than California, in which **EACH** named plaintiff resides (Use an additional sheet if necessary)
☐ Check here if the U.S. government, its agencies or employees is a named plaintiff.
Petitioners Independent Living Center of Southern California, Inc., Gerald Shapiro d/b/a "Uptown Pharmacy & Gift Shoppe," and Sharon Steen d/b/a "Central Pharmacy" are located in Los Angeles County. Petitioner Gray Panthers of San Francisco is located in San Francisco County. Petitioner Gray Panthers of Sacramento is located in Sacramento County. Petitioner Tran Pharmacy, Inc., is located in Orange County. Petitioners Mark Beckwith, Margaret Dowling, and Jason Young's counties of residence are not alleged in the Petition.

List the California County, or State if other than California, in which **EACH** named defendant resides. (Use an additional sheet if necessary).
☐ Check here if the U.S. government, its agencies or employees is a named defendant.
Respondents Sandra Shewry and the California Department of Health Care Services are located in Sacramento County, but have offices in Los Angeles County.

List the California County, or State if other than California, in which **EACH** claim arose. (Use an additional sheet if necessary)
Note: In land condemnation cases, use the location of the tract of land involved.
The Petition was filed in Los Angeles County Superior Court.

X. SIGNATURE OF ATTORNEY (OR PRO PER): Sara Uy **Date** 5/19/08

Notice to Counsel/Parties: The CV-71 (JS-44) Civil Cover Sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law. This form, approved by the Judicial Conference of the United States in September 1974, is required pursuant to Local Rule 3-1 is not filed but is used by the Clerk of the Court for the purpose of statistics, venue and initiating the civil docket sheet. (For more detailed instructions, see separate instructions sheet.)

Key to Statistical codes relating to Social Security Cases:

Nature of Suit Code	Abbreviation	Substantive Statement of Cause of Action
861	HIA	All claims for health insurance benefits (Medicare) under Title 18, Part A, of the Social Security Act, as amended. Also, include claims by hospitals, skilled nursing facilities, etc., for certification as providers of services under the program. (42 U.S.C. 1935FF(b))
862	BL	All claims for "Black Lung" benefits under Title 4, Part B, of the Federal Coal Mine Health and Safety Act of 1969. (30 U.S.C. 923)
863	DIWC	All claims filed by insured workers for disability insurance benefits under Title 2 of the Social Security Act, as amended; plus all claims filed for child's insurance benefits based on disability. (42 U.S.C. 405(g))
863	DIWW	All claims filed for widows or widowers insurance benefits based on disability under Title 2 of the Social Security Act, as amended. (42 U.S.C. 405(g))
864	SSID	All claims for supplemental security income payments based upon disability filed under Title 16 of the Social Security Act, as amended.
865	RSI	All claims for retirement (old age) and survivors benefits under Title 2 of the Social Security Act, as amended. (42 U.S.C. (g))

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-CA DOJ/LA B&T HEW SECTION-

***** UF-8000 v2 ********** -9TH FLOOR NORTH - ***** - 2138972672- *********

EDMUND G. BROWN JR.
Attorney General

State of California
DEPARTMENT OF JUSTICE

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DATE: May 19, 2008 **TIME:** 1:25 PM **NO. OF PAGES:** 3 (Including Fax Cover Sheet)

TO:

NAME: **Lynn S. Carman**
OFFICE: Medicare Defense Fund
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FROM:

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OFFICE:
LOCATION: **Los Angeles**
FAX NO.: **(213) 897-2805** PHONE NO.: **(213) 897-2461**

MESSAGE/INSTRUCTIONS

Re: Independent Living Ctr. of So. Cal., et al. v. DHCS; USDC Case No. TBD

Please see attached document:

RESPONDENTS' NOTICE OF INTERESTED PARTIES

*Hard copies sent via Overnight Delivery

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EXHIBIT - A

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Attorneys for Petitioners Independent Living Center of Southern California. Inc.; Gray Panthers of Sacramento; The Gray Panthers of San Francisco; Gerald Shapiro, Pharm.D., dba Uptown Pharmacy & Gift Shoppe; Sharon Steen, dba Central Pharmacy; Mark Beckwith; Margaret Dowling; Tran Pharmacy, dba Tran Pharmacy; and Jason Young

SUPERIOR COURT OF THE STATE OF CALIFORNIA

IN AND FOR THE COUNTY OF LOS ANGELES, UNLIMITED JURISDICTION

INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC., a nonprofit corporation; GRAY PANTHERS OF SACRAMENTO, a nonprofit corporation; THE GRAY PANTHERS OF SAN FRANCISCO, a nonprofit corporation; GERALD SHAPIRO, Pharm.D., doing business as Uptown Pharmacy and Gift Shoppe; SHARON STEEN, doing business as Central Pharmacy; MARK BECKWITH; and MARGARET DOWLING; TRAN PHARMACY, INC., a corporation, doing business s Tran Pharmacy; and JASON YOUNG,

Petitioners,

-vs.-

SANDRA SHEWRY, Director of Department of Health Care Services of the State of California; DEPARTMENT OF HEALTH CARE SERVICES, a department of the State of California; and DOES 1 through 50,

Respondents. /

No. BS 114459

Date: June 5, 2008
Time: 9:30 a.m.
Dept.: 85
Judge: Hon. James C. Calfant

PETITIONERS' MEMORANDUM IN SUPPORT OF WRIT OF MANDAMUS, OR IN THE ALTERNATIVE, FOR PERMANENT OR PRELIMINARY INJUNCTION

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PETITIONERS' MEMORANDUM IN SUPPORT OF WRIT OF MANDAMUS, OR IN THE ALTERNATIVE, PERMANENT INJUNCTION

Petitioners ("plaintiffs") Margaret Dowling; Mark Beckwith; Gerald Shapiro, Pharm.D., dba Uptown Pharmacy and Gift Shoppe; Sharon Steen, dba Central Pharmacy; Tran Pharmacy, Inc, dba Tran Pharmacy; the Independent Living Center of Southern California, Inc.; and The Gray Panthers of San Francisco, ("San Francisco Gray Panthers"), -- file this Memorandum in support of their motion for peremptory writ of mandamus, or in the alternative, a permanent or preliminary injunction, **in the First Cause of Action only**, to restrain the respondents Department of Health Services and its Director, Sandra Shewry, as set forth below.[1]

--ooOOoo–

This is a Supremacy Clause preemption case.[2]

The movant petitioners are:

-- two Medi-Cal recipients who are in Medi-Cal fee-for-service;'
-- three pharmacies who are providers in Medi-Cal fee-for-service;[3]
-- an independent living center whose disabled clients are Medi-Cal fee-for-service;[4]

---

[1] The petitioners Gray Panthers of Sacramento, and Jason Young, are not moving parties in this within motion.

[2] The Supremacy Clause (article VI, cl. 2 of U.S. Constitution) provides:

"This Constitution, and the laws of the United States which shall be made in pursuance thereof, . . . shall be the supreme law of the land; and the judges of every state shall be bound thereby, anything in the Constitution or laws of any State to the contrary, notwithstanding."

[3] Gerald Shapiro, Pharm.D., owner of Uptown Pharmacy in Los Angeles; Sharon Steen, copartner in a copartnership which owns Central Pharmacy in Santa Monica; Tran Pharmacy, Inc., owner of Tran Pharmacy, Inc,, in Garden Grove.

[4] Independent Living Center of Southern California, Inc., ("ILCSCal"), who annually assists and advocates for 7,500 disabled persons, who are mostly SSI recipients who receive their health care from Medi-Cal fee-for-service.

-- the San Francisco Gray Panthers which has several members in Medi-Cal fee-for-service.

They seek peremptory writ of mandamus under § 1085 Code Civ. Proc. (or in the alternative, a permanent or preliminary injunction), in the First Cause of Action only, to order the California Department of Health Care Services ("DHCS") and Sandra Shewry, its Director, to set aside their policy to implement, and to refrain from implementing a 10% across-the-board cut in reimbursement paid by the Medi-Cal program to providers in the Medi-Cal fee-for-services program, for dates of service on and after July 1, 2008; -- all, as provided in subds. (a), (b)(1), (b)(2), and (c) - (e) of § 14105.19 Welf. & Inst. Code; and § 14166.245 Welf. & Inst. Code, -- which were part of Sections 14 and 15 Assembly Bill X3 5, which was enacted Feb. 16, 2008.[5]

Movants shall refer to these provisions, (subds. (a), (b)(1), (b)(2), and (c) - (e) of § 14105.19 Welf. & Inst. Code; and § 14166.245 Welf. & Inst. Code), collectively, as the "FFS Payment Statutes."[6]

However, the FFS Payment Statutes violate the below federal statutes, so as to be preempted, -- due to the Supremacy Clause, -- by the below preempting federal statutes; namely:

- the "quality of care" clause of subd. (a)(30)(A) of 42 U.S.C. § 1396a, -- herein, "Sec.

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[5] Assembly Bill X3 5 was chaptered as Chapter 3, Statutes of 2007-2008 Third Extraordinary Session.

[6] A copy of Sections 14 and 15 of Assembly Bill X3 5, which contain the FFS Payment Statutes -- (namely, subds. (a), (b)(1), (b)(2), and (c) - (e) of § 14105.19 Welf. & Inst. Code; and § 14166.245 Welf. & Inst. Code) -- is attached as **Exhibit A** to this brief.

Petitioners have requested judicial notice of the FFS Payment Statutes, in **Paragraph A** of Petitioners' Request for Judicial Notice in Support of Petition for Writ of Mandamus and Other Relief, ("**RJN**"), filed herewith.

30(A);[7] and,

- the "equal access" clause of Sec. 30(A),[8]

and, as the inevitable result, (1) each of the two movant Medi-Cal recipients, (Dowling and Beckwith), the pharmacy plaintiffs, the plaintiff Southern California Independent Living Center, Inc. ("ILCSoCal"), and the plaintiff Gray Panthers of San Francisco ("Gray Panthers"), as well as (2) the patients, clients, and members of the plaintiff pharmacies, ILCSCal, and Gray Panthers (who are their prudential *jus tertii* representatives), as well as millions of other Medi-Cal beneficiaries receiving health care in the Medi-Cal fee-for-service program, will be injured or put at risk of injury by implementation of the 10% provider payment cuts to Medi-Cal fee-for-service providers, under the federally preempted FFS Payment Statute; -- all as set forth later in this brief, and, in their declarations filed herewith.

See, generally, Ex Parte Young, 209 U.S. 123 (1908).

DISCUSSION

The FFS Payment Statutes of Assembly Bill 3X 5 were enacted by a legislative history replete with gubernatorial and legislative declarations which identify the bill as a pure budget

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[7] The "quality of care" clause of Sec. 30(A) provides in relevant part:

> "(a) A state plan for medical assistance must– (30)(A) provide such methods and procedures relating to 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 . . . "

[8] The "equal access" clause of Sec. 30(A) provides in relevant part:

> "(a) A state plan for medical assistance must– (30)(A) provide such methods and procedures relating to the . . . payment for, care and services available under the the plan . . . as may be necessary . . . to assure that payments . . . 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."

reducing measure, not, any measure in respect to which the Legislature, the Lord forbid, might engage in any inquiry or consideration of whether the 10% reduced payments would be sufficient to assure that payments are consistent with quality of care, and with beneficiary equal access to quality care, as absolutely required by Sec. 30(A).

LEGISLATIVE HISTORY OF ASSEMBLY BILL X3 5

1. On January 10, 2008, the Governor proclaimed a State fiscal emergency, sent a proposed 2008-09 budget bill to the Legislature, and called the Legislature into special session.[9] [10]

2. On February 4, 7, and 15, 2008, Assembly Bill X3 5, a health budget trailer bill was introduced, then amended to include the FFS Payment Statutes in Sections 14 and 15, and was enacted on February 16, 2008.[11] [12]

3. A copy of the FFS Payment Statutes of Assembly Bill X3 5 is set forth in **Exhibit A** attached to this Memorandum; and is also set forth as **Exhibit A** of petitioners' RJN.

4. When Assembly Bill X3 5 was scheduled for final vote, the Assembly Floor Analysis of the Assembly Budget Committee informed legislators that the Governor's original proposal to commence the 10% Medi-Cal provider cut in June 2008, was postponed, in Assembly Bill X3 5, to commence in July 2008. The analysis explained:

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[9] Governor's website, Jan. 10, 2008. (A download copy is set forth in **Exhibit F** of RJN.)

[10] A copy of the Governor's fiscal emergency proclamation is set forth in **Exhibit B** of Petitioner's Request for Judicial Notice in Support of Writ of Mandamus and Other Relief, ("RJN").
A copy of the Governor's special session proclamation is set forth in **Exhibit C** of RJN.

[11] Bill Documents of Assembly Bill 3X 5, set forth in **Exhibit D** of RJN.

[12] Bill Documents, (**Exhibit D** of RJN).

> "The primary purpose of the delay of the reduction until the start of the new fiscal year is to **allow time for further review** of provider rates during the regular budget process to **identify any particularly critical consequences** of the reduction and to **evaluate** the possibility of **using a more refined approach** to mitigate those consequences while still achieving savings." (Boldface emphasis supplied.)[13]

As, in Alice in Wonderland, *sentence first, verdict afterwards*. Thus, in the rush to cut provider rates 10%, the Legislature here articulated its conscious and deliberate purpose to postpone and refrain from considering, before the bill was enacted, the effect of the 10% payment cut and whether the cut was consistent with quality of care and beneficiary access to quality care.

(But, this violated Sec. 30(A), which requires that a State consider all factors which relate to whether a proposed Medicaid rate is consistent with quality and with recipient access, **before** a new rate is promulgated. *See*, Orthopaedic Hospital v. Belshe, 103 F.3d 1491, 1500 (9th Cir.1997), which is a very strong case on this point.[14])

5. The Legislature, within the four corners of Assembly Bill X3 5 itself, also repeatedly articulated that the Legislature's purpose in the bill was to reduce the State budget.

6. Thus, Sec. 14 of Assembly Bill X3 5 added § 14105.19 to the Welf. & Inst. Code, to provide:

> "(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." (Emphasis supplied.)

This is an admission by the Legislature that the **purpose** of the 10% Medi-Cal provider cut in Section 14 of Assembly Bill X3 5, was to **implement the Governor's budget reductions** in the fiscal 2008-09 budget bill, (not, to consider whether the cuts would affect quality of services or beneficiary access to quality services).

---

[13] Page 1 of Assembly Floor Analysis for Third Reading. (**Exhibit E** of RJN.)

[14] This point will be later more fully addressed.

7. Then, Section 15 of Assembly Bill X3 5, -- which imposes the 10% cut in Medi-Cal payments to non-contract hospitals, -- added §14105.245, subd. (a) to Welf. & Inst. Code, to expressly provide

> "(a) The Legislature finds and declares that the state faces a fiscal crisis that requires unprecedented measures to be taken to reduce General Fund expenditure to avoid reducing vital government services necessary for the protection of the health, safety, and welfare of the citizens of the State of California." (Emphasis supplied.)[15]

8. Also, Sec. 16 of Assembly Bill X3 5 expressly provides:

> "SEC. 16. This act addresses the fiscal emergency declared by the Governor by proclamation on January 10, 2008, pursuant to subdivision (f) of Section 10 of Article IV of the California Constitution." (Emphasis supplied.)[16]

9. And, Section 17 of Assembly Bill X3 5 expressly provides:

> "SEC. 17. . . . In order to make statutory changes needed to implement cost containment measures affecting health services, at the earliest possible time, it is necessary that this act take effect immediately." (Emphasis supplied.)[17]

Comment and ultimate factual finding

It is manifest from the legislative history that the **conclusive factor** in enacting the FFS Payment Statutes, in Sections 14 and 15 of Assembly Bill X3 5, complained of, was not whether the Legislature could assure that the new rates were consistent with quality and access, --- as required by Sec. 30(a), -- but, rather, were solely **budgetary considerations.**

---

[15] Section 15 of Assembly Bill X3 5 is set forth in **Exhibit A** attached to this brief, and, in **Exhibit A** of petitioners' RJN.

[16] Section 16 of Assembly Bill X3 5 is set forth in **Exhibit A** attached to this brief, and, in **Exhibit A** of petitioners' RJN.

[17] Section 15 of Assembly Bill X3 5 is set forth in **Exhibit A** attached to this brief, and, in **Exhibit A** of petitioners' RJN.

Ultimate finding of fact, conclusion of law, and relief to be issued

From the above legislative history of Assembly Bill X3 5, including:

- the Assembly Budget Committee told Assembly members in February 2008 that they should first pass the cuts now, then take time, only later, to determine the effect of their action;

- the four declarations in Sections 14, 15, 16, and 17 of Assembly Bill X3 5, that, essentially, the Legislature was enacting these provisions for budgetary reasons, only, because of the need to cut State expenditures; and,

- the context which surrounds the bill, namely, that the 10% rate cut was enacted within 37 days from the Governor's proclamation that the State's economic sky was falling, and that an unprecedented budget shortfall required the Legislature to drastically reduce State spending, it follows that the Legislature, in enacting the 10% Medi-Cal cut in payments to fee-for-service providers in and by the FFS Payment Statutes, -- (i.e., subds. (a), (b)(1), (b)(2), and (c) - (e) of § 14105.19 Welf. & Inst. Code; and § 14166.245 Welf. & Inst. Code, which are part of Sections 14 ands 15 of Assembly Bill X3 5), -- (1) did so solely for budgetary reasons; (2) without consideration of the factors necessary to be considered to determine if the proposed new rates were consistent with quality of care and access to services; and, that (3) the conclusive factor in the decision of the Legislature to make these cuts was budgetary considerations.

