

No. 08-56422

IN THE
UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, *et al.*,
Petitioners-Appellees/Petitioners-Appellants,
and

SACRAMENTO FAMILY MEDICAL CLINICS, INC., *et al.*
Intervenors-Appellees,
v.

SANDRA SHEWRY, DIRECTOR OF THE DEPARTMENT OF HEALTH
CARE SERVICES, STATE OF CALIFORNIA
Respondent-Appellant/Respondent-Appellee.

On Appeal from the U.S.D.C. for the Central District of California
CV08-03315 CAS (MANx) –
The Honorable Christina A. Snyder, Judge

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LAW CENTER, NATIONAL HEALTH LAW PROGRAM, INC.
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CORPORATE DISCLOSURE STATEMENT

AARP The Internal Revenue Service has determined that AARP is organized and operated exclusively for the promotion of social welfare pursuant to Section 501(c)(4) of the Internal Revenue Code and is exempt from income tax. AARP is also organized and operated as a non-profit corporation pursuant to the provisions of Title 29 of chapter 6 of the District of Columbia Code 1951. Other legal entities related to *amicus curiae* AARP include AARP Foundation, AARP Services, Inc., Legal Counsel for the Elderly, AARP Financial, AARP Global Network and Focalyst.

National Senior Citizens Law Center (NSCLC) The Internal Revenue Service has determined that NSCLC is organized and operated exclusively for charitable, or educational purposes pursuant to Section 501 (c)(3) of the Internal Revenue Code and is exempt from income tax. NSCLC is also organized and operated as a non-profit corporation under the laws of the State of California.

National Health Law Program (NHeLP). The Internal Revenue Service has determined that NHeLP is organized and operated pursuant to Section 501(c)(3) of the Internal Revenue Code and is exempt from income tax. NHeLP is operated as a non-profit corporation under the laws of the State of California.

Barbara A. Jones

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STATEMENT OF INTEREST OF *AMICI CURIAE*

AARP is a nonpartisan, nonprofit membership organization for people 50 and over, with close to 40 million members, including approximately 3.4 million members in California. Access to health care is a top priority for AARP. During 2007, AARP spent much of the year working for passage of health care reform in California and throughout the nation. AARP supports access to affordable health care, including prescription drugs, for everyone. Thus, AARP advocates for health and economic security for everyone and in particular for vulnerable people of all ages, including low-income persons and persons with disabilities. To that end, AARP supports legislative efforts at the state and national level to ensure that these individuals have continuous access to quality health care through publicly administered health insurance programs, including Medicaid. AARP encourages states to exercise available options for expanding Medicaid eligibility and services and to ensure the highest level of Medicaid participation among all health care providers. AARP has participated as amicus curiae in a variety of Medicaid cases nationwide supporting access to health care.

The **National Senior Citizens Law Center** (“NSCLC”) is a non-profit organization that advocates nationwide to promote the independence and well-being of low-income older persons and people with disabilities. For more than 35 years, NSCLC has served these populations through litigation, administrative

advocacy, legislative advocacy, and assistance to attorneys and paralegals in legal aid programs. Medicaid is a critical source of health insurance to millions of older persons and people with disabilities, and NSCLC has participated as counsel in numerous lawsuits on behalf of these populations in suits involving access to Medicaid. NSCLC is profoundly concerned about the impact that the Court's decision may have on its clients' access to Medicaid

The **National Health Law Program, Inc. (NHeLP)** is a national public interest law firm working to improve access to quality health care on behalf of limited income people by providing litigation assistance, legal and policy analysis, information and education. Since its inception nearly forty years ago, NHeLP has represented thousands of families, children and people with disabilities in federal court cases when state Medicaid programs are not acting consistent with the federal Medicaid Act. NHeLP has developed recognized expertise in public insurance and disability law. NHeLP shares its expertise with a nationwide network of attorneys working on health access issues and serves as a national clearinghouse for legal information.

SUMMARY OF ARGUMENT

This Court should affirm the district court's order granting in part, Petitioners-Appellees' (Petitioners) motion for preliminary injunction. The California Medicaid program, Medi-Cal, has the lowest Medicaid spending per

enrollee in the nation and one of the lowest physician reimbursement rates. Due to these low rates, the ratio of primary care physicians to Medi-Cal beneficiaries is already well below the federal minimum standard.¹ Numerous studies focused on California, reflect that even before the cuts, few physicians were willing to take Medicaid payments due to the low provider rates. The California Legislature approved a 10 percent cut in provider reimbursement, which absent an injunction would further decrease doctor participation in the program and force some health facilities to close completely, making health care even more inaccessible to low-income California residents. Delayed care and lack of access to care will result in increased morbidity and mortality for California's most vulnerable citizens, particularly older individuals and the disabled.