Hence, such action of the Legislature to promulgate the FFS Payment Statutes of Assembly Bill X3 5, -- as well as the respondent DHCS and the Director's policy and action to implement these measures, -- were and are arbitrary and capricious, and contrary to law; namely,

in violation of the aforesaid quality and access clauses of Sec. 30(A); so as to be thereby preempted, under the Supremacy Clause, by Sec. 30(A).

Hence, an appropriate peremptory writ of mandamus (or in the alternative, a permanent injunction), or at the very least, a preliminary injunction must be issued before July 1, 2008, to order DHCS and its Director (1) to set aside their policy to implement the 10% payment cut of the FFS Payment Statutes of Assembly Bill X3 5, and (2) to refrain from implementing the same.

FURTHER DISCUSSION

1. **Courts, in reviewing the setting of Sec. 30(A) rates, use the "arbitrary and capricious" standard of review. Thus, if the State fails to adequately consider provider costs or any other factor which bears on whether the rates are consistent with quality and access, the rate is void *ab* initio; indeed, without any necessity for the plaintiff to show that it is likely that the new rates will negatively impact quality care or beneficiaries' access to quality care.**

The case at bar is *deja vu* all over again.

In 2003 the Legislature enacted a prior bill to cut all Medi-Cal provider and managed care payments 5% across-the-board for budgetary reasons; and declared in the bill, -- just as in case at bar, -- that it was enacted due to a budget shortfall, to implement reduction in funding for health services.

In Clayworth v. Bonta, 295 F.Supp.2d 1110, 1126-1130 (E.D.Cal.2003), preliminary injunction issued to enjoin the 5% rate cut in the Medi-Cal fee-for-service program, on the basis that because budgetary considerations were the conclusive factor in enacting the cut, that the action of the State to reduce Medicaid rates was arbitrary and capricious, in violation of the requirement of Sec. 30(A) that a Medicaid rate setter must consider quality and access in setting

the rate.[18]

The District Court in Clayworth concluded that the State's purpose in enacting the 5% cut "was to reduce the budget shortfall," noting that "the statute declares on its face that the rate reduction is '[d]ue to the significant state budget deficit projected for the year," (*id.*, 295 F.Supp. at 1128), and held that:

> "Budget constraints are not alone a valid justification for rate setting. *See*, Ark. Med. Soc'y., 6 F3d at 531 ('Abundant persuasive precedent supports the proposition that budgetary considerations cannot be the conclusive factor in decisions regarding Medicaid,'); Orthopaedic Hosp., 103 F.3d at 1499, n.3;[19] Amisub, 879 F.2 at 800-01."[20]

In analyzing Sec. 30(A) the District Court in Clayworth relied on Orthopaedic Hospital v. Belshe, 103 F.3d 1491, 1496-1497, 1500. The District Court noted that Orthopaedic Hosp. 103 F.3d at 1500, held that under the quality clause of Sec. 30(A) that there must be a reasonable relationship between the rates set and providers' costs to provide quality care. (Clayworth, 295 F.Supp. at 1126.)

Further, this rule is procedural, (Clayworth, 103 F.3d at 1127): if the State does not consider providers' costs, or cuts rates without any evidence that the cut can be sustained by

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[18] **Note:** The order for preliminary injunction in Clayworth was reversed in the 9th Circuit, in a one-sentence order filed August 2, 2005, stating that the Sanchez v. Johnson, 416 F.3d 1051 (9th Cir.2005), holding that Congress did not intend, in 42 U.S.C. § 1983, to create any private right of action in Medicaid beneficiaries or providers, compelled reversal of the Clayworth preliminary injunction. (Copy of the 9th Circuit order is set forth in **Exhibit G** of RJN.)

In sum, the 9th Circuit reversal of the Clayworth preliminary injunction did not overrule or relate to any of the District Court's ruling in Clayworth, *supra,* other than the single (erroneous) order of the District Court, to wit, that § 1983 afforded jurisdiction to the federal courts to entertain challenges by Medicaid beneficiaries and providers to California's compliance with Sec. 30(A), -- which § 1983 issue is irrelevant to any issue raised by plaintiffs in the case at bar.

[19] Arkansas Medical Society, Inc. v. Reynolds, 6 F.3d 519 (8th Cir.19983).

[20] Amisub (PSL), Inc. v. Colorado Dept. of Soc. Ser., 879 F.2d 789 (10th Cir.1989).

providers, in light of their costs, without a loss of quality or equal access for Medi-Cal recipients, (*see*, Clayworth, 295 F.Supp. at 1128), then the rate is held to be "arbitrary and capricious," contrary to Sec. 30(A), and hence void, without more. -- i.e., **without any necessity for the plaintiff to show** that the rate is too low to enable providers to furnish quality services, or, that insufficient providers will continue in the program. (Orthopaedic Hosp., 103 F.3d at 1500; Clayworth, 295 F/Supp.2d at 1127.)

The basis for enjoining a Medicaid rate set arbitrarily and capriciously, without consideration of provider costs or without consideration of quality or access at all, is that:

> "(I)t is safe to assume that a rate that is set arbitrarily, without reference to the Sec. 30(A) requirements, is unlikely to meet the equal access and quality requirements. Thus, a beneficiary plaintiff may insist that the State, at a minimum, consider the effect of a rate reduction on qual access to quality services in light of provider costs." Clayworth, 295 F.Supp.2d at 1127, citing Orthopaedic Hosp., 103 F.3d at 1500.

Conclusion

One would have to believe in the tooth fairy, to believe on this legislative record that the Legislature, -- in enacting the 10% provider rate, -- considered whether the reduced payments are consistent with quality of services and access to quality services, or considered whether the reduced payment amounts bear a reasonable relation to provider costs, (as required Sec. 30(A) under the rulings of Orthopaedic Hosp., 103 F.3d at 1500, and Clayworth, 295 F.Supp. at 1117, fn.6).

2. **The Supremacy Clause has always been a shield against State action, (1) which threatens to injure Medicaid beneficiaries and providers, and (2) is preempted, under the Supremacy Clause, by contrary provisions of the Medicaid Act, such as, especially, Sec. 30(A).**

In Wisconsin Hospital Assn. v. Reivitz, 735 F.2d 1226, 1227 (7th Cir.), a hospital association and several hospitals had standing to sue to enforce Sec. 30(A), under the Supremacy

Clause.

In Harmony Nursing Homes, Inc. v. Anderson. 341 F. Supp. 957, 958 (D.Minn.1972), a nursing home had standing to sue under the Supremacy Clause to restrain a state's"freeze" on Medicaid payments to providers.

Also, the three pharmacy plaintiffs, the plaintiff ILCSCAL, and the plaintiff San Francisco Gray Panthers have just as much or more a right, under the Supremacy Clause, to sue to obtain a protective injunction, for themselves and the benefit of their Medi-Cal patients, clients, or members, against the **federally preempted** 10% Medi-Cal provider cut, (due to its violation of Sec. 30(A)), as did the pharmaceutical manufacturers association in Pharmaceutical Research and Manufacturers of America (PhRMA) v. Concannon, (249 F.3d 66 (1st Cir.2001) to sue to enjoin state action, in violation of the Medicaid Act, injuring the manufacturers and the Medicaid patients whom they prudentially represented.

In PhRMA, a pharmaceutical manufacturers association, -- not one of whose members had any professional relationship with Medicaid beneficiaries,-- was readily afforded prudential standing to sue under the Supremacy Clause to pre-empt a state statute enacted in violation of the Medicaid Act.

I.e., all that is necessary to be a plaintiff in a Supremacy Clause claim, (Article VI, cl. 2, Constitution), is a showing that the interests of the plaintiff are within the zone of interests arguably to be protected by the federal statute. Thus PhRMA held, (249 F.3d 66, 72-74 (1st Cir. 2001):

> "The initial question is whether PhRMA has prudential standing to challenge the prior authorization provision of the Act. . . . The Supreme Court recently reiterated the standard for determining prudential standing:
>
> > In applying the 'zone of interests" test, we do not ask whether, in enacting the

> statutory provision at issue, Congress specifically intended to benefit the plaintiff. Instead, we first discern the interests 'arguably . . . to be protected' by the statutory provision at issue; we then inquire whether the plaintiff's interests affected by the agency action in question are among them.

(National Credit Union Adm. v. First National Bank & Trust Co., 522 U.S. 479, 492 (1998).

. . .

> PhRMA has not asserted an action to enforce rights under the Medicaid statute, . . . but rather a preemption-based challenge under the Supremacy Clause. In this type of action, it is the interests protected by the Supremacy Clause, not by the preempting statute, that are at issue. [Citation.] As the Third Circuit recently pointed out, an entity does not need prudential standing to invoke the protection of the Supremacy Clause:
>
> > We know of no governing authority to the effect that the federal statutory provision which allegedly preempts enforcement of local legislation by conflict must confer a right on the party that argues in favor of preemption. On the contrary, a state or territorial law can be unenforceable as preempted by federal law even when the federal law secures no substantive right for the party arguing preemption.
>
> Id. Thus, regardless of whether the Medicaid statute's relevant provisions were designed to benefit PhRMA, PhRMA can invoke the statute's preemptive force. . . . Given that PhRMA has prudential standing grounded in the Supremacy Clause, we think it may fairly assert the rights of Medicaid recipients for purposes of this action. Where a party has established a concrete injury in fact, and otherwise has standing to challenge the lawfulness of the statute, it is 'entitled to assert those concomitant rights of third parties that would be "diluted or adversely affected" should [its] constitutional challenge fail and the statute remain in force. . . . " (Emphasis supplied.)

Conclusion on sub-point: It follows form this unbroken line of cases on the Supremacy Clause, that Medicaid providers as well as beneficiaries are within the "zone of interests" intended to be protected, by Congress, in enacting the Medicaid Act; especially, Sec. 30(A).

Thus both Medicaid beneficiaries and providers may sue, as in case at bar, to protect against injury from state action which violates, and is hence preempted, under the Supremacy Clause, by the Medicaid Act, (here, Sec. 30(A)).

Accordingly, the two Medi-Cal beneficiaries (Dowling and Beckwith) who obtain their

Medi-Cal services in the Medi-Cal fee-for-service program, plus, the three Medi-Cal fee-for-service pharmacy plaintiffs, (the Uptown, Central, and Tran pharmacies), are manifestly entitled, under Supremacy Clause decisional law, to a writ of mandamus or injunction, **in the First Cause of Action**, to enjoin the respondents from injuring them by implementing the 10% cut in payments to Medi-Cal fee-for-service providers, under the FFS Payment Statutes, (namely, subds. (a), (b)(1), (b)(2), and (c) - (e) of § 14105.19 Welf. & Inst. Code; and § 14166.245 Welf. & Inst. Code), enacted as part of Sections 14 and 15 of the Assembly Bill X3 5, which violate the quality and access provisions of Sec. 30(A), -- i.e., , 42 U.S.C.. § 1396a(a)(30)(A).

FURTHER DISCUSSION OF STANDING TO SUE, AND INJURY

3. **Next. The plaintiffs each sue, as authorized by Green v. Obledo, 29 Cal.3d 126 (1981), on their own behalf and on behalf of the public, to procure performance of public duty by public officials; hence, need not show they have any legal or special interest in the result.**

It is sufficient, held Green, *supra*, that the plaintiff "is interested as a citizen in having the laws executed and the duty in question enforce." (29 Cal.3d at 144-145.)

Thus each of the movant plaintiffs, -- who are citizens and residents of the State of California as shown by their declarations, -- may sue in this case to enforce the public duty of the respondent State officials to comply with the public duty, -- pursuant to the Supremacy Clause, -- to obey federal law where, as in case at bar, Sec. 30(A) preempts contrary state law, (here, the 10% Medi-Cal provider rate cut promulgated by subds. (a), (b)(1), (b)(2), and (c) - (e) of § 14105.19 Welf. & Inst. Code; and § 14166.245 Welf. & Inst. Code, (which are part of Sections 14 and 15 of the Assembly Bill X3 5 ("**Exhibit A** attached).

4. **Clayworth, 295 F.Supp.2d at 1117-1119, ruled that providers and beneficiary associations have prudential standing to assert the interests of their patients or members. Under the view of these rulings, the plaintiff pharmacies, the ILCSCal, and the San Francisco Gray Panthers may, on a prudential basis, assert the interests of their patients, clients, or members (as the case may be), in the within proceeding.**

The interest of Medi-Cal beneficiaries, -- who are patients, clients, or members of the two pharmacy plaintiffs, the ILCSCal, and the San Francisco Gray Panthers, -- is the interest of not being injured from implementation of the 10% cut in payments to Medi-Cal provider in the Medi-Cal fee-for-serve program, in violation of the federally pre-empted FFS Payment Statutes, (namely, the aforesaid subds. (a), (b)(1), (b)(2), and (c) - (e) of § 14105.19 Welf. & Inst. Code; and § 14166.245 Welf. & Inst. Code, -- (which provisions are part of Sections 14 and 15 Assembly Bill X3 5, in **Exhibit A** attached).

As shown by the declarations of the CEO of the ILCSCal, and the co-chief of the San Francisco Gray Panthers, filed herein, each of these beneficial or member organizations meet the tests described by Clayworth, 295 F.Supp/2d at 1117-1119, for having prudential standing to assert the rights of their clients or members who are Medi-Cal beneficiaries, in the case at bar.

Injury

Also, plaintiffs have introduced evidence of a severe shortage of dentists and of doctors and specialists, which will be exacerbated by this newest 10% payment cut to fee-for-service providers. Also, the declarations of the two movant Medi-Cal beneficiaries, -- Beckwith and Dowling, the former a quadriplegic who requires oxygen and 8 attendants daily to stay alive, and the latter a paraplegic with diagnosis of terminal rectal cancer, -- show they will be injured, and are at severe risk for injury, pain and suffering, and of being forced into institutions, and of even death, -- (as are thousands like them), -- from loss of their doctors and specialists, and access to

quality medical and pharmacy services, which will certainly occur if the 10% payment cut to Medi-Cal fee-for-service patients, is not enjoined by a writ or injunction, which is requested..

Summary, and relief requested:

Petitioners request that the Court, based on the above Memorandum of facts and law, and the facts of prospective severe injury to Medi-Cal fee-for-service recipients, (including the plaintiffs Dowling and Beckwith), which are shown by the supporting declarations, order:

A. That a writ of mandamus be issued **in the First Cause of Action** under § 1085 Code Civ. Proc., or in the alternative, a permanent injunction, (or at the very least, a preliminary injunction), which orders the respondents Department of Health Care Services, and its Director to set aside their policy to implement the FFS Payment Statutes,(namely, subds. (a), (b)(1), (b)(2), and (c) - (e) of § 14105.19 Welf. & Inst. Code; and § 14166.245 Welf. & Inst. Code), which are part of Sections 14 and 15 of Assembly Bill X3 5, (Chapter 3, Statutes 2007-2008 Third Extraordinary Session), and to refrain from implementing the 10% reduction of payments to Medi-Cal fee-for-service providers specified in the aforesaid FFS Payment Statutes, or any other reduction of payments to providers in the Medi-Cal fee-for-service program, for dates of service on or after July 1, 2008, or at any other time..

B. That petitioners have costs of suit, plus reasonable attorneys' fees under § 1021.5 Code Civ. Proc, and such other and further relief as may be just.

Dated: May 12, 2008.

Respectfully submitted,

LYNN S. CARMAN
STANLEY L. FRIEDMAN

By _____
Attorneys for Petitioners

Exhibit A

Assembly Bill No. 5

CHAPTER 3

An act to amend Section 95004 of the Government Code, and to amend Sections 4640.6, 4643, 4648.4, 4681.3, 4681.5, 4691.6, 4781.6, and 4783 of, and to add Sections 4681.6, 4689.8, 4691.9, 14041.1, 14105.19, and 14166.245 to, the Welfare and Institutions Code, relating to health, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor February 16, 2008. Filed with Secretary of State February 16, 2008.]

LEGISLATIVE COUNSEL'S DIGEST

AB 5, Committee on Budget. Public health programs.

Under existing law, the State Department of Developmental Services provides funding for regional centers for the provision or purchase of services and supports to persons with developmental disabilities. Existing law prescribes a specified ratio for regional center service coordinator to consumer, which is in effect until June 30, 2008.

This bill would extend indefinitely the effective date of this ratio.

Existing law provides for the assessment of certain individuals for whom benefits are provided by regional centers. Existing law provides that if assessment is needed, prior to July 1, 2008, the assessment shall be performed within 120 days following initial intake, and requires that assessments after that date shall be performed within 60 days following intake.

This bill would extend indefinitely the 120-day assessment requirement.

Existing law, with certain exceptions, for the 2007–08 fiscal year, prohibits a regional center from paying any provider of specified services a rate that is greater than the rate that is in effect on July 1, 2007, unless the increase is required by contract between the regional center and the vendor that is in effect on June 30, 2007.

This bill would extend indefinitely this prohibition with respect to the payment of rates in excess of those in effect on June 30, 2008.

Existing law provides that, during the 2007–08 fiscal year, no regional center may approve any service level for a residential service provider.

This bill would extend indefinitely this provision. It would also prohibit, commencing July 1, 2008, a regional center from negotiating rates with residential care providers, except as prescribed.

Existing law requires the State Department of Developmental Services to make payments to providers of supported living services for adults with developmental disabilities. Under existing law, the department, by July 1, 2002, is required to establish, by regulation, an equitable and cost-effective

methodology for the determination of supported living costs and a methodology of payment for these providers.

This bill would, commencing July 1, 2008, impose prescribed rate increase restrictions on reimbursement to these service providers and would also prohibit a regional center from negotiating rates with these providers, except as prescribed.

Existing law prohibits, during the 2007–08 fiscal year, the State Department of Developmental Services from establishing any permanent payment rate for a community-based day program or in-home respite care agency that has a temporary payment rate in effect on July 1, 2007, or from making other specified changes or adjustments that would result in a rate increase.

This bill would extend indefinitely this provision, and would apply it to rates in effect June 30, 2008. It would also prohibit a regional center from negotiating rates with these providers, except as prescribed.

Existing law provides that, for the 2007–08 fiscal year only, a regional center shall not expend any purchase of service funds for the startup of any new program unless the expenditure is necessary to protect the consumer's health or safety or because of other extraordinary circumstances and the department has granted prior written authorization.

This bill would extend indefinitely this prohibition.

Under existing law, the California Early Start Intervention Services Act, various state entities provide coordinated services to infants and toddlers with disabilities and their families. Existing law requires early intervention services to be provided directly to eligible infants and toddlers and their families through the regional center system and the local education system. Existing law requires that, in providing services under the act, regional centers comply with the Lanterman Developmental Disabilities Services Act, and its implementing regulations, including, but not limited to, those provisions relating to vendorization and ratesetting, except where compliance with those provisions would result in any delays in, or any cost to families for, the provision of early intervention, or otherwise conflict with the act or its implementing regulations. Existing law, until July 1, 2009, also contains family cost participation requirements for specified services obtained by regional centers for persons with developmental disabilities.

This bill would extend indefinitely the family cost participation requirements, and would also require that, subject to federal approval, in providing those early intervention services under the Lanterman Developmental Disabilities Services Act, regional centers apply the family cost participation requirements that require families of children receiving early intervention services to contribute a specified amount to the cost of those services based on family size and scaled income levels. It would also revise the family cost participation schedule and the procedures governing how a parent may appeal a decision made by the executive director of a regional center, with respect to the amount of the parents' cost participation.

Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services, under which qualified low-income persons are provided with a variety of health services.

Existing law contains various provisions governing reimbursement rates for Medi-Cal providers.

This bill would, notwithstanding any other provision of law, and to the extent not otherwise conflicting with federal law, authorize the department to withhold, or direct the medical fiscal intermediary to withhold, payments for providers, as described, for a period of one month for a month ending prior to January 1, 2009.

Existing law creates various health programs, including the Child Health and Disability Prevention Program, the California Children's Services Program, the Genetically Handicapped Person's Program, and specified family planning programs.

This bill would, with certain exceptions, for services rendered under these programs on and after July 1, 2008, require the Director of Health Care Services to reduce provider reimbursement rates by 10%.

The bill would specify that the reductions imposed pursuant to the bill would apply only to the General Fund share of the payment, and only to payments for services from funds appropriated to the department.

Existing law establishes the Medi-Cal Hospital/Uninsured Care Demonstration Project Act, which revises hospital reimbursement methodologies under the Medi-Cal program in order to maximize the use of federal funds consistent with federal Medicaid law and stabilize the distribution of funding for hospitals that provide care to Medi-Cal beneficiaries and uninsured patients. This demonstration project provides for funding, in supplementation of Medi-Cal reimbursement, to various hospitals, including designated public hospitals, nondesignated public hospitals, and private hospitals, as defined in accordance with certain provisions relating to disproportionate share hospitals.

This bill would reduce by 10% payments for inpatient hospital services to acute care hospitals not under selective contracts with the department that are provided on and after July 1, 2008.

The California Constitution authorizes the Governor to declare a fiscal emergency and to call the Legislature into special session for that purpose. The Governor issued a proclamation declaring a fiscal emergency, and calling a special session for this purpose, on January 10, 2008.

This bill would state that it addresses the fiscal emergency declared by the Governor by proclamation issued on January 10, 2008, pursuant to the California Constitution.

This bill would declare that it is to take effect immediately as an urgency statute.

compliance for these implementing regulations shall be filed within 24 months following the adoption of the first emergency regulations filed pursuant to this subdivision.

(n) By April 1, 2005, and annually thereafter, the department shall report to the appropriate fiscal and policy committees of the Legislature on the status of the implementation of the Family Cost Participation Program established under this section. On and after April 1, 2006, the report shall contain all of the following:

(1) The annual total purchase of services savings attributable to the program per regional center.

(2) The annual costs to the department and each regional center to administer the program.

(3) The number of families assessed a cost participation per regional center.

(4) The number of cost participation adjustments granted pursuant to paragraph (5) of subdivision (g) per regional center.

(5) The number of appeals filed pursuant to subdivision (k) and the number of those appeals granted, modified, or denied.

SEC. 13. Section 14041.1 is added to the Welfare and Institutions Code, to read:

14041.1. (a) Notwithstanding any other provision of law, and to the extent not otherwise conflicting with federal law, the department may hold for a period of one month, or direct the medical fiscal intermediary for the Medi-Cal program to hold for a period of one month, payments to providers or their designated agents for health care services that are provided pursuant to this chapter, and payments to entities that contract with the department pursuant to this chapter, Chapter 8 (commencing with Section 14200) and Chapter 8.75 (commencing with Section 14590) for the delivery of health care services.

(b) The authority described in subdivision (a) shall be limited to payments for one month only, and only for a month ending prior to January 1, 2009.

SEC. 14. Section 14105.19 is added to the Welfare and Institutions Code, to read:

14105.19. (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 and after July 1, 2008.

(2) Except as provided in subdivision (c), payments shall be reduced by 10 percent for non-Medi-Cal programs described in Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, and Section 14105.18, for dates of service on and after July 1, 2008.

(3) For managed health care plans that contract with the department pursuant to this chapter, Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14590), payments shall be reduced

by the actuarial equivalent amount of the payment reduction specified in this subdivision pursuant to contract amendments or change orders effective on July 1, 2008.

(c) The services listed in this subdivision shall be exempt from the payment reductions specified in subdivision (b):

(1) Acute hospital inpatient services, except for payments to hospitals not under contract with the State Department of Health Care Services, as provided in Section 14166.245.

(2) Federally qualified health center services, including those facilities deemed to have federally qualified health center status pursuant to a waiver under subdivision (a) of Section 1315 of Title 42 of the United States Code.

(3) Rural health clinic services.

(4) All of the following facilities:

(A) A skilled nursing facility pursuant to subdivision (c) of Section 1250 of the Health and Safety Code, except a skilled nursing facility that is a distinct part of a general acute care hospital. For purposes of this paragraph, "distinct part" has the same meaning as defined in Section 72041 of Title 22 of the California Code of Regulations.

(B) An intermediate care facility for the developmentally disabled pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code, or a facility providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14495.10.

(C) A subacute care unit, as defined in Section 51215.5 of Title 22 of the California Code of Regulations.

(5) Payments to facilities owned or operated by the State Department of Mental Health or the State Department of Developmental Services.

(6) Hospice.

(7) Contract services as designated by the director pursuant to subdivision (e).

(8) Payments to providers to the extent that the payments are funded by means of a certified public expenditure or an intergovernmental transfer pursuant to Section 433.51 of Title 42 of the Code of Federal Regulations.

(9) Services pursuant to local assistance contracts and interagency agreements to the extent the funding is not included in the funds appropriated to the department in the annual Budget Act.

(10) Payments to Medi-Cal managed care plans pursuant to Section 4474.5 for services to consumers transitioning from Agnews Developmental Center into Alameda, San Mateo, and Santa Clara Counties pursuant to the Plan for the Closure of Agnews Developmental Center.

(11) Breast and cervical cancer treatment provided pursuant to Section 14007.71.

(12) The Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program pursuant to Section 14105.18.

(d) Subject to the exception for services listed in subdivision (c), the payment reductions required by subdivision (b) shall apply to the services rendered by any provider who may be authorized to bill for the service,

(e) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the director may implement subdivision (b) by means of a provider bulletin, or other similar instruction, without taking regulatory action.

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

SEC. 16. This act addresses the fiscal emergency declared by the Governor by proclamation on January 10, 2008, pursuant to subdivision (f) of Section 10 of Article IV of the California Constitution.

SEC. 17. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make statutory changes needed to implement cost containment measures affecting health services, at the earliest possible time, it is necessary that this act take effect immediately.

O

EXHIBIT - B

CM-010

ATTORNEY OR PARTY WITHOUT ATTORNEY (Name, State Bar number, and address):
LYNN S CARMAN SB028660
28 IXECOURT LANDING DR.
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ATTORNEY FOR (Name):

FOR COURT USE ONLY

CONFORMED COPY
OF ORIGINAL FILED
Los Angeles Superior Court

APR 22 2008

John A. Clarke, Executive Officer/Clerk
By D.M. SWAIN Deputy

SUPERIOR COURT OF CALIFORNIA, COUNTY OF LOS ANGELES
STREET ADDRESS:
MAILING ADDRESS:
CITY AND ZIP CODE:
BRANCH NAME: CENTRAL

CASE NAME: INDEPENDENT LIVING CENTER OF SO. CAL et al v. SANDRA SHEWRY et al

CASE NUMBER: BS114459

JUDGE:

DEPT:

CIVIL CASE COVER SHEET

☒ **Unlimited** (Amount demanded exceeds $25,000) ☐ **Limited** (Amount demanded is $25,000 or less)

Complex Case Designation

☐ **Counter** ☐ **Joinder**

Filed with first appearance by defendant (Cal. Rules of Court, rule 3.402)

Items 1–6 below must be completed (see instructions on page 2).

1. Check **one** box below for the case type that best describes this case:

Auto Tort
- ☐ Auto (22)
- ☐ Uninsured motorist (46)

Other PI/PD/WD (Personal Injury/Property Damage/Wrongful Death) Tort
- ☐ Asbestos (04)
- ☐ Product liability (24)
- ☐ Medical malpractice (45)
- ☐ Other PI/PD/WD (23)

Non-PI/PD/WD (Other) Tort
- ☐ Business tort/unfair business practice (07)
- ☒ Civil rights (08)
- ☐ Defamation (13)
- ☐ Fraud (16)
- ☐ Intellectual property (19)
- ☐ Professional negligence (25)
- ☐ Other non-PI/PD/WD tort (35)

Employment
- ☐ Wrongful termination (36)
- ☐ Other employment (15)

Contract
- ☐ Breach of contract/warranty (06)
- ☐ Rule 3.740 collections (09)
- ☐ Other collections (09)
- ☐ Insurance coverage (18)
- ☐ Other contract (37)

Real Property
- ☐ Eminent domain/Inverse condemnation (14)
- ☐ Wrongful eviction (33)
- ☐ Other real property (26)

Unlawful Detainer
- ☐ Commercial (31)
- ☐ Residential (32)
- ☐ Drugs (38)

Judicial Review
- ☐ Asset forfeiture (05)
- ☐ Petition re: arbitration award (11)
- ☐ Writ of mandate (02)
- ☐ Other judicial review (39)

Provisionally Complex Civil Litigation (Cal. Rules of Court, rules 3.400–3.403)
- ☐ Antitrust/Trade regulation (03)
- ☐ Construction defect (10)
- ☐ Mass tort (40)
- ☐ Securities litigation (28)
- ☐ Environmental/Toxic tort (30)
- ☐ Insurance coverage claims arising from the above listed provisionally complex case types (41)

Enforcement of Judgment
- ☐ Enforcement of judgment (20)

Miscellaneous Civil Complaint
- ☐ RICO (27)
- ☐ Other complaint *(not specified above)* (42)

Miscellaneous Civil Petition
- ☐ Partnership and corporate governance (21)
- ☐ Other petition *(not specified above)* (43)

2. This case ☐ is ☒ is not complex under rule 3.400 of the California Rules of Court. If the case is complex, mark the factors requiring exceptional judicial management:
   a. ☐ Large number of separately represented parties
   b. ☐ Extensive motion practice raising difficult or novel issues that will be time-consuming to resolve
   c. ☐ Substantial amount of documentary evidence
   d. ☐ Large number of witnesses
   e. ☐ Coordination with related actions pending in one or more courts in other counties, states, or countries, or in a federal court
   f. ☐ Substantial postjudgment judicial supervision
3. Remedies sought *(check all that apply)*: a. ☐ monetary b. ☒ nonmonetary; declaratory or injunctive relief c. ☐ punitive
4. Number of causes of action *(specify)*:
5. This case ☐ is ☒ is not a class action suit.
6. If there are any known related cases, file and serve a notice of related case. *(You may use form CM-015.)*

Date: 4/22/08

(TYPE OR PRINT NAME)

(SIGNATURE OF PARTY OR ATTORNEY FOR PARTY)

NOTICE

- Plaintiff must file this cover sheet with the first paper filed in the action or proceeding (except small claims cases or cases filed under the Probate Code, Family Code, or Welfare and Institutions Code). (Cal. Rules of Court, rule 3.220.) Failure to file may result in sanctions.
- File this cover sheet in addition to any cover sheet required by local court rule.
- If this case is complex under rule 3.400 et seq. of the California Rules of Court, you must serve a copy of this cover sheet on **all** other parties to the action or proceeding.
- Unless this is a collections case under rule 3.740 or a complex case, this cover sheet will be used for statistical purposes only.

EXHIBIT - C

SHORT TITLE: Independent Living Center of Southern California et al v. Sandra Shewry, et. al. | CASE NUMBER BS114459

CIVIL CASE COVER SHEET ADDENDUM AND STATEMENT OF LOCATION (CERTIFICATE OF GROUNDS FOR ASSIGNMENT TO COURTHOUSE LOCATION)

This form is required pursuant to LASC Local Rule 2.0 in all new civil case filings in the Los Angeles Superior Court.

Item I. Check the types of hearing and fill in the estimated length of hearing expected for this case:

JURY TRIAL? ☐ YES CLASS ACTION? ☐ YES LIMITED CASE? ☐ YES TIME ESTIMATED FOR TRIAL 3 ☐ HOURS/ ☒ DAYS

Item II. Select the correct district and courthouse location (4 steps – If you checked "Limited Case", skip to Item III, Pg. 4):

Step 1: After first completing the Civil Case Cover Sheet Form, find the main civil case cover sheet heading for your case in the left margin below, and, to the right in Column **A**, the Civil Case Cover Sheet case type you selected.

Step 2: Check **one** Superior Court type of action in Column **B** below which best describes the nature of this case.

Step 3: In Column **C**, circle the reason for the court location choice that applies to the type of action you have checked. For any exception to the court location, see Los Angeles Superior Court Local Rule 2.0.

Applicable Reasons for Choosing Courthouse Location (see Column C below)

1. Class Actions must be filed in the Stanley Mosk Courthouse, Central District.
2. May be filed in Central (Other county, or no Bodily Injury/Property Damage).
3. Location where cause of action arose.
4. Location where bodily injury, death or damage occurred.
5. Location where performance required or defendant resides.
6. Location of property or permanently garaged vehicle.
7. Location where petitioner resides.
8. Location wherein defendant/respondent functions wholly.
9. Location where one or more of the parties reside.
10. Location of Labor Commissioner Office.

Step 4: Fill in the information requested on page 4 in Item III; complete Item IV. Sign the declaration.

	A Civil Case Cover Sheet Category No.	B Type of Action (Check only one)	C Applicable Reasons - See Step 3 Above
Auto Tort	Auto (22)	☐ A7100 Motor Vehicle - Personal Injury/Property Damage/Wrongful Death	1., 2., 4.
	Uninsured Motorist (46)	☐ A7110 Personal Injury/Property Damage/Wrongful Death – Uninsured Motorist	1., 2., 4.
Other Personal Injury/Property Damage/Wrongful Death Tort	Asbestos (04)	☐ A6070 Asbestos Property Damage	2.
		☐ A7221 Asbestos - Personal Injury/Wrongful Death	2.
	Product Liability (24)	☐ A7260 Product Liability (not asbestos or toxic/environmental)	1., 2., 3., 4., 8.
	Medical Malpractice (45)	☐ A7210 Medical Malpractice - Physicians & Surgeons	1., 2., 4.
		☐ A7240 Other Professional Health Care Malpractice	1., 2., 4.
	Other Personal Injury Property Damage Wrongful Death (23)	☐ A7250 Premises Liability (e.g., slip and fall)	1., 2., 4.
		☐ A7230 Intentional Bodily Injury/Property Damage/Wrongful Death (e.g., assault, vandalism, etc.)	1., 2., 4.
		☐ A7270 Intentional Infliction of Emotional Distress	1., 2., 3.
		☐ A7220 Other Personal Injury/Property Damage/Wrongful Death	1., 2., 4.
Non-Personal Injury/Property	Business Tort (07)	☐ A6029 Other Commercial/Business Tort (not fraud/breach of contract)	1., 2., 3.
	Civil Rights (08)	☒ A6005 Civil Rights/Discrimination	1., 2., 3.
	Defamation (13)	☐ A6010 Defamation (slander/libel)	1., 2., 3.
	Fraud (16)	☐ A6013 Fraud (no contract)	1., 2., 3.