The district court was correct in its holding that 42 U.S.C. § 1396a(a)(30)(A) (2008) preempts Cal. Assemb. B. 5, X3 Sess. Ca. (2008), the state statute that cut provider rates. This Court has previously rejected the argument, advanced by Respondents-Appellants (Respondents), that the repeal of the Boren Amendment was “intended ‘to terminate ... judicial oversight’ of reimbursement rates.

¹ This motion is referred to as the Supplemental Motion for Preliminary Injunction in the Respondents' pleadings.

ARGUMENT

I. MEDICAID ACT AND REGULATIONS REQUIRE PARTICIPATING STATES TO PROVIDE MEDICAL SERVICES TO BENEFICIARIES AT LEAST TO THE EXTENT THAT THOSE SERVICES ARE AVAILABLE TO THE GENERAL POPULATION

Medicaid is a health care reimbursement program for low-income residents that is administered by the states but funded jointly by the state and federal governments. The federal government provides matching funds to the states² on the condition that they comply with federally mandated Medicaid laws and regulations.³ The general purpose of Medicaid is to “ensure adequate access and quality of care” in the context of both institutional and non-institutional providers.⁴ To that end, the Medicaid statute and implementing regulations require that medical services be provided to beneficiaries at least to the extent that those

² The federal government currently matches state Medicaid expenditures at a rate of 50 to 83 percent, depending on the state’s per capita income level as compared to the national average. Centers for Medicare and Medicaid Services, Medicaid Program - Technical Summary (Dec. 14, 2005), *available at* <http://www.cms.hhs.gov/MedicaidGenInfo/03_TechnicalSummary.asp>.

³ Non-compliance with federal Medicaid laws can result in revocation of federal funds. 42 C.F.R. § 430.35 (2007); *See also* 42 U.S.C. § 1396 (2006); *Antrican v. Odom*, 290 F.3d 178, 191 (4th Cir. 2002), cert. denied, 537 U.S. 973 (2002) (holding that “[T]he Medicaid Act clearly mandates that a State provide a certain level and quality of ...care”).

⁴ *Arkansas Medical Society v. Reynolds*, 6 F.3d 519,530 (8th Cir. 1993).

services are available to the general population living in the same geographic area.⁵ In addition, Medicaid regulations require that the amount, duration, and scope of each covered service sufficiently or reasonably achieve the purpose of the service provided.⁶

California's Medicaid program, known as Medi-Cal, is the main source of health care insurance for 6.6 million Californians.⁷ Medi-Cal reimburses medical providers for care provided to eligible low-income individuals, including families with children, pregnant women, and people with specific diseases,⁸ and fills in gaps in Medicare coverage for persons aged 65 and over, or for persons who are

⁵ 42 U.S.C. § 1396a(a)(30)(A)(2006); 42 C.F.R. § 447.204 (2007); *see Clark v. Kizer*, 758 F. Supp. 572 (E.D. Cal. 1990), 575, *aff'd in relevant part, rev'd on other grounds*, 967 F.2d 585 (9th Cir. 1992).

⁶ 42 C.F.R. § 440.230(b)(2007); *see J.K. v. Dillenberg*, 836 F. Supp. 694, 696 (D. Ariz. 1993).

⁷ Cal. HealthCare Found., *Medi-Cal Facts and Figures: A Look at California's Medicaid Program* (May 2007), *available at* <<http://www.chcf.org/topics/medi-cal/index.cfm?itemID=21659>>.

⁸ Medicaid provides coverage to people who have chronic disabilities including blindness, physical impairments, limitations from spinal cord injuries, severe mental and emotional conditions, and other disabling conditions such as cerebral palsy, cystic fibrosis, Downs Syndrome, mental retardation, muscular dystrophy, autism, spina bifida, and HIV/AIDS. Jeff S. Crowley & Risa Elias, *The Kaiser Comm'n on Medicaid and the Uninsured, Medicaid's Role for People with Disabilities 2* (Aug. 2003).

disabled.⁹ California, like all participating state governments, has a legal obligation to pay for and administer medical assistance that program beneficiaries need in compliance with the requirements of the Medicaid Act and implementing regulations.¹⁰

Notwithstanding the state's obligations, the Legislature passed a ten percent reduction in reimbursement rates for many Medi-Cal providers, including doctors, hospitals, clinics, and managed care plans.¹¹ This reduction will lead to a dire reduction of health services for the state's most needy residents. Reducing provider reimbursement will significantly reduce a fundamental element of health care service - access to providers. As discussed below, physician participation in

⁹ Medi-Cal pays for two-thirds of all nursing home care and long-term care services make up nearly a third of all Medi-Cal spending. Kaiser Family Found., The Kaiser Commission on Medicaid and the Uninsured, *The California Medicaid Program at a Glance*, 1, 3 (July 2004), *available at* <<http://www.kff.org/statepolicy/upload/The-California-Medicaid-Program-at-a-Glance.pdf>>.