SHORT TITLE: Independent Living Center of Southern California, et al. v. Sandra Shewry et al	CASE NUMBER

	A Civil Case Cover Sheet Category No.	B Type of Action (Check only one)	C Applicable Reasons - See Step 3 Above
Judicial Review (Cont'd.)	Writ of Mandate (02)	☐ A6151 Writ - Administrative Mandamus ☐ A6152 Writ - Mandamus on Limited Court Case Matter ☐ A6153 Writ - Other Limited Court Case Review	2., 8. 2. 2.
	Other Judicial Review (39)	☐ A6150 Other Writ /Judicial Review	2., 8.
Provisionally Complex Litigation	Antitrust/Trade Regulation (03)	☐ A6003 Antitrust/Trade Regulation	1., 2., 8.
	Construction Defect (10)	☐ A6007 Construction defect	1., 2., 3.
	Claims Involving Mass Tort (40)	☐ A6006 Claims Involving Mass Tort	1., 2., 8.
	Securities Litigation (28)	☐ A6035 Securities Litigation Case	1., 2., 8.
	Toxic Tort Environmental (30)	☐ A6036 Toxic Tort/Environmental	1., 2., 3., 8.
	Insurance Coverage Claims from Complex Case (41)	☐ A6014 Insurance Coverage/Subrogation (complex case only)	1., 2., 5., 8.
Enforcement of Judgment	Enforcement of Judgment (20)	☐ A6141 Sister State Judgment ☐ A6160 Abstract of Judgment ☐ A6107 Confession of Judgment (non-domestic relations) ☐ A6140 Administrative Agency Award (not unpaid taxes) ☐ A6114 Petition/Certificate for Entry of Judgment on Unpaid Tax ☐ A6112 Other Enforcement of Judgment Case	2., 9. 2., 6. 2., 9. 2., 8. 2., 8. 2., 8., 9.
Miscellaneous Civil Complaints	RICO (27)	☐ A6033 Racketeering (RICO) Case	1., 2., 8.
	Other Complaints (Not Specified Above) (42)	☐ A6030 Declaratory Relief Only ☐ A6040 Injunctive Relief Only (not domestic/harassment) ☐ A6011 Other Commercial Complaint Case (non-tort/non-complex) ☐ A6000 Other Civil Complaint (non-tort/non-complex)	1., 2., 8. 2., 8. 1., 2., 8. 1., 2., 8.
	Partnership Corporation Governance(21)	☐ A6113 Partnership and Corporate Governance Case	2., 8.
Miscellaneous Civil Petitions	Other Petitions (Not Specified Above) (43)	☐ A6121 Civil Harassment ☐ A6123 Workplace Harassment ☐ A6124 Elder/Dependent Adult Abuse Case ☐ A6190 Election Contest ☐ A6110 Petition for Change of Name ☐ A6170 Petition for Relief from Late Claim Law ☐ A6100 Other Civil Petition	2., 3., 9. 2., 3., 9. 2., 3., 9. 2. 2., 7. 2., 3., 4., 8. 2., 9.

EXHIBIT - D

S. Alexander
5/12/08
16:48

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Attorneys for Petitioners Independent Living Center of Southern California; Gray Panthers of Sacramento; Gray Panthers of San Francisco; Gerald Shapiro, Pharm.D., dba Uptown Pharmacy & Gift Shoppe; Sharon Steen, dba Central Pharmacy; Mark Beckwith; Margaret Dowling; Tran Pharmacy, Inc. dba Tran Pharmacy; and Jason Young

To the person served - You are hereby served as person necessary to be served to effect service upon each of the respondents Department of Health Care Services, and Sandra Shewry, Director of the Department

SUPERIOR COURT OF THE STATE OF CALIFORNIA

IN AND FOR THE COUNTY OF LOS ANGELES, UNLIMITED JURISDICTION

5/12/08

INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, a nonprofit corporation; GRAY PANTHERS OF SACRAMENTO, a nonprofit corporation; THE GRAY PANTHERS OF SAN FRANCISCO, a nonprofit corporation; GERALD SHAPIRO, Pharm.D., doing business as Uptown Pharmacy and Gift Shoppe; SHARON STEEN, doing business as Central Pharmacy; MARK BECKWITH; MARGARET DOWLING; TRAN PHARMACY, INC., a corporation, doing business as Tran Pharmacy; and JASON YOUNG,

-vs.-

SANDRA SHEWRY, Director of Department of Health Care Services of the State of California; DEPARTMENT OF HEALTH CARE SERVICES, a department of the State of California; and DOES 1 through 50,

Respondents. /

No. BS 114459

VERIFIED FIRST AMENDED PETITION FOR WRIT OF MANDAMUS

VERIFIED FIRST AMENDED PETITION FOR WRIT OF MANDAMUS
(§ 1085 Code of Civil Procedure)

TO THE ABOVE-ENTITLED HONORABLE COURT:

The verified first amended petition for writ of mandamus, under § 1085 Code of Civil Procedure, of petitioners Independent Living Center of Southern California, Inc.; Gray Panthers of Sacramento; The Gray Panthers of San Francisco; Gerald Shapiro, Pham.D., dba Uptown Pharmacy & Gift Shoppe; Sharon Steen, dba Central Pharmacy; Mark Beckwith; Margaret Dowling; Tran Pharmacy, Inc., dba Tran Pharmacy; and Jason Young, respectfully shows:

Jurisdiction and Venue[1]

1. The above-entitled Superior Court has jurisdiction under Article VI, section 10, California Constitution, and § 1085 Code of Civil Procedure ("Code Civ. Proc."). Venue lies under § 401 Code Civ. Proc. which provides that an action may be filed against an officer or agency of the State of California in any county in which the California Attorney General has an office; and under § 393(b) Code Civ. Proc., which provides that an action may be filed in a county in which a public officer has an office.

Parties

2. (a) The petitioner INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC. ("ILCSCal") is a nonprofit California corporation which was duly organized and incorporated in California on July 25, 1977 pursuant to the General Nonprofit Corporation Law of the State of California.

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[1] Headings and captions are not allegations, and need not be traversed or denied; but, are set forth only to assist the reader.

(b) ILCSCal has its principal office and place of business in, and does business in the County of Los Angeles, California.

3. The petitioner GRAY PANTHERS OF SACRAMENTO ("Gray Panthers Sacto") is a California nonprofit public benefit corporation, whose principal office and place of business is, and does business, in the County of Sacramento, California.

4. (a) The petitioner THE GRAY PANTHERS OF SAN FRANCISCO ("Gray Panthers SF") is a nonprofit California corporation which was duly organized and incorporated in California on August 28, 1978, pursuant to the General Nonprofit Corporation Law of the State of California.

(b) GRAY PANTHERS SF has its principal office and place of business in, and does business, in the City and County of San Francisco, California.

5. (a) The petitioner GERALD SHAPIRO, Pharm.D., is a duly licensed registered pharmacist with License No. 24377, who owns and operates a duly licensed retail pharmacy under the fictitious name of Uptown Pharmacy & Gift Shoppe, under retail pharmacy license No. PHY 41615, in the City of Los Angeles, California.

(b) The petitioner SHAPIRO's pharmacy participates in the Medi-Cal fee-for-service program and also in Medi-Cal managed care plans, under Medi-Cal provider identification No. PHA 416150.

6. (a) The petitioner SHARON STEEN is an individual who is a copartner in a copartnership which owns and operates a licensed retail pharmacy, under the fictitious name Central Pharmacy, under retail pharmacy license No. PHY 38051, in the City of Santa Monica, California.

(b) The petitioner STEEN's pharmacy participates in the Medi-Cal fee-

for-service program and also in Medi-Cal managed care plans, under Medi-Cal provider identification No. PHA 380510.

7. The petitioners MARK BECKWITH, MARGARET DOWLING, and JASON YOUNG are individuals who are recipients in the state-federal Medicaid program in California (which is called "Medi-Cal").

8. (a) The Petitioner TRAN PHARMACY, INC. is California corporation which owns and operates a duly licensed retail pharmacy under the fictitious name of Tran Pharmacy, under retail pharmacy license No. PHY 43647, in Garden Grove, California.

(b) The TRAN PHARMACY, INC.'s pharmacy participates in the Medi-Cal fee-for-service program and also in Medi-Cal managed care plans, under Medi-Cal provider identification No. PHA 436470.

9. (a) The respondent DEPARTMENT OF HEALTH CARE SERVICES ("Department") is a department of the State of California. The Department administers the Medi-Cal program under § 14000 et seq. California Welfare and Institutions ("Welf. & Inst.") Code. The Department has an office in the County of Los Angeles, California.

(b) The respondent SANDRA SHEWRY ("Director"), is the director of the Department. The Director is exclusively empowered by §§ 14100.1 and 14105 Welf. & Inst. Code to set all policies, rules and regulations in the Medi-Cal program, including all rates payable to Medi-Cal providers. The Director has an office in the County of Los Angeles. The Director SANDRA SHEWRY is sued in her official capacity, only.

(c) Respondents DOES 1 through 50 are persons and officers whose

identity is unknown to petitioners, and who are agents, officers, and servants of the State of California, and who have some function, unknown to petitioners at this time, to assist or to carry out the actions of the respondents complained of in this Petition. Petitioners pray leave of the Court to amend this Petition as and when the identity and functions of DOES 1 through 50 become known to the petitioners.

STANDING

Purposes of the Gray Panther petitioners

10. The membership of each of the Gray Panthers Sacto and of the Gray Panthers SF, respectively, is predominantly over the age of 50. A primary function and purpose of the Gray Panthers Sacto, and of the Gray Panthers SF, respectively, is to advocate and advance the health care and the health care rights and civil rights of their members, (1) a number of whom are Medi-Cal recipients in the Medi-Cal fee-for-services program, (2) a number of whom are Medi-Cal recipients in Medi-Cal managed care plans.

Suit as authorized by Green v. Obledo and the common law

11. (a) The petitioners MARK BECKWITH, MARGARET DOWLING, GERALD SHAPIRO, Pharm.D, SHARON STEEN, and JASON YOUNG are each citizens and residents of the State of California. The ILCSCal, the Gray Panthers Sacto, the Gray Panthers SF, and the Tran Pharmacy, Inc., dba Tran Pharmacy, are also each a corporate citizen and resident of the State of California.

(b) Each of the petitioners, mentioned the preceding sub-Paragraph (a) of Paragraph 11, sue on their own behalf In their own interest, respectively, as well as, also, on behalf of the public of the State of California, to procure the performance by the

program. His Medi-Cal identification number is 568-29-5405-A.

18. - (a) The ILCSCal is a non-profit corporation located in Van Nuys, Santa Clarita and Lancaster, California. The amended articles of incorporation of ILCSCal state that its primary purposes are to:

> " . . . initiate, sponsor, promote, and carry out plans, policies, and activities that will further the prosperity of and enhance the development of persons with disabilities."

The ILCSCal is a designated center for independent living (CIL). CILs are community-based organizations established under the California Rehabilitation Act (§ 19800 Welf. & Inst. Code) to advocate for and provide services to enable people with disabilities to achieve independence, including equal access to society and to all activities of society.

- (b) The ILCSCal works on issues of benefits counseling, cross-disability peer modeling/peer counseling, housing referrals, personal assistants referrals, advocacy, and providing technical assistance, information and referral and emergency services, and assistance in locating medical, pharmacy, and other providers to treat, cure, and alleviate their illness, injury, or condition.

19. The ILCSCal serves over 8,000 individuals with disabilities annually, the majority of whom, (96% or more than 7,500), are categorically linked to Medi-Cal as their primary insurance type, because they are SSI beneficiaries under the Social Security Act; and as such, are not mandated into Medi-Cal managed care, so that most of the clients of ILCSCal who receive SSI are not enrolled in Medi-Cal managed care, and instead receive their Medi-Cal services, including physician , dental, and pharmacy services, from fee-for-service Medi-Cal providers.

- (c) Out of these 7,500 clients with disabilities served annually by ILCSCal, approximately 15%, or 1,200, are eligible for both Medi-Cal and Medicare Part B, and as such:

- (1) receive their physician under Medicare, (except for such physician services which are not covered by Medicare, in which case Medi-Cal pays for the physician service), and, also receive their pharmacy services under Medicare Part D, (except for certain "carve out" drug products which are excluded from Medicare Part D and are instead dispensed under the Medi-Cal program); and,

- (2) receive their dental care under Medi-Cal fee-for-service.

LEGISLATIVE HISTORY OF ASSEMBLY BILL X3 5

20. On January 10, 2008, the California Governor proclaimed a State fiscal emergency, sent a proposed 2008-2009 budget bill to the Legislature, and called the Legislature into special session.

21. (a) On February 16, 2008 the Governor signed into law the Special Session Budget Bill, (Assembly Bill X3), and, also, Assembly Bill X3 5 (the Special Session health care trailer bill), and Assembly Bill X3 6 (the Special Session human services trailer bill).

(b) Assembly Bill X3 5, eff. February 16, 2008, was chaptered as Chapter 3, Statutes 2007-2008 Third Extraordinary Session.

Assembly Bill X3 5

22. Section 14 of Assembly Bill X3 5 added §14105.19 Welf. & Inst. Code, which:

- in subds. (a), (b)(1), (b)(2), and (c) - (e) provides that reimbursement shall be

cut 10% across-the-board in Medi-Cal fee-for-service to physicians, dentists, pharmacies, skilled nursing facilities, acute care hospitals (in respect to inpatient hospital services) who have no contract with the Department, and other providers in the Medi-Cal fee-for-service program, for services for dates of service on and after July 1, 2008; and,

- in subd. (b)(3) provides that payments shall be reduced by the actuarial equivalent amount specified in subd. (b) of § 14105.9 Welf. & Inst. Code, (i.e., an amount of 10%), to Medi-Cal managed care plans, which reduction is to be effected pursuant to contract amendments or change orders effective on July 1, 2008.

23. Section 15 of Assembly Bill X3 5 added §14105.245 Welf. & Inst. Code, which provides that amounts paid interim payments to acute care hospitals not under contract with the Department, for amounts paid as interim payments for inpatient hospital services covered by Medi-Cal, shall also be cut 10% across-the-board in Medi-Cal fee-for-service for acute care hospitals who have no contract with the Department for fiscal year 2008-09, (commencing July 1, 2008).

24. § 14105.245 Welf. & Inst. Code, (added by Section 15 of Assembly Bill X3 5 as set forth above), provides:

> "(a) 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." (Emphasis supplied.)

25. Finally, Secs. 16 and 17 of Assembly Bill X3 5 provide:

> "SEC. 16. This act addresses the fiscal emergency declared by the Governor by proclamation on January 10, 2008, pursuant to subdivision (f) of Section 10 of

Article IV of the California Constitution.

SEC. 17. . . . In order to make statutory changes needed to implement cost containment measures affecting health services, at the earliest possible time, it is necessary that this act take effect immediately." (Emphasis supplied.)

Concrete injury from implementing Secs. 14 and 15 of Assembly Bill X3 5.

26. Each of the Petitioners, as well as:

- all Medi-Cal recipients who receive provider services in the Medi-Cal fee-for-service program,

- all Medi-Cal recipients enrolled in Medi-Cal managed care plans,

- all Medi-Cal providers in the Medi-Cal fee-for-service program who are subject to the aforesaid 10% cut in Medi-Cal payments,

- all Medi-Cal managed care plans, and,

- all Medi-Cal providers in respect to or with whom Medi-Cal managed care plans have contracted with or arranged for covered Medi-Cal managed care services to be furnished by them, (in respect to whom the managed care plans will foreseeably and inevitably pass through the aforesaid 10% cut commencing July 1, 2008),

will, respectively, and foreseeably and inevitably, suffer concrete injury, and are threatened with concrete injury, and are put at risk of concrete injury, by the aforesaid 10% cut, or the actuarial equivalent thereof, which will be put into effect commencing

respondent public officials of public duty, as authorized by Green v. Obledo, 29 Cal.3d 126 (1981); namely, the performance of the mandatory ministerial duty (1) to set aside their policy to implement Sections 14 and 15 of Assembly Bill X3 5 (enacted and eff. Feb. 16, 2008, at Chapter 3, Statutes 2007-2008 Third Extraordinary Session), and (2) to refrain from implementing Sections 14 and 15 of Assembly Bill X3 5, including refraining from reducing payments 10% to Medi-Cal doctors, dentists, pharmacies, those acute care hospitals who have no contract with the Department, and, other providers in the Medi-Cal fee-for-service program, and Medi-Cal managed care plans, commencing July 1, 2008; -- which aforesaid actions of the respondents are preempted, under the Supremacy Clause, (article VI, U.S. Constitution), in that the aforesaid actions:

- (1) violate 42 U.S.C. § 1396a(a)(30)(A), (herein, "Sec. 30(A)," including the quality and access clauses of Sec. 30(A).

- (2) violate the federal Americans with Disabilities Act of 1990, ("ADA");

which suit is permitted and authorized by all laws made and provided therefor, the common law, and by Green v. Obledo (1981) 29 Cal.3d 126.

Prudential *jus tertii* suits

12. (a) Each of the pharmacy petitioners, (namely, the Uptown Pharmacy, Central Pharmacy, and Tran Pharmacy, (and their owners who are the plaintiffs Gerald Shapiro, Pharm.D., Sharon Steen, and the Tran Pharmacy, Inc.), also sue in a prudential *jus tertii* capacity to assert, respectively, the interests of their respective Medi-Cal beneficiary patients, as well as the interests of their patients with disabilities, in the

causes of action, claims, Supremacy Clause preemption, and relief which is sued upon and sought in the within case.

(b) The petitioner ILCSCal also sues in a prudential *jus tertii* capacity, in its capacity as an independent living center, -- designated and organized as such, and with purposes and powers therefore, under and as authorized by the state Rehabilitation Act, § 19800 et seq. Welf. & Inst. Code, -- to assert the interests of its clients who are Medi-Cal beneficiary patients, as well as the interests of its clients with disabilities, in the causes of action, claims, Supremacy Clause preemption, and relief which is sued upon and sought in the within case.

(c) The petitioners Gray Panthers Sacto and Gray Panthers SF also sue in a prudential *jus tertii* capacity, respectively, to assert the interests of their respective members who are Medi-Cal beneficiary patients, as well as the interests of their members clients with disabilities, in the causes of action, claims, Supremacy Clause preemption, and relief which is sued upon and sought in the within case.

13. Each of the respondents Gerald Shapiro and Sharon Steen, and the Tran Pharmacy, Inc., a resident California corporation, also sue on all Causes of Action herein in their capacity as citizen resident taxpayers of the State of California, under the common law and under § 526a, Code Civ. Proc., -- in that each is a taxpayer who has been assessed and paid a state income tax, within12 months on the filing of this Verified First Amended Petition for Writ of Mandamus, to the State of California.