¹⁰ *Antrican v. Odom, supra*, 290 F.3d 178, 191 (4th Cir. 2002), cert. denied, 537 U.S. 973 (2002) (noting that “the Medicaid Act clearly mandates that a State provide a certain level and quality of ...care”).

¹¹ Cal. Assem. B. 5, X3 Sess. (Ca. 2008); Cal. Budget Project, *Legislature Approves Midyear Cuts* (Feb. 15, 2008), *available at* <http://www.cbp.org/pdfs/2008/080214_Midyearcuts.pdf> [hereinafter *Midyear Cuts*]. Other proposed changes to Medi-Cal, including increased premiums and copayments for children's health care and the elimination of ten medically necessary services for adults, including dental, podiatry, and optometry services, are still pending in the legislature. Cal. Budget Project, *Governor's Proposed Health Cuts Would Increase Ranks of Uninsured, Reduce Access* 1-4 (May 2008).

Medi-Cal is already dwindling due to the state's historically low reimbursement rates; and if the proposed cuts go into effect, California's most vulnerable populations will be at risk of significantly increased morbidity and mortality due to delayed and inaccessible health care.

II. CUTS IN PROVIDER REIMBURSEMENT RATES WILL RESULT IN A MASS EXODUS OF PHYSICIANS FROM THE MEDI-CAL PROGRAM

Numerous studies have shown a strong relationship between low provider payment rates and the unwillingness of primary care physicians to accept Medicaid patients.¹² Some studies show that physician fee levels affect not only access but the medical outcomes for Medicaid patients.¹³ Studies focused on California, reflect that even before the cuts, few physicians were willing to take Medi-Cal payments due to the low payment rates of Medi-Cal. A 2001 study focused on children concluded that "on average, the overhead cost to an orthopedic surgeon to

¹² See e.g., Steve Berman et al., *Factors that Influence the Willingness of Private Primary Care Pediatricians to Accept More Medicaid Patients*, 110 PEDIATRICS 239 (2002); David L. Skaggs, et al., *Access to Orthopedic Care for Children With Medicaid Versus Private Insurance: Results of a National Survey*, 26 J. PEDIATRICS ORTHOPEDICS 400 (2006); David L. Skaggs, et al., *Insurance Status and Delay in Orthotic Treatment in Children*, 27 J. PEDIATRICS ORTHOPAEDICS 94 (2007).

¹³ Stephen Norton, *Recent Trends in Medicaid Physician Fees, 1993-1998*, URB. INST., (Aug. 1, 1999), available at <<http://www.urban.org/UploadedPDF/discussion99-12.pdf>

treat a patient with Medi-Cal is more than the reimbursement”.¹⁴ Other reports have “documented the inequality of access to subspecialty healthcare” for patients with Medicaid and other government health care.¹⁵

California already has the lowest Medicaid spending per enrollee¹⁶ and one of the lowest physician reimbursement rates in the nation.¹⁷ Nine in ten primary care physicians say Medi-Cal rates are inadequate,¹⁸ and as a result there are only 46 primary care physicians per 100,000 beneficiaries, well below the federal minimum standard of 60 to 80 providers per 100,000.¹⁹ Participation among

14 David L. Skaggs et al., *Access to Orthopedic Care for Children With Medicaid Versus Private Insurance In California*, 107 PEDIATRICS 1045, 1046 (2001).

15 See e.g., Andrew H. Hwang et al., *Access to Urological Care for Children in California: Medicaid Versus Private Insurance*, 66 UROLOGY 170 (2005) citing ANDREW B. BINDMAN ET AL., PHYSICIAN PARTICIPATION IN MEDI-CAL, 2001 1-50 (2003).

16 The Henry J. Kaiser Family Found., *Medicaid Payments Per Enrollee, FY 2005*, available at <<http://www.statehealthfacts.org/comparetable.jsp?ind=183 cat=4>>.

17 The Henry J. Kaiser Family Found., *Medicaid Physician Fee Index, 2003*, available at <<http://www.statehealthfacts.org/comparetable.jsp?ind=195&cat=4&sub=51&yr=1&typ=1&o=a&sort=245>>.