14. Each of the petitioners, -- as well as each of the patients, clients, and members in respect to whom the pharmacy plaintiffs, the ILCSCal, and the Gray Panthers petitioners are prudential *jus tertii* representatives, -- also has standing

inasmuch as each has suffered, will suffer, and is threatened to be caused to suffer, concrete and irreparable injury as shall hereinafter be specified, unless respondents are restrained by a writ of mandamus from implementing the statutes which are preempted, under the Supremacy Clause, by Sec. 30(A), and by the ADA, as set forth hereinafter.

FACTS COMMON TO ALL CLAIMS

15. The petitioner MARK BECKWITH was born on October 5, 1957, in Corry, Pennsylvania. He is a citizen and resident of the State of California who resides at 2931 Ellis St., Berkeley, California. He is a paraplegic on account of spinal muscular atrophy, who requires oxygen at all times, who receives medical and pharmacy services under the Medi-Cal program. He is a SSI recipient who receives $870 monthly from SSI. His Medi-Cal identification number is 90111132A05026

16. The petitioner MARGARET DOWLING was born in Sandusky, Ohio, on July 29, 1940. She is a citizen and resident of the State of California who resides at 426 W. 11th St., Pittsburg, California. She is a paraplegic who receives part of her medical services under the Medi-Cal program. Her Medi-Cal identification number is 90230720A35028.

17. The petitioner JASON YOUNG was born in Inglewood, California on July 15, 1962. He is a citizen and resident of the State of California who resides at 8926 Independence, #204, Parthenia, California. He suffers disabilities of blindness and brain damage and is a Supplemental Security Income (SSI) recipient, with SSI identification number of 568-29-405. He receives assistive services from In-Home Supportive Services and medical and other health services from the Medi-Cal managed care

July 1, 2008 by the respondents, pursuant to their policy to implement the aforesaid Sections 14, and 15 of Assembly Bill X3 5, including, without limitation thereby, (1) the 10% across-the-board reduction in reimbursement to physicians, dentists, pharmacies, acute-care hospitals who have no contract with the Department, and other providers in the Medi-Cal fee-for-service program; and (2) the equivalent actuarial 10% reduction in payments to Medi-Cal managed care plans, commencing July 1, 2008; (hereinafter referred to, collectively, as "the Medi-Cal cuts"); which concrete injury from the Medi-Cal cuts is great, immediate, and irreparable.

Denial of access to physicians, and denial of quality medical services

27. More particularly, it is a fact that Medi-Cal rates for physicians are 61% or less of what Medicare pays for the same physician services; that a 10% cut will reduce reimbursement to Medi-Cal physicians to only 57% of what Medicare would pay; and that as a result of the low Medi-Cal rates, only 55% of primary care physicians and less than 50% or specialists are willing to participate in the Medi-Cal program, (either in the Medi-Cal fee-for-service program, or in Medi-Cal managed care programs). (1) These facts are verified and reported by the Legislative Analyst in Analysis of the 2008-2009 Budget Bill, (Budget Analysis"), citing studies on the subject, at pages C-37 and C-38 of the Budget Analysis; and (2) studies funded by the California Healthcare Foundation, (a respected organization with whom the Department often contracts to provide studies and information to the Department), consistently so report.

28. Further:

- **First.** It is a fact that persons with disabilities such as the petitioners DOWLING, BECKWITH, and YOUNG, and the thousands of disabled clients of the

petitioner ILCSCal, and the thousands of home shut-ins to whom petitioner SHAPIRO and STEEN deliver prescriptions in the Medi-Cal fee-for-service program, have more difficulty in locating primary care and specialists who are needed by them to adequately follow and care for their complex medical needs, and keep them alive, than do Medi-Cal recipients without disabilities.

- **Second**. It is a fact that although Medi-Cal managed care plans do assign a Medi-Cal enrollee to a primary care physician, nevertheless, persons with severe disabilities such as the petitioners DOWLING, BECKWITH, and YOUNG require more complex care, from specialists, than Medi-Cal managed care plans are able to furnish them, due to a shortage of specialists in both Medi-Cal fee-for-service and Medi-Cal managed care.

- **But,** specialists who have the capability to treat and follow the complex needs of disabled persons, -- such as the paraplegic DOWLING , the quadriplegic BECKWITH, and the blind and brain damaged YOUNG, -- are difficult to find and retain over any period of time, **whether the specialist is being sought** by disabled Medi-Cal recipients in the Medi-Cal fee-for-service program, or by disabled Medi-Cal recipients in Medi-Cal managed care plans.

- This above situation, set forth in this Paragraph, is due to the fact that payment of specialists is so low that **less than 50% of specialists** have Medi-Cal patients; and, those that do, repeatedly state in surveys that they are **not willing to accept new** Medi-Cal patients, (whether they come from the Medi-Cal fee-for-service program or from Medi-Cal managed care plans).

- However, given the facts which are set forth above in this Paragraph, it is

inevitable that, if the Medi-Cal cuts of Sections 14 and 15 of Assembly Bill X3 5 are implemented for dates of service on and after July 1, 2008, that thousands of Medi-Cal recipients in both Medi-Cal fee-for-service and Medi-Cal managed care, -- including (1) the petitioners DOWLING, BECKWITH, and YOUNG; (2) the thousands of disabled patients of the petitioner pharmacies (Uptown, Central, and Tran), in Los Angeles and Orange counties, (3) the thousands of disabled clients of the petitioner ILCSCal, and (4) the members of the Sacto Gray Panthers and the SF Gray Panthers who are Medi-Cal recipients, **will be driven,** and will at the least be put at great risk, of being forced into institutions in order to survive, if at all.

Denial of access to dentists, and to quality dental care

29. It is also a fact, which is reflected in court decisions and studies, that because of too-low rates, approximately 90% of dentists refuse to accept Medi-Cal patients. Accordingly, the 10% reduction in Medi-Cal payments to dentists, will simply intensify the denial of access and quality dentistry, which already presently exists.

Denial of access to pharmacy care

30. California pharmacies, both chain pharmacies and independent pharmacies, uniformly earn less than a 10% net profit.

31. Further, it is fact, -- as demonstrated by the 2006 survey by Myers & Stauffer of California pharmacy costs to operate, and their costs to acquire prescription drug products, that approximately 27.5 % of a typical pharmacy's prescriptions in the Medi-Cal program are single source (brand) drugs; that approximately 36 % of the prescriptions are multi-source (generic) drugs; and that approximately 36.2 % of the prescriptions are low-priced drugs in respect to which the federal government has set a

federal upper limit ("FUL") or Medi-Cal has set a maximum allowable ingredient cost ("MAIC") limit for reimbursing the pharmacy's cost to acquire such FUL or MAIC.

32. However, the figures set forth in this Myers & Stauffer report to the Department are consistent with the fact, -- when the 10% payment cut commences July 1, 2008, -- that although California pharmacies including the petitioner pharmacies would still have a **small net profit** on the 36 % of their Medi-Cal prescriptions which are multi-source (generic) prescriptions without a Ful or MAIC cap, nevertheless, they would have a **larger net loss, collectively,** on the 27.5 % of their Medi-Cal prescriptions which are single source (brand) and the 36.2 % of their Medi-Cal prescriptions which are subject to a FUL or a MAIC cap; so that on the whole that California pharmacies, including the petitioner pharmacies, will not be able to dispense Medi-Cal prescriptions in the Medi-Cal fee-for-service program except at a net loss on the entire bulk of their Medi-Cal prescription business, (brand, generic, and capped prescriptions).

33. Further, Medi-Cal managed care programs, (such as the Medi-Cal county organized health system managed care program in Orange County which is known as "CalOptima"), typically, (including CalOptima) pass through all reductions in payments by Medi-Cal to Medi-Cal managed care plans; so that (1) pharmacies in Medi-Cal managed care plans, including the petitioner pharmacies, and their patients, will suffer the same reduction in ability to furnish or receive quality pharmacy care, and (2) specialists will become even more scare in managed care plans, so that the frail, elderly, disabled Medi-Cal patients in both the Medi-Cal fee-for-service program, and in Medi-Cal managed care plans, will suffer inability, and be put at risk of inability to obtain specialists, and to obtain quality pharmacy services, if the July 1, 2008 10% cut in

payment to Medi-Cal managed care plans is not enjoined by the Court.

34. Accordingly, it is manifest, foreseeable and probable, from the foregoing facts set forth above in this Petition, that the 10% reduction in total reimbursement to pharmacies in the Medi-Cal fee-for-service program, (as well as an actuarially equivalent 10% reduction to Medi-Cal managed care plans), will result in not only many, but most independent pharmacies, such as the petitioners GERALD SHAPIRO, Pharm.D., (owner of Uptown Pharmacy in Los Angeles), and SHARON STEEN, (owner of the independent Central Pharmacy in Santa Monica), and the TRAN PHARMACY, either (1) going out of business, or (2) refusing to accept Medi-Cal any longer, or (3) refusing to fill those particular Medi-Cal prescriptions in respect to which they suffer a net loss in the acquisition and costs to dispense, or (4) reducing staff, hours of pharmacy operation, and eliminating or reducing delivery services to shut-ins, under the new 10% Medi-Cal payment reduction.

35. Further, many independent pharmacies, but few chain pharmacies, deliver Medi-Cal prescriptions to the aged, frail, and disabled Medi-Cal recipients who are shut-in to their homes.

36. For example, 98% of the prescriptions dispensed by the independent Uptown Pharmacy in Los Angeles, -- owned by the petitioner GERALD SHAPIRO, Pharm.D., -- are deliveries to approximately 5,000 home shut-ins.

37. More particularly, approximately 55% of the shut-ins to whom Uptown Pharmacy delivers prescriptions receive their medications under Medicare Part D, (i.e., those who are 65 or older, or are Social Security Disability Income beneficiaries). But, also, approximately 30% of the shut-in clientele of Uptown Pharmacy are on the Medi-

Cal fee-for-service program, due to the fact they are under 65 or, although disabled, have not qualified for S.S.D.I.

38. However, Uptown's net profit on its entire pharmacy business is less than 10% net profit. Accordingly, the petitioner SHAPIRO, -- and two other delivery pharmacies whose owners he knows in Los Angeles, -- have no realistic choice but to close their pharmacies if the 10% cut in pharmacy reimbursement is implemented in July 2008; or at the best, eliminate or reduce deliveries. Thus, if the 10% cut is not restrained by the Court, **thousands of disabled home shut-ins** in Los Angeles, (and similar in other parts of the state), who are Medi-Cal recipients, will no longer have **any access** to life-necessary drugs, and, many of them will suffer and die therefrom.

Summary of overall effect of the 10% Medi-Cal cut

39. Accordingly, due to the too-low rates already paid physicians, dentists, pharmacies, and other providers by Medi-Cal, (1) the further 10% payments reduction if implemented in July 2008, to physicians, will drive and tend to drive even more primary care physicians and specialists, and dentists, pharmacies, and other providers out of the Medi-Cal program, or cause them to terminate present provider-patient relationships, or reduce services, or refuse to new Medi-Cal patients, or increase appointment wait periods; such that (2) many Medi-Cal recipients, both in the Medi-Cal fee-for-service program and in the Medi-Cal managed care program, -- and, especially the tens of thousands who are home-bound shut-ins who depend upon medicine delivery, and also those who are disabled, - will be denied access to life-sustaining medical, dental, and prescription services, with (3) the consequence that Medi-Cal recipients in general will be denied quality medical services and access to quality medical services. More

particularly, due to the 10% provider payment cuts (including the actuarial equivalent thereof to Medi-Cal managed care plans, many **disabled Medi-Cal recipients** such as the petitioners DOWLING, BECKWITH, and YOUNG, and the thousands of clients of independent living centers such as the petitioner ILCSCal, will lose, or are threatened with loss, of their primary care and specialist physicians, so that many persons with disabilities, including the petitioners Beckwith and Dowling, will be forced into institutions or will be at risk of being forced into institutions in order to survive, and will suffer injury and pain from untreated illness, injury, or condition.

FIRST CAUSE OF ACTION

By each of the petitioners except petitioner Jason Young, for mandamus and injunctive relief to enjoin each of the respondents to refrain from implementing a 10% reduction of payments to Medi-Cal fee-for-service providers under subds. (a), (b)(1), (b)(2), and (c) - (e) of § 14105.19 Welf. & Inst. Code, and § 14166.245 Welf. & Inst. Code), -- which state statutes and the state action of respondents to implement the state statutes violate, and are hence preempted under the Supremacy Clause by, the quality and equal access clauses of 42 U.S.C. § 1396a(a)(30(A).

* * * * * * *

40. Petitioners ref er to and incorporate each of the allegations in each of the preceding Paragraphs of this Petition, as if fully set forth herein.

41. The Medicaid Act, in 42 U.S.C. § 1396a, subd. (a)(30)(A), provides:

"(a) A State plan for medical assistance **must** - (30)(A) **provide for** such methods and procedures relating to the utilization of, and **the payment for, care and services available under the plan** (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title) **as may be necessary** to safeguard against unnecessary utilization of such care and services and **to assure that payments are consistent with** efficiency, economy, and **quality of care** and are **sufficient to enlist enough providers** so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area; . . . " (Emphasis supplied.)

44. 42 U.S.C. § 1396a, subd. (a)(30)(A), shall hereinafter be referred to as "Sec. 30(A)."

45. However, in view of the fact that on January 10, 2008, the Governor proclaimed a fiscal emergency and called the Legislature into Special Session; and that on February 16, 2008 the Legislature enacted and the Governor signed into law Assembly Bill X3 5, which proclaims in Sec. 15 that "the state faces a fiscal crisis that requires unprecedented measures to be taken to reduce General Fund expenditures," and which proclaims in Sections 16 and 17 that:

> "SEC. 16. This act addresses the fiscal emergency declared by the Governor by proclamation on January 10, 2008, pursuant to subdivision (f) of Section 10 of Article IV of the California Constitution.
>
> SEC. 17. . . . In order to make statutory changes needed to implement cost containment measures affecting health services, at the earliest possible time, it is necessary that this act take effect immediately." (Emphasis supplied.)

it is manifest that the sole function and purpose, and the conclusive consideration in the Legislature's decision to enact subds. (a), (b)(1), (b)(2), and (c) - (e) of § 14105.19 Welf. & Inst. Code; and § 14166.245 Welf. & Inst. Code, -- which provides that the respondents shall (1) cut Medi-Cal payments to providers in the Medi-Cal fee-for-service program, was budgetary considerations, to "address the fiscal emergency" declared by the Governor, and to effect "cost containment measures affecting health services," by making statutory changes needed to reduce expenditures, (to fit the State's reduced budget), commencing July 1, 2008.

46. However, therein, by each and all of the above allegations, the enactment of subds. (a), (b)(1), (b)(2), and (c) - (e) of § 14105.19 Welf. & Inst. Code; and

§ 14166.245 Welf. & Inst. Code, by the Legislature (1) was without any consideration of quality and access as required by Sec. 30(A),[2] and as without any consideration of what it costs providers to perform the various services and procedures, as required by Sec. 30(A);[3] such that the State's sole purpose, and the conclusive factor, in enacting the across-the-board 10% reduction in reimbursement to providers in the Medi-Cal fee-for-service program, was to **reduce the budget deficit**. Accordingly, under the standard of Orthopaedic Hosp., 103 F.3d 1491, at 1500 (1997); and Arkansas Medical Society, Inc. v. Reynolds, 6 F.3d 519 (8th Cir.1983), the action of the Legislature to enact the aforesaid subds. (a), (b)(1), (b)(2), and (c) - (e) of §14105.19 Welf. & Inst. Code; and § 14166.245 Welf. & Inst. Code, and the policy and action of the respondents to implement these statutes by reducing payments to providers in the Medi-Cal fee-for-service program, was and is arbitrary and capricious, and contrary to and in violation of the quality and access provisions of Sec. 30(A); so that hence, under the Supremacy Clause, the aforesaid subds. (a), (b)(1), (b)(2), and (c) - (e) of §14105.19 Welf. & Inst. Code; and § 14166.245 Welf. & Inst. Code are preempted by Sec. 30(A)..

47. Accordingly, by each and all of the foregoing facts alleged, subds. (a), (b)(1), (b)(2), and (c) - (e) of § 14105.19 Welf. & Inst. Code; and § 14166.245 Welf. & Inst. Code., were and are unlawful, in violation of the quality and access provisions of Sec. 30(A), so as to be preempted, under the Supremacy Clause, by the quality and

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[2] Othopaedic Hospital v. Belshe, 103 F.3d 1491, 1500 (9th Cir.1997).

[3] *Id.*, 103 F.3d at 1500; Arkansas Medical Society, Inc. v. Reynolds, 6 F.3d 519 (8th Cir. 1993).

access provisions of Sec. 30(A), such that the respondent Director and the respondent Department act in excess of and without jurisdiction to implement subds. (a), (b)(1), (b)(2), and (c) - (e) of § 14105.19 Welf. & Inst. Code; and § 14166.245 Welf. & Inst. Code, in implementing the provisions therein of reducing reimbursement to physicians, dentists, pharmacies, and other providers, in the Medi-Cal fee-for-service program, commencing July 1, 2008.

48. Further, unless restrained by the Court by an appropriate writ of mandamus under § 1085 Code Civ. Proc. or by an appropriate injunction, the respondents Director and Department will implement the aforesaid subds. (a), (b)(1), (b)(2), and (c) - (e) of § 14105.19 Welf. & Inst. Code; and § 14166.245 Welf. & Inst. Code, and thereby will cause injury to each of the petitioners (except petitioner Jason Young, who is in a Medi-Cal managed care plan); which injury is irreparable, all, as has been hereinbefore set forth in detail in the within amended Petition, but, the petitioners have no administrative remedy, and the petitioners have no plain, speedy, or adequate remedy whatsoever or at all, except by this Verified First Amended Petition for Writ of Mandamus.

WHEREFORE, the Petitioners respectively pray for judgment as shall hereinafter be specified:

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SECOND CAUSE OF ACTION

By petitioners Jason Young and the Tran Pharmacy, Inc., dba Tran Pharmacy, for mandamus and injunctive relief to enjoin each of the respondents to refrain from implementing the actuarial equivalent' of a 10% reduction of payments to Medi-Cal managed care plans under subd. (b)(3) of § 14105.19 Welf. & Inst. Code, which state statute and the action of respondents to implement the state statutes violate, and are hence preempted under the Supremacy Clause by, the quality and equal access clauses of 42 U.S.C. § 1396a(a)(30(A).

* * * * *

49. Petitioners refer to and incorporate each of the allegations in each of the preceding Paragraphs of this Petition, as if fully set forth herein; and, especially, refer to and incorporate each of the allegations in the First Cause of Action as if fully set forth herein.

50. The provisions of 42 U.S.C. § 1396a(a)(30)(A), -- herein, "Sec. 30(A)" -- apply to all managed care plans and managed care entities, who arrange to furnish or otherwise furnish Medi-Cal services to their members or beneficiaries, just as directly, fully, and equally as Sec. 30(A) applies to providers in the Medi-Cal fee-for-service program.

51. The provisions of Social Security Act § 1915(b)(4), (42 U.S.C. § 1396n(b)(4)), also specifically, by its terms, requires that the State of California set rates and payments for Medi-Cal managed care plans and Medi-Cal managed care entities, upon the same standards as are set forth in Sec. 30(A).

52. Accordingly, -- by each and all of the allegations in the preceding Paragraphs of this Petition, -- and because Medi-Cal managed care plans and entities are

agents of the State who, in effect, set the rates which shall be payable to providers for services to Medi-Cal recipients in Medi-Cal managed care plans, -- the actions of the Legislature in enacting subd. (b)(3) of § 14105.19 Welf. & Inst. Code, to reduce payments to Medi-Cal managed care plans and entities by 10%, or the actuarial equivalent thereof, was arbitrary and capricious, and contrary to Sec. 30(A), and contrary to Social Security Act § 1915(b)(4), (42 U.S.C. § 1396n(b)(4); such that the policy of the respondents to implement, and the action of the respondents to implement subd. (b)(3) of § 14105.19 Welf. & Inst. Code, including the reduction of payments to Medi-Cal managed care plans and entities by 10%, or the actuarial equivalent thereof, managed care plans and entities, is thereby, under the Supremacy Clause, preempted by Sec. 30(A) and by Social Security Act § 1915(b)(4), (42 U.S.C. § 1396n(b)(4)), such that, unless the Court issues an appropriate writ of mandamus or injunction, the petitioner Jason Young and the petitioner Tran Pharmacy, Inc., dba Tran Pharmacy, (who are a managed care recipient and managed care provider), -- will be irreparably injured, and put at risk of injury, in the same wise as has been prior alleged in the First Cause of Action, by the respondents reducing payments, commencing July 1, 2008, to Medi-Cal managed care plans, in the actuarial equivalent of a 10% reduction in payment, which reduction will be passed through to providers who serve Medi-Cal managed care plan patients, causing fewer providers to participate in Medi-Cal managed care plans and injuring Medi-Cal managed care patients such as petitioner Josh Young, and forcing them or tending to force into institutions in order to survive..

WHEREFORE, the petitioners pray for judgment as shall hereinafter be specified:

THIRD CAUSE OF ACTION

(By all petitioners against each respondent.)

Preemption by the Americans with Disabilities Act of 1990, 42 U.S.C. § 12132, ("ADA"), under the Supremacy Clause, of Sections 14, and 15 of Assembly Bill X3 5, for violation of the ADA, 42 U.S.C. § 12132, by forcing or threatening to force disabled persons into institutions, -- such that such administration of the Medi-Cal program prevents, and does not provide, disabled persons with the most integrated setting appropriate to their needs, as mandated by the ADA and by Olmstead v. L.C., 527 U.S. 581 (1999).

53. Petitioners here refer to and incorporate each of the allegations in the preceding Paragraphs as if fully set forth herein.

54. By each and all of the foregoing facts alleged in Paragraphs 1 through 53 of this Petition, Sections 14, and 15 of Assembly Bill X3 5 are, singly and cumulatively, unlawful, in violation of the Americans with Disabilities Act of 1990, ("ADA"), 42 U.S.C. § 12132, which provides:

> "Subject to the provisions of this subchapter, no qualified individual with a disability shall, by reason of such disability, be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity(,"

in that the aforesaid 10% cut in Medi-Cal provider and hospital reimbursement of Sections 14 and 15 of Assembly Bill X3 5, will, singly, cumulatively, and proximately result in forcing, and threatening to force, thousands of persons who are qualified individuals with a disability, as defined in the ADA, into institutions, and place them at risk of being forced into institutions, in order to survive; and many will in any event be injured in their person and in their spirit and will die or be put at risk of dying; including

but not limited to:

- the petitioners Margaret Dowling, Mark Beckwith, and Jason Young;

- hundreds of SSI recipients who are clients of the petitioner ILCSCal;

- many patients of the patients of the pharmacy petitioners,

- some members of the SF Gray Panthers and Sacto Gray Panthers,

so that therein, many qualified individuals with a disability, (as defined in the ADA), including but not limited to disabled SSI recipients who depend on Medi-Cal services to be able to live in the community, will be denied and will become unable to live in the **most integrated setting** appropriate to (1) the needs of those hundreds of thousands of Medi-Cal recipients who are SSI disabled persons, including (2) the needs of the disabled petitioners Margaret Dowling, Mark Beckwith, and Jason Young, and including (3) the needs of thousands of SSI disabled persons who are clients of the petitioner ILCSCal; and including (4) disabled patients of the pharmacy petitioners; so that **such administration of the Medi-Cal program does not provide qualified individuals with a disability the most integrated setting appropriate to their needs,** as mandated by the ADA, by Olmstead v. L.C., *supra*, 527 U.S. 581 (1999), and 28 Code of Federal Regulations, § 35.130(d). [1988].

55. Further, once the State has placed qualified individuals with a disability, (as defined by the ADA), in the community, including the petitioners Dowling, Beckwith, and Young, and the disabled persons listed in the preceding Paragraph; all,

with medical, attendant, and other services and life-needed supplied furnished and paid by Medi-Cal fee-for-service and managed care program, or, assisted by these Medi-Cal programs of the State, so as to enable them to be so integrated into the community, the State has the burden, under the ADA, to justify and to show reasonable grounds why such level, kinds, and quality of supporting services, assistance, and framework for independent living may be withdrawn by the State, as, in case at bar, by (1) provider payments for one month being arbitrarily and capriciously held for one month, and (2) provider and hospital payments being reduced 10%, permanently, by the State to Medi-Cal providers and Medi-Cal managed care plans, (which reductions to the managed care plans, will foreseeably and inevitably be passed through to the providers who provide the services of the Medi-Cal managed care plan to Medi-Cal recipients).

56. Therein and thereby, as set forth in the preceding Paragraphs of this Third Cause of Action, Secs. 14, and 15 of Assembly Bill X3 5 violate the ADA, and are preempted, under the Supremacy Clause, by the ADA specifically, by 42 U.S.C. § 12132, by forcing or threatening to force, individuals with a disability (as defined by the ADA), into institutions, and by putting them at risk to be forced into institutions, (including the petitioners Dowling, Beckwith, and Young, and the patients, clients, and members of the petitioner pharmacies, the ILCSCal, the Sacto Gray Panthers, and the SF Gray Panthers, -- which is not the most integrated setting appropriate to their needs, as mandated by ADA and by Olmstead v. L.C., *supra*, 527 U.S. 581.

Therein and thereby, the respondent Director and Department, by violating the ADA and of Olmstead on a statewide basis, are and will act in excess of without jurisdiction to implement the aforesaid statutes (i.e., Secs. 14, and 15 of Assembly Bill

X3 5).

57. Further, unless restrained by the Court by an appropriate writ of mandamus under § 1085 Code Civ. Proc. or by an appropriate injunction, the respondents Director and Department will implement the aforesaid Secs. 14, and 15 of Assembly Bill X3 5, and therein will cause each of the petitioners concrete injury, which is irreparable, as set forth in detail in the preceding Paragraphs of this Verified First Amended Petition for Writ of Mandamus; but, the petitioners have no administrative remedy, and no plain, speedy, or adequate remedy whatsoever or at all, except by this Verified First Amended Petition for Writ of Mandamus.

WHEREFORE, the Petitioners respectively pray for judgment as shall hereinafter be specified:

FOURTH CAUSE OF ACTION

Separate statement of violation of ADA

(By each petitioner against each respondent.)

58. Petitioners here refer to and incorporate each of the allegations in the preceding Paragraphs as if fully set forth herein.

59. Each and all of the acts of each of the respondents in violation of the ADA, which are set forth in the preceding Third Cause of Action, tend to force, do force, and threaten to force qualified individuals with a disability in the Medi-Cal program, -- (including the petitioners Margaret Dowling, Mark Beckwith, and Jason Young, and the disabled patients, clients, and members of the remaining petitioners), -- into institutions; all, in violation of the ADA (42 U.S.C. §12132) and Olmstead, *supra*. Accordingly,

under the ADA, including 42 U.S.C. §§ 12123, and 12133, -- which incorporates, via 29 U.S.C. § 794a(a)(2), the remedies of Title VI of the Civil Rights Act of 1964, (namely, 42 U.S.C. § 2000d-1 et seq.), -- the petitioners herein have a federal right to an appropriate injunction herein to restrain the respondents from implementing Secs. 14, and 15 of Assembly Bill X3 5, plus, statutory reasonable attorneys's fees as provided by 42 U.S.C. § 12133.

WHEREFORE, the petitioners and each of them pray for judgment as follows;

1. That petitioners have judgment against each of the respondents, and that respondents take nothing.

First Cause of Action

2. That an alternative writ of mandamus, and then a peremptory writ of mandamus, and/or an injunction, be issued to command the respondents DEPARTMENT OF HEALTH CARE SERVICES ("Department") and SANDRA SHEWRY, Director of the Department, to set aside their preempted policy to implement subds. (a), (b)(1), (b)(2), and (c) - (e) of § 14105.19 Welf. & Inst. Code; and § 14166.245 Welf. & Inst. Code, and to refrain from implementing the aforesaid subds. (a), (b)(1), (b)(2), and (c) - (e) of § 14105.19 Welf. & Inst. Code; and § 14166.245 Welf. & Inst. Code, including refraining from reducing payments by 10%, or at all, to providers in the Medi-Cal fee-for service program;

3. That petitioners have reasonable attorneys' fees under § 1021.5 Code Civ. Proc.

Second Cause of Action

4. That an alternative writ of mandamus, and then a peremptory writ of

mandamus, and/or an injunction, be issued to command the respondents DEPARTMENT OF HEALTH CARE SERVICES ("Department") and SANDRA SHEWRY, Director of the Department, to set aside their preempted policy to implement subd. (b)(3) of § 14105.19 Welf. & Inst. Code, and to refrain from implementing the aforesaid preempted subd. (b)(3) of § 14105.19 Welf. & Inst. Code, including refraining from reducing payments to Medi-Cal managed care plans by 10%, or by the actuarial equivalent thereof, and in any other amount of payment reduction.

5. That petitioners have reasonable attorneys' fees under § 1021.5 Code Civ. Proc.

Third Cause of Action

6. That a writ of mandamus or injunction be issued to order the respondents DEPARTMENT OF HEALTH CARE SERVICES ("Department") and SANDRA SHEWRY, Director of the Department, to set aside their preempted policy of implementing Sections 14, and 15 of Assembly Bill X3 5, and refrain from implementing the aforesaid preempted Sections 14, ands 15 of Assembly Bill X3 5, in whole or in part; including, refraining from educing payments by 10% or any other amount of reduction, to Medi-Cal providers in the Medi-Cal fee-for-service program, and Medi-Cal managed care plans, for dates of service on and after July 1, 2008, or at any other time.

7. That petitioners have reasonable attorneys' fees under § 1021.5 Code of Civil Procedure.

Fourth Cause of Action

8. That an injunction be issued under the Americans with Disabilities Act of 1990, ("ADA"), to command the respondents DEPARTMENT OF HEALTH CARE

SERVICES ("Department") and SANDRA SHEWRY, Director of the Department, to refrain from implementing Secs. 14, and 15 of Assembly Bill X3 5, in whole and in every part, including, refraining from implementing a 10% reduction, or any other reduction in payments, to Medi-Cal fee-for-services providers and Medi-Cal managed care plans.

9. That petitioners have reasonable attorneys' fees under 42 U.S.C. § 12133.

All Causes of Action

10. That petitioners have costs of suit incurred, together with such other and further relief as may be just.

Dated: May 12, 2008.

LYNN S. CARMAN
STANLEY L. FRIEDMAN

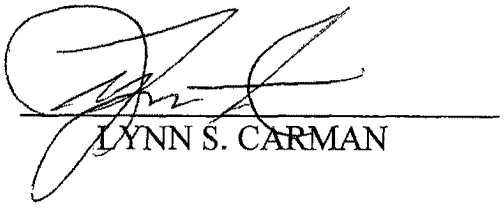
By: _____
Attorneys for Petitioners
Independent Living Center of Southern California, Inc.; Gray Panthers of Sacramento; The Gray Panthers of San Francisco; Gerald Shapiro, Pharm.D., dba Uptown Pharmacy & Gift Shoppe; Sharon Steen, dba Central Pharmacy; Tran Pharmacy, Inc., dba Tran Pharmacy; Margaret Dowling; Mark Beckwith; and Jason Young

VERIFICATION

LYNN S. CARMAN deposes and says:

I am the attorney for the Petitioners in the within Verified First Amended Petition for Writ of Mandamus. I make this verification for the reason that the Petitioners are absent from the county where I have my office. I have read the pleading and I am informed and believe the matters therein to be true and on that ground allege that the matters stated therein are true.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed in Novato, California, on May 12, 2008.



LYNN S. CARMAN

EXHIBIT - E

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SUPERIOR COURT OF THE STATE OF CALIFORNIA

IN AND FOR THE COUNTY OF LOS ANGELES, UNLIMITED JURISDICTION

INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC., a nonprofit corporation; GRAY PANTHERS OF SACRAMENTO, a nonprofit corporation; THE GRAY PANTHERS OF SAN FRANCISCO, a nonprofit corporation; GERALD SHAPIRO, Pharm.D., doing business as Uptown Pharmacy and Gift Shoppe; SHARON STEEN, doing business as Central Pharmacy; MARK BECKWITH; and MARGARET DOWLING; TRAN PHARMACY, INC., a corporation, doing business s Tran Pharmacy; and JASON YOUNG,

Petitioners,

-vs.-

SANDRA SHEWRY, Director of Department of Health Care Services of the State of California; DEPARTMENT OF HEALTH CARE SERVICES, a department of the State of California; and DOES 1 through 50,

Respondents. /

No. BS 114459

Date: June 5, 2008
Time: 9:30 a.m.
Dept.: 85
Judge: Hon. James C. Calfant

PETITIONERS' MEMORANDUM IN SUPPORT OF WRIT OF MANDAMUS, OR IN THE ALTERNATIVE, FOR PERMANENT OR PRELIMINARY INJUNCTION

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PETITIONERS' MEMORANDUM IN SUPPORT OF WRIT OF MANDAMUS, OR IN THE ALTERNATIVE, PERMANENT INJUNCTION

Petitioners ("plaintiffs") Margaret Dowling; Mark Beckwith; Gerald Shapiro, Pharm.D., dba Uptown Pharmacy and Gift Shoppe; Sharon Steen, dba Central Pharmacy; Tran Pharmacy, Inc, dba Tran Pharmacy; the Independent Living Center of Southern California, Inc.; and The Gray Panthers of San Francisco, ("San Francisco Gray Panthers"), -- file this Memorandum in support of their motion for peremptory writ of mandamus, or in the alternative, a permanent or preliminary injunction, **in the First Cause of Action only**, to restrain the respondents Department of Health Services and its Director, Sandra Shewry, as set forth below.[1]

--ooOOoo–

This is a Supremacy Clause preemption case.[2]

The movant petitioners are:

-- two Medi-Cal recipients who are in Medi-Cal fee-for-service;'
-- three pharmacies who are providers in Medi-Cal fee-for-service;[3]
-- an independent living center whose disabled clients are Medi-Cal fee-for-service;[4]

---

[1] The petitioners Gray Panthers of Sacramento, and Jason Young, are not moving parties in this within motion.

[2] The Supremacy Clause (article VI, cl. 2 of U.S. Constitution) provides:

"This Constitution, and the laws of the United States which shall be made in pursuance thereof, . . . shall be the supreme law of the land; and the judges of every state shall be bound thereby, anything in the Constitution or laws of any State to the contrary, notwithstanding."

[3] Gerald Shapiro, Pharm.D., owner of Uptown Pharmacy in Los Angeles; Sharon Steen, copartner in a copartnership which owns Central Pharmacy in Santa Monica; Tran Pharmacy, Inc., owner of Tran Pharmacy, Inc,, in Garden Grove.

[4] Independent Living Center of Southern California, Inc., ("ILCSCal"), who annually assists and advocates for 7,500 disabled persons, who are mostly SSI recipients who receive their health care from Medi-Cal fee-for-service.

-- the San Francisco Gray Panthers which has several members in Medi-Cal fee-for-service.

They seek peremptory writ of mandamus under § 1085 Code Civ. Proc. (or in the alternative, a permanent or preliminary injunction), in the First Cause of Action only, to order the California Department of Health Care Services ("DHCS") and Sandra Shewry, its Director, to set aside their policy to implement, and to refrain from implementing a 10% across-the-board cut in reimbursement paid by the Medi-Cal program to providers in the Medi-Cal fee-for-services program, for dates of service on and after July 1, 2008; -- all, as provided in subds. (a), (b)(1), (b)(2), and (c) - (e) of § 14105.19 Welf. & Inst. Code; and § 14166.245 Welf. & Inst. Code, -- which were part of Sections 14 and 15 Assembly Bill X3 5, which was enacted Feb. 16, 2008.[5]

Movants shall refer to these provisions, (subds. (a), (b)(1), (b)(2), and (c) - (e) of § 14105.19 Welf. & Inst. Code; and § 14166.245 Welf. & Inst. Code), collectively, as the "FFS Payment Statutes."[6]

However, the FFS Payment Statutes violate the below federal statutes, so as to be preempted, -- due to the Supremacy Clause, -- by the below preempting federal statutes; namely:

- the "quality of care" clause of subd. (a)(30)(A) of 42 U.S.C. § 1396a, -- herein, "Sec.

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[5] Assembly Bill X3 5 was chaptered as Chapter 3, Statutes of 2007-2008 Third Extraordinary Session.

[6] A copy of Sections 14 and 15 of Assembly Bill X3 5, which contain the FFS Payment Statutes -- (namely, subds. (a), (b)(1), (b)(2), and (c) - (e) of § 14105.19 Welf. & Inst. Code; and § 14166.245 Welf. & Inst. Code) -- is attached as **Exhibit A** to this brief.

Petitioners have requested judicial notice of the FFS Payment Statutes, in **Paragraph A** of Petitioners' Request for Judicial Notice in Support of Petition for Writ of Mandamus and Other Relief, ("**RJN**"), filed herewith.

30(A);[7] and,

- the "equal access" clause of Sec. 30(A),[8]

and, as the inevitable result, (1) each of the two movant Medi-Cal recipients, (Dowling and Beckwith), the pharmacy plaintiffs, the plaintiff Southern California Independent Living Center, Inc. ("ILCSoCal"), and the plaintiff Gray Panthers of San Francisco ("Gray Panthers"), as well as (2) the patients, clients, and members of the plaintiff pharmacies, ILCSCal, and Gray Panthers (who are their prudential *jus tertii* representatives), as well as millions of other Medi-Cal beneficiaries receiving health care in the Medi-Cal fee-for-service program, will be injured or put at risk of injury by implementation of the 10% provider payment cuts to Medi-Cal fee-for-service providers, under the federally preempted FFS Payment Statute; -- all as set forth later in this brief, and, in their declarations filed herewith.

See, generally, Ex Parte Young, 209 U.S. 123 (1908).

DISCUSSION

The FFS Payment Statutes of Assembly Bill 3X 5 were enacted by a legislative history replete with gubernatorial and legislative declarations which identify the bill as a pure budget

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[7] The "quality of care" clause of Sec. 30(A) provides in relevant part:

> "(a) A state plan for medical assistance must– (30)(A) provide such methods and procedures relating to 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 . . . "

[8] The "equal access" clause of Sec. 30(A) provides in relevant part:

> "(a) A state plan for medical assistance must– (30)(A) provide such methods and procedures relating to the . . . payment for, care and services available under the the plan . . . as may be necessary . . . to assure that payments . . . 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."

reducing measure, not, any measure in respect to which the Legislature, the Lord forbid, might engage in any inquiry or consideration of whether the 10% reduced payments would be sufficient to assure that payments are consistent with quality of care, and with beneficiary equal access to quality care, as absolutely required by Sec. 30(A).

LEGISLATIVE HISTORY OF ASSEMBLY BILL X3 5

1. On January 10, 2008, the Governor proclaimed a State fiscal emergency, sent a proposed 2008-09 budget bill to the Legislature, and called the Legislature into special session.[9] [10]

2. On February 4, 7, and 15, 2008, Assembly Bill X3 5, a health budget trailer bill was introduced, then amended to include the FFS Payment Statutes in Sections 14 and 15, and was enacted on February 16, 2008.[11] [12]

3. A copy of the FFS Payment Statutes of Assembly Bill X3 5 is set forth in **Exhibit A** attached to this Memorandum; and is also set forth as **Exhibit A** of petitioners' RJN.

4. When Assembly Bill X3 5 was scheduled for final vote, the Assembly Floor Analysis of the Assembly Budget Committee informed legislators that the Governor's original proposal to commence the 10% Medi-Cal provider cut in June 2008, was postponed, in Assembly Bill X3 5, to commence in July 2008. The analysis explained:

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[9] Governor's website, Jan. 10, 2008. (A download copy is set forth in **Exhibit F** of RJN.)

[10] A copy of the Governor's fiscal emergency proclamation is set forth in **Exhibit B** of Petitioner's Request for Judicial Notice in Support of Writ of Mandamus and Other Relief, ("RJN").
A copy of the Governor's special session proclamation is set forth in **Exhibit C** of RJN.

[11] Bill Documents of Assembly Bill 3X 5, set forth in **Exhibit D** of RJN.

[12] Bill Documents, (**Exhibit D** of RJN).

> "The primary purpose of the delay of the reduction until the start of the new fiscal year is to **allow time for further review** of provider rates during the regular budget process to **identify any particularly critical consequences** of the reduction and to **evaluate** the possibility of **using a more refined approach** to mitigate those consequences while still achieving savings." (Boldface emphasis supplied.)[13]

As, in Alice in Wonderland, *sentence first, verdict afterwards*. Thus, in the rush to cut provider rates 10%, the Legislature here articulated its conscious and deliberate purpose to postpone and refrain from considering, before the bill was enacted, the effect of the 10% payment cut and whether the cut was consistent with quality of care and beneficiary access to quality care.

(But, this violated Sec. 30(A), which requires that a State consider all factors which relate to whether a proposed Medicaid rate is consistent with quality and with recipient access, **before** a new rate is promulgated. *See*, Orthopaedic Hospital v. Belshe, 103 F.3d 1491, 1500 (9th Cir.1997), which is a very strong case on this point.[14])

5. The Legislature, within the four corners of Assembly Bill X3 5 itself, also repeatedly articulated that the Legislature's purpose in the bill was to reduce the State budget.

6. Thus, Sec. 14 of Assembly Bill X3 5 added § 14105.19 to the Welf. & Inst. Code, to provide:

> "(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." (Emphasis supplied.)

This is an admission by the Legislature that the **purpose** of the 10% Medi-Cal provider cut in Section 14 of Assembly Bill X3 5, was to **implement the Governor's budget reductions** in the fiscal 2008-09 budget bill, (not, to consider whether the cuts would affect quality of services or beneficiary access to quality services).

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[13] Page 1 of Assembly Floor Analysis for Third Reading. (**Exhibit E** of RJN.)

[14] This point will be later more fully addressed.

7. Then, Section 15 of Assembly Bill X3 5, -- which imposes the 10% cut in Medi-Cal payments to non-contract hospitals, -- added §14105.245, subd. (a) to Welf. & Inst. Code, to expressly provide

> "(a) The Legislature finds and declares that the state faces a fiscal crisis that requires unprecedented measures to be taken to reduce General Fund expenditure to avoid reducing vital government services necessary for the protection of the health, safety, and welfare of the citizens of the State of California." (Emphasis supplied.)[15]

8. Also, Sec. 16 of Assembly Bill X3 5 expressly provides:

> "SEC. 16. This act addresses the fiscal emergency declared by the Governor by proclamation on January 10, 2008, pursuant to subdivision (f) of Section 10 of Article IV of the California Constitution." (Emphasis supplied.)[16]

9. And, Section 17 of Assembly Bill X3 5 expressly provides:

> "SEC. 17. . . . In order to make statutory changes needed to implement cost containment measures affecting health services, at the earliest possible time, it is necessary that this act take effect immediately." (Emphasis supplied.)[17]

Comment and ultimate factual finding

It is manifest from the legislative history that the **conclusive factor** in enacting the FFS Payment Statutes, in Sections 14 and 15 of Assembly Bill X3 5, complained of, was not whether the Legislature could assure that the new rates were consistent with quality and access, --- as required by Sec. 30(a), -- but, rather, were solely **budgetary considerations.**

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[15] Section 15 of Assembly Bill X3 5 is set forth in **Exhibit A** attached to this brief, and, in **Exhibit A** of petitioners' RJN.

[16] Section 16 of Assembly Bill X3 5 is set forth in **Exhibit A** attached to this brief, and, in **Exhibit A** of petitioners' RJN.

[17] Section 15 of Assembly Bill X3 5 is set forth in **Exhibit A** attached to this brief, and, in **Exhibit A** of petitioners' RJN.

Ultimate finding of fact, conclusion of law, and relief to be issued

From the above legislative history of Assembly Bill X3 5, including:

- the Assembly Budget Committee told Assembly members in February 2008 that they should first pass the cuts now, then take time, only later, to determine the effect of their action;

- the four declarations in Sections 14, 15, 16, and 17 of Assembly Bill X3 5, that, essentially, the Legislature was enacting these provisions for budgetary reasons, only, because of the need to cut State expenditures; and,

- the context which surrounds the bill, namely, that the 10% rate cut was enacted within 37 days from the Governor's proclamation that the State's economic sky was falling, and that an unprecedented budget shortfall required the Legislature to drastically reduce State spending, it follows that the Legislature, in enacting the 10% Medi-Cal cut in payments to fee-for-service providers in and by the FFS Payment Statutes, -- (i.e., subds. (a), (b)(1), (b)(2), and (c) - (e) of § 14105.19 Welf. & Inst. Code; and § 14166.245 Welf. & Inst. Code, which are part of Sections 14 ands 15 of Assembly Bill X3 5), -- (1) did so solely for budgetary reasons; (2) without consideration of the factors necessary to be considered to determine if the proposed new rates were consistent with quality of care and access to services; and, that (3) the conclusive factor in the decision of the Legislature to make these cuts was budgetary considerations.

Hence, such action of the Legislature to promulgate the FFS Payment Statutes of Assembly Bill X3 5, -- as well as the respondent DHCS and the Director's policy and action to implement these measures, -- were and are arbitrary and capricious, and contrary to law; namely,

in violation of the aforesaid quality and access clauses of Sec. 30(A); so as to be thereby preempted, under the Supremacy Clause, by Sec. 30(A).

Hence, an appropriate peremptory writ of mandamus (or in the alternative, a permanent injunction), or at the very least, a preliminary injunction must be issued before July 1, 2008, to order DHCS and its Director (1) to set aside their policy to implement the 10% payment cut of the FFS Payment Statutes of Assembly Bill X3 5, and (2) to refrain from implementing the same.

FURTHER DISCUSSION

1. **Courts, in reviewing the setting of Sec. 30(A) rates, use the "arbitrary and capricious" standard of review. Thus, if the State fails to adequately consider provider costs or any other factor which bears on whether the rates are consistent with quality and access, the rate is void *ab* initio; indeed, without any necessity for the plaintiff to show that it is likely that the new rates will negatively impact quality care or beneficiaries' access to quality care.**

The case at bar is *deja vu* all over again.

In 2003 the Legislature enacted a prior bill to cut all Medi-Cal provider and managed care payments 5% across-the-board for budgetary reasons; and declared in the bill, -- just as in case at bar, -- that it was enacted due to a budget shortfall, to implement reduction in funding for health services.

In Clayworth v. Bonta, 295 F.Supp.2d 1110, 1126-1130 (E.D.Cal.2003), preliminary injunction issued to enjoin the 5% rate cut in the Medi-Cal fee-for-service program, on the basis that because budgetary considerations were the conclusive factor in enacting the cut, that the action of the State to reduce Medicaid rates was arbitrary and capricious, in violation of the requirement of Sec. 30(A) that a Medicaid rate setter must consider quality and access in setting

the rate.[18]

The District Court in Clayworth concluded that the State's purpose in enacting the 5% cut "was to reduce the budget shortfall," noting that "the statute declares on its face that the rate reduction is '[d]ue to the significant state budget deficit projected for the year," (*id.*, 295 F.Supp. at 1128), and held that:

> "Budget constraints are not alone a valid justification for rate setting. *See*, Ark. Med. Soc'y., 6 F3d at 531 ('Abundant persuasive precedent supports the proposition that budgetary considerations cannot be the conclusive factor in decisions regarding Medicaid,'); Orthopaedic Hosp., 103 F.3d at 1499, n.3;[19] Amisub, 879 F.2 at 800-01."[20]

In analyzing Sec. 30(A) the District Court in Clayworth relied on Orthopaedic Hospital v. Belshe, 103 F.3d 1491, 1496-1497, 1500. The District Court noted that Orthopaedic Hosp. 103 F.3d at 1500, held that under the quality clause of Sec. 30(A) that there must be a reasonable relationship between the rates set and providers' costs to provide quality care. (Clayworth, 295 F.Supp. at 1126.)

Further, this rule is procedural, (Clayworth, 103 F.3d at 1127): if the State does not consider providers' costs, or cuts rates without any evidence that the cut can be sustained by

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[18] **Note:** The order for preliminary injunction in Clayworth was reversed in the 9th Circuit, in a one-sentence order filed August 2, 2005, stating that the Sanchez v. Johnson, 416 F.3d 1051 (9th Cir.2005), holding that Congress did not intend, in 42 U.S.C. § 1983, to create any private right of action in Medicaid beneficiaries or providers, compelled reversal of the Clayworth preliminary injunction. (Copy of the 9th Circuit order is set forth in **Exhibit G** of RJN.)

In sum, the 9th Circuit reversal of the Clayworth preliminary injunction did not overrule or relate to any of the District Court's ruling in Clayworth, *supra,* other than the single (erroneous) order of the District Court, to wit, that § 1983 afforded jurisdiction to the federal courts to entertain challenges by Medicaid beneficiaries and providers to California's compliance with Sec. 30(A), -- which § 1983 issue is irrelevant to any issue raised by plaintiffs in the case at bar.

[19] Arkansas Medical Society, Inc. v. Reynolds, 6 F.3d 519 (8th Cir.19983).

[20] Amisub (PSL), Inc. v. Colorado Dept. of Soc. Ser., 879 F.2d 789 (10th Cir.1989).

providers, in light of their costs, without a loss of quality or equal access for Medi-Cal recipients, (*see*, Clayworth, 295 F.Supp. at 1128), then the rate is held to be "arbitrary and capricious," contrary to Sec. 30(A), and hence void, without more. -- i.e., **without any necessity for the plaintiff to show** that the rate is too low to enable providers to furnish quality services, or, that insufficient providers will continue in the program. (Orthopaedic Hosp., 103 F.3d at 1500; Clayworth, 295 F/Supp.2d at 1127.)

The basis for enjoining a Medicaid rate set arbitrarily and capriciously, without consideration of provider costs or without consideration of quality or access at all, is that:

> "(I)t is safe to assume that a rate that is set arbitrarily, without reference to the Sec. 30(A) requirements, is unlikely to meet the equal access and quality requirements. Thus, a beneficiary plaintiff may insist that the State, at a minimum, consider the effect of a rate reduction on qual access to quality services in light of provider costs." Clayworth, 295 F.Supp.2d at 1127, citing Orthopaedic Hosp., 103 F.3d at 1500.

Conclusion

One would have to believe in the tooth fairy, to believe on this legislative record that the Legislature, -- in enacting the 10% provider rate, -- considered whether the reduced payments are consistent with quality of services and access to quality services, or considered whether the reduced payment amounts bear a reasonable relation to provider costs, (as required Sec. 30(A) under the rulings of Orthopaedic Hosp., 103 F.3d at 1500, and Clayworth, 295 F.Supp. at 1117, fn.6).

2. **The Supremacy Clause has always been a shield against State action, (1) which threatens to injure Medicaid beneficiaries and providers, and (2) is preempted, under the Supremacy Clause, by contrary provisions of the Medicaid Act, such as, especially, Sec. 30(A).**

In Wisconsin Hospital Assn. v. Reivitz, 735 F.2d 1226, 1227 (7th Cir.), a hospital association and several hospitals had standing to sue to enforce Sec. 30(A), under the Supremacy

Clause.

In Harmony Nursing Homes, Inc. v. Anderson. 341 F. Supp. 957, 958 (D.Minn.1972), a nursing home had standing to sue under the Supremacy Clause to restrain a state's"freeze" on Medicaid payments to providers.

Also, the three pharmacy plaintiffs, the plaintiff ILCSCAL, and the plaintiff San Francisco Gray Panthers have just as much or more a right, under the Supremacy Clause, to sue to obtain a protective injunction, for themselves and the benefit of their Medi-Cal patients, clients, or members, against the **federally preempted** 10% Medi-Cal provider cut, (due to its violation of Sec. 30(A)), as did the pharmaceutical manufacturers association in Pharmaceutical Research and Manufacturers of America (PhRMA) v. Concannon, (249 F.3d 66 (1st Cir.2001) to sue to enjoin state action, in violation of the Medicaid Act, injuring the manufacturers and the Medicaid patients whom they prudentially represented.

In PhRMA, a pharmaceutical manufacturers association, -- not one of whose members had any professional relationship with Medicaid beneficiaries,-- was readily afforded prudential standing to sue under the Supremacy Clause to pre-empt a state statute enacted in violation of the Medicaid Act.

I.e., all that is necessary to be a plaintiff in a Supremacy Clause claim, (Article VI, cl. 2, Constitution), is a showing that the interests of the plaintiff are within the zone of interests arguably to be protected by the federal statute. Thus PhRMA held, (249 F.3d 66, 72-74 (1st Cir. 2001):

> "The initial question is whether PhRMA has prudential standing to challenge the prior authorization provision of the Act. . . . The Supreme Court recently reiterated the standard for determining prudential standing:
>
> > In applying the 'zone of interests" test, we do not ask whether, in enacting the

> statutory provision at issue, Congress specifically intended to benefit the plaintiff. Instead, we first discern the interests 'arguably . . . to be protected' by the statutory provision at issue; we then inquire whether the plaintiff's interests affected by the agency action in question are among them.

(National Credit Union Adm. v. First National Bank & Trust Co., 522 U.S. 479, 492 (1998).

. . .

> PhRMA has not asserted an action to enforce rights under the Medicaid statute, . . . but rather a preemption-based challenge under the Supremacy Clause. In this type of action, it is the interests protected by the Supremacy Clause, not by the preempting statute, that are at issue. [Citation.] As the Third Circuit recently pointed out, an entity does not need prudential standing to invoke the protection of the Supremacy Clause:
>
> > We know of no governing authority to the effect that the federal statutory provision which allegedly preempts enforcement of local legislation by conflict must confer a right on the party that argues in favor of preemption. On the contrary, a state or territorial law can be unenforceable as preempted by federal law even when the federal law secures no substantive right for the party arguing preemption.
>
> Id. Thus, regardless of whether the Medicaid statute's relevant provisions were designed to benefit PhRMA, PhRMA can invoke the statute's preemptive force. . . . Given that PhRMA has prudential standing grounded in the Supremacy Clause, we think it may fairly assert the rights of Medicaid recipients for purposes of this action. Where a party has established a concrete injury in fact, and otherwise has standing to challenge the lawfulness of the statute, it is 'entitled to assert those concomitant rights of third parties that would be "diluted or adversely affected" should [its] constitutional challenge fail and the statute remain in force. . . . " (Emphasis supplied.)

Conclusion on sub-point: It follows form this unbroken line of cases on the Supremacy Clause, that Medicaid providers as well as beneficiaries are within the "zone of interests" intended to be protected, by Congress, in enacting the Medicaid Act; especially, Sec. 30(A).

Thus both Medicaid beneficiaries and providers may sue, as in case at bar, to protect against injury from state action which violates, and is hence preempted, under the Supremacy Clause, by the Medicaid Act, (here, Sec. 30(A)).

Accordingly, the two Medi-Cal beneficiaries (Dowling and Beckwith) who obtain their

Medi-Cal services in the Medi-Cal fee-for-service program, plus, the three Medi-Cal fee-for-service pharmacy plaintiffs, (the Uptown, Central, and Tran pharmacies), are manifestly entitled, under Supremacy Clause decisional law, to a writ of mandamus or injunction, **in the First Cause of Action**, to enjoin the respondents from injuring them by implementing the 10% cut in payments to Medi-Cal fee-for-service providers, under the FFS Payment Statutes, (namely, subds. (a), (b)(1), (b)(2), and (c) - (e) of § 14105.19 Welf. & Inst. Code; and § 14166.245 Welf. & Inst. Code), enacted as part of Sections 14 and 15 of the Assembly Bill X3 5, which violate the quality and access provisions of Sec. 30(A), -- i.e., , 42 U.S.C.. § 1396a(a)(30)(A).

FURTHER DISCUSSION OF STANDING TO SUE, AND INJURY

3. **Next. The plaintiffs each sue, as authorized by Green v. Obledo, 29 Cal.3d 126 (1981), on their own behalf and on behalf of the public, to procure performance of public duty by public officials; hence, need not show they have any legal or special interest in the result.**

It is sufficient, held Green, *supra*, that the plaintiff "is interested as a citizen in having the laws executed and the duty in question enforce." (29 Cal.3d at 144-145.)

Thus each of the movant plaintiffs, -- who are citizens and residents of the State of California as shown by their declarations, -- may sue in this case to enforce the public duty of the respondent State officials to comply with the public duty, -- pursuant to the Supremacy Clause, -- to obey federal law where, as in case at bar, Sec. 30(A) preempts contrary state law, (here, the 10% Medi-Cal provider rate cut promulgated by subds. (a), (b)(1), (b)(2), and (c) - (e) of § 14105.19 Welf. & Inst. Code; and § 14166.245 Welf. & Inst. Code, (which are part of Sections 14 and 15 of the Assembly Bill X3 5 ("**Exhibit A** attached).

4. **Clayworth, 295 F.Supp.2d at 1117-1119, ruled that providers and beneficiary associations have prudential standing to assert the interests of their patients or members. Under the view of these rulings, the plaintiff pharmacies, the ILCSCal, and the San Francisco Gray Panthers may, on a prudential basis, assert the interests of their patients, clients, or members (as the case may be), in the within proceeding.**

The interest of Medi-Cal beneficiaries, -- who are patients, clients, or members of the two pharmacy plaintiffs, the ILCSCal, and the San Francisco Gray Panthers, -- is the interest of not being injured from implementation of the 10% cut in payments to Medi-Cal provider in the Medi-Cal fee-for-serve program, in violation of the federally pre-empted FFS Payment Statutes, (namely, the aforesaid subds. (a), (b)(1), (b)(2), and (c) - (e) of § 14105.19 Welf. & Inst. Code; and § 14166.245 Welf. & Inst. Code, -- (which provisions are part of Sections 14 and 15 Assembly Bill X3 5, in **Exhibit A** attached).

As shown by the declarations of the CEO of the ILCSCal, and the co-chief of the San Francisco Gray Panthers, filed herein, each of these beneficial or member organizations meet the tests described by Clayworth, 295 F.Supp/2d at 1117-1119, for having prudential standing to assert the rights of their clients or members who are Medi-Cal beneficiaries, in the case at bar.

Injury

Also, plaintiffs have introduced evidence of a severe shortage of dentists and of doctors and specialists, which will be exacerbated by this newest 10% payment cut to fee-for-service providers. Also, the declarations of the two movant Medi-Cal beneficiaries, -- Beckwith and Dowling, the former a quadriplegic who requires oxygen and 8 attendants daily to stay alive, and the latter a paraplegic with diagnosis of terminal rectal cancer, -- show they will be injured, and are at severe risk for injury, pain and suffering, and of being forced into institutions, and of even death, -- (as are thousands like them), -- from loss of their doctors and specialists, and access to

quality medical and pharmacy services, which will certainly occur if the 10% payment cut to Medi-Cal fee-for-service patients, is not enjoined by a writ or injunction, which is requested..

Summary, and relief requested:

Petitioners request that the Court, based on the above Memorandum of facts and law, and the facts of prospective severe injury to Medi-Cal fee-for-service recipients, (including the plaintiffs Dowling and Beckwith), which are shown by the supporting declarations, order:

A. That a writ of mandamus be issued **in the First Cause of Action** under § 1085 Code Civ. Proc., or in the alternative, a permanent injunction, (or at the very least, a preliminary injunction), which orders the respondents Department of Health Care Services, and its Director to set aside their policy to implement the FFS Payment Statutes,(namely, subds. (a), (b)(1), (b)(2), and (c) - (e) of § 14105.19 Welf. & Inst. Code; and § 14166.245 Welf. & Inst. Code), which are part of Sections 14 and 15 of Assembly Bill X3 5, (Chapter 3, Statutes 2007-2008 Third Extraordinary Session), and to refrain from implementing the 10% reduction of payments to Medi-Cal fee-for-service providers specified in the aforesaid FFS Payment Statutes, or any other reduction of payments to providers in the Medi-Cal fee-for-service program, for dates of service on or after July 1, 2008, or at any other time..

B. That petitioners have costs of suit, plus reasonable attorneys' fees under § 1021.5 Code Civ. Proc, and such other and further relief as may be just.

Dated: May 12, 2008.

Respectfully submitted,

LYNN S. CARMAN
STANLEY L. FRIEDMAN

By _____
Attorneys for Petitioners

Exhibit A

Assembly Bill No. 5

CHAPTER 3

An act to amend Section 95004 of the Government Code, and to amend Sections 4640.6, 4643, 4648.4, 4681.3, 4681.5, 4691.6, 4781.6, and 4783 of, and to add Sections 4681.6, 4689.8, 4691.9, 14041.1, 14105.19, and 14166.245 to, the Welfare and Institutions Code, relating to health, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor February 16, 2008. Filed with Secretary of State February 16, 2008.]

LEGISLATIVE COUNSEL'S DIGEST

AB 5, Committee on Budget. Public health programs.

Under existing law, the State Department of Developmental Services provides funding for regional centers for the provision or purchase of services and supports to persons with developmental disabilities. Existing law prescribes a specified ratio for regional center service coordinator to consumer, which is in effect until June 30, 2008.

This bill would extend indefinitely the effective date of this ratio.

Existing law provides for the assessment of certain individuals for whom benefits are provided by regional centers. Existing law provides that if assessment is needed, prior to July 1, 2008, the assessment shall be performed within 120 days following initial intake, and requires that assessments after that date shall be performed within 60 days following intake.

This bill would extend indefinitely the 120-day assessment requirement.

Existing law, with certain exceptions, for the 2007–08 fiscal year, prohibits a regional center from paying any provider of specified services a rate that is greater than the rate that is in effect on July 1, 2007, unless the increase is required by contract between the regional center and the vendor that is in effect on June 30, 2007.

This bill would extend indefinitely this prohibition with respect to the payment of rates in excess of those in effect on June 30, 2008.

Existing law provides that, during the 2007–08 fiscal year, no regional center may approve any service level for a residential service provider.

This bill would extend indefinitely this provision. It would also prohibit, commencing July 1, 2008, a regional center from negotiating rates with residential care providers, except as prescribed.

Existing law requires the State Department of Developmental Services to make payments to providers of supported living services for adults with developmental disabilities. Under existing law, the department, by July 1, 2002, is required to establish, by regulation, an equitable and cost-effective

methodology for the determination of supported living costs and a methodology of payment for these providers.

This bill would, commencing July 1, 2008, impose prescribed rate increase restrictions on reimbursement to these service providers and would also prohibit a regional center from negotiating rates with these providers, except as prescribed.

Existing law prohibits, during the 2007–08 fiscal year, the State Department of Developmental Services from establishing any permanent payment rate for a community-based day program or in-home respite care agency that has a temporary payment rate in effect on July 1, 2007, or from making other specified changes or adjustments that would result in a rate increase.

This bill would extend indefinitely this provision, and would apply it to rates in effect June 30, 2008. It would also prohibit a regional center from negotiating rates with these providers, except as prescribed.

Existing law provides that, for the 2007–08 fiscal year only, a regional center shall not expend any purchase of service funds for the startup of any new program unless the expenditure is necessary to protect the consumer's health or safety or because of other extraordinary circumstances and the department has granted prior written authorization.

This bill would extend indefinitely this prohibition.

Under existing law, the California Early Start Intervention Services Act, various state entities provide coordinated services to infants and toddlers with disabilities and their families. Existing law requires early intervention services to be provided directly to eligible infants and toddlers and their families through the regional center system and the local education system. Existing law requires that, in providing services under the act, regional centers comply with the Lanterman Developmental Disabilities Services Act, and its implementing regulations, including, but not limited to, those provisions relating to vendorization and ratesetting, except where compliance with those provisions would result in any delays in, or any cost to families for, the provision of early intervention, or otherwise conflict with the act or its implementing regulations. Existing law, until July 1, 2009, also contains family cost participation requirements for specified services obtained by regional centers for persons with developmental disabilities.

This bill would extend indefinitely the family cost participation requirements, and would also require that, subject to federal approval, in providing those early intervention services under the Lanterman Developmental Disabilities Services Act, regional centers apply the family cost participation requirements that require families of children receiving early intervention services to contribute a specified amount to the cost of those services based on family size and scaled income levels. It would also revise the family cost participation schedule and the procedures governing how a parent may appeal a decision made by the executive director of a regional center, with respect to the amount of the parents' cost participation.

Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services, under which qualified low-income persons are provided with a variety of health services.

Existing law contains various provisions governing reimbursement rates for Medi-Cal providers.

This bill would, notwithstanding any other provision of law, and to the extent not otherwise conflicting with federal law, authorize the department to withhold, or direct the medical fiscal intermediary to withhold, payments for providers, as described, for a period of one month for a month ending prior to January 1, 2009.

Existing law creates various health programs, including the Child Health and Disability Prevention Program, the California Children's Services Program, the Genetically Handicapped Person's Program, and specified family planning programs.

This bill would, with certain exceptions, for services rendered under these programs on and after July 1, 2008, require the Director of Health Care Services to reduce provider reimbursement rates by 10%.

The bill would specify that the reductions imposed pursuant to the bill would apply only to the General Fund share of the payment, and only to payments for services from funds appropriated to the department.

Existing law establishes the Medi-Cal Hospital/Uninsured Care Demonstration Project Act, which revises hospital reimbursement methodologies under the Medi-Cal program in order to maximize the use of federal funds consistent with federal Medicaid law and stabilize the distribution of funding for hospitals that provide care to Medi-Cal beneficiaries and uninsured patients. This demonstration project provides for funding, in supplementation of Medi-Cal reimbursement, to various hospitals, including designated public hospitals, nondesignated public hospitals, and private hospitals, as defined in accordance with certain provisions relating to disproportionate share hospitals.

This bill would reduce by 10% payments for inpatient hospital services to acute care hospitals not under selective contracts with the department that are provided on and after July 1, 2008.

The California Constitution authorizes the Governor to declare a fiscal emergency and to call the Legislature into special session for that purpose. The Governor issued a proclamation declaring a fiscal emergency, and calling a special session for this purpose, on January 10, 2008.

This bill would state that it addresses the fiscal emergency declared by the Governor by proclamation issued on January 10, 2008, pursuant to the California Constitution.

This bill would declare that it is to take effect immediately as an urgency statute.

compliance for these implementing regulations shall be filed within 24 months following the adoption of the first emergency regulations filed pursuant to this subdivision.

(n) By April 1, 2005, and annually thereafter, the department shall report to the appropriate fiscal and policy committees of the Legislature on the status of the implementation of the Family Cost Participation Program established under this section. On and after April 1, 2006, the report shall contain all of the following:

(1) The annual total purchase of services savings attributable to the program per regional center.

(2) The annual costs to the department and each regional center to administer the program.

(3) The number of families assessed a cost participation per regional center.

(4) The number of cost participation adjustments granted pursuant to paragraph (5) of subdivision (g) per regional center.

(5) The number of appeals filed pursuant to subdivision (k) and the number of those appeals granted, modified, or denied.

SEC. 13. Section 14041.1 is added to the Welfare and Institutions Code, to read:

14041.1. (a) Notwithstanding any other provision of law, and to the extent not otherwise conflicting with federal law, the department may hold for a period of one month, or direct the medical fiscal intermediary for the Medi-Cal program to hold for a period of one month, payments to providers or their designated agents for health care services that are provided pursuant to this chapter, and payments to entities that contract with the department pursuant to this chapter, Chapter 8 (commencing with Section 14200) and Chapter 8.75 (commencing with Section 14590) for the delivery of health care services.

(b) The authority described in subdivision (a) shall be limited to payments for one month only, and only for a month ending prior to January 1, 2009.

SEC. 14. Section 14105.19 is added to the Welfare and Institutions Code, to read:

14105.19. (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 and after July 1, 2008.

(2) Except as provided in subdivision (c), payments shall be reduced by 10 percent for non-Medi-Cal programs described in Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, and Section 14105.18, for dates of service on and after July 1, 2008.

(3) For managed health care plans that contract with the department pursuant to this chapter, Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14590), payments shall be reduced

by the actuarial equivalent amount of the payment reduction specified in this subdivision pursuant to contract amendments or change orders effective on July 1, 2008.

(c) The services listed in this subdivision shall be exempt from the payment reductions specified in subdivision (b):

(1) Acute hospital inpatient services, except for payments to hospitals not under contract with the State Department of Health Care Services, as provided in Section 14166.245.

(2) Federally qualified health center services, including those facilities deemed to have federally qualified health center status pursuant to a waiver under subdivision (a) of Section 1315 of Title 42 of the United States Code.

(3) Rural health clinic services.

(4) All of the following facilities:

(A) A skilled nursing facility pursuant to subdivision (c) of Section 1250 of the Health and Safety Code, except a skilled nursing facility that is a distinct part of a general acute care hospital. For purposes of this paragraph, "distinct part" has the same meaning as defined in Section 72041 of Title 22 of the California Code of Regulations.

(B) An intermediate care facility for the developmentally disabled pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code, or a facility providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14495.10.

(C) A subacute care unit, as defined in Section 51215.5 of Title 22 of the California Code of Regulations.

(5) Payments to facilities owned or operated by the State Department of Mental Health or the State Department of Developmental Services.

(6) Hospice.

(7) Contract services as designated by the director pursuant to subdivision (e).

(8) Payments to providers to the extent that the payments are funded by means of a certified public expenditure or an intergovernmental transfer pursuant to Section 433.51 of Title 42 of the Code of Federal Regulations.

(9) Services pursuant to local assistance contracts and interagency agreements to the extent the funding is not included in the funds appropriated to the department in the annual Budget Act.

(10) Payments to Medi-Cal managed care plans pursuant to Section 4474.5 for services to consumers transitioning from Agnews Developmental Center into Alameda, San Mateo, and Santa Clara Counties pursuant to the Plan for the Closure of Agnews Developmental Center.

(11) Breast and cervical cancer treatment provided pursuant to Section 14007.71.

(12) The Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program pursuant to Section 14105.18.

(d) Subject to the exception for services listed in subdivision (c), the payment reductions required by subdivision (b) shall apply to the services rendered by any provider who may be authorized to bill for the service,

(e) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the director may implement subdivision (b) by means of a provider bulletin, or other similar instruction, without taking regulatory action.

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

SEC. 16. This act addresses the fiscal emergency declared by the Governor by proclamation on January 10, 2008, pursuant to subdivision (f) of Section 10 of Article IV of the California Constitution.

SEC. 17. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make statutory changes needed to implement cost containment measures affecting health services, at the earliest possible time, it is necessary that this act take effect immediately.

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