18 *Id.*

19 CAL. HEALTHCARE FOUND., *MEDI-CAL FACTS AND FIGURES: A LOOK AT CALIFORNIA'S MEDICAID PROGRAM* 49 (2007), available at <<http://www.chcf.org/documents/policy/MediCalFactsAndFigures2007.pdf>>.

medical and surgical specialists is even lower.²⁰ The access to office-based physicians is already so limited some recipients languish months before getting an appointment.²¹ Many physicians who are continuing to see their current Medi-Cal patients will be forced to not accept any new patients once the rates are cut.²² Such a trend, if allowed to continue, would erode, and possibly destroy, the future of the Medi-Cal program.

In addition to physicians, the ten percent cuts will also apply to dentists, pharmacies, mental health facilities, Adult Day Health Care programs and health clinics.²³ Many of these providers will eliminate services as a result of the ten percent cuts because they operate on tight budgets and rely almost entirely on Medi-Cal reimbursement to cover their operating expenses.²⁴ The consequences of

²⁰ *Id.*

²¹ See e.g., Evan Hapler, *Further Fee Cuts Force a Medi-Cal Exodus: Doctors are Rejecting New Patients*, L.A. Times, Mar. 24, 2008, 2008 WLNR 5628983; Duane Gang, *Riverside County Threatens to Pull out of Medi-Cal Mental Health Program*, Press Enter., Apr. 1, 2008, available at <http://www.pe.com/localnews/healthcare/stories/PE_News_Local_H_board02.430192d.html>.

²² See Hapler, *supra* note 21.

²³ Midyear Cuts, *supra* note 11; Kaiser Network, *Lawsuit Filed to Stop 10% Medicaid Provider Payment Rate Reduction in California* (May 6, 2008).

²⁴ See Gang, *supra* note 21; Evan George, *Pharmacists Fight Pending Medi-Cal Cuts*, *Los Angeles Daily J.* (April 30, 2008) (noting that if the cuts go into effect pharmacists could actually lose money on some prescriptions.).

Adult Day Health Care (ADHC) closings will be devastating to many of California's Medi-Cal older and disabled recipients who rely upon ADHCs in order to live independently.²⁵ Adult Day Health Care is a licensed community-based day care program providing a variety of health, therapeutic, and social services to those at risk of being placed in a nursing home. Currently, over 300 centers exist in many urban and rural areas of the state.²⁶ ADHCs help aging and disabled Medi-Cal patients live in the community instead of in nursing homes, which preserves these patients quality of life by avoiding undesirable institutionalization.²⁷

III. THE DISTRICT COURT WAS REQUIRED TO CONSIDER THE “PUBLIC INTEREST” OF NON-PARTIES WHEN ANALYZING THE EVIDENCE OF IRREPARABLE HARM

Where the public interest is involved, as it is in this case, the court must also examine whether the public interest favors the petitioners. This Court has held that “[t]he public interest inquiry primarily addresses impact on non-parties rather than

²⁵ Nina Nolcox, Op-Ed, *Sick Seniors to Take Big Hit from State Budget Cuts*, Los Angeles Bus. J., available at <<http://labusinessjournal.com/article.asp?aid=47516749.3687357.1596764.2150019.7713571.254>>

²⁶ Cal. Dept. of Aging, *Adult Day Health Care (2007)*, available at <<http://www.aging.ca.gov/programs/adhc/adhc.asp>>.

²⁷ *Id.*; AARP, *Home and Community Based Care: Expanding Options for Long-Term Care*, Statement for the Record Submitted to the Senate Finance Committee, 5 (Sept. 25, 2007) [hereinafter *Home and Community Based Care*].

parties.” See e.g., *Sammartano v. First Judicial District, In and For the County of Carson*, 303 F.3d 959, 974 (9th Cir. 2002). Contrary to the Respondents’ arguments, this Court must consider the impact of the cuts on California’s 6.6 million Medi-Cal recipients in determining the public interest. See e.g., *American Medical Ass’n v. Weinberger*, 522 F.2d 921 (7th Cir. 1975) (Holding that the “public interest” favored granting of preliminary injunction enjoining the enforcement of regulatory changes.)

A. Fewer Providers Mean Delayed Access And Lack Of Access To Health Care For California’s Most Vulnerable Populations

Recipients of government benefits frequently constitute the most vulnerable sector of the population. Numerous courts have held that reductions in either government benefits or medical care cause irreparable harm even when the cuts are of a relatively small magnitude.²⁸ When doctors pull out of Medi-Cal due to inadequate provider rates, the ability of Medi-Cal patients to find another Medi-Cal provider willing and able to treat them becomes even more limited than it currently is. Consequently, Medi-Cal recipients without access to a Medi-Cal doctor may be

²⁸ See e.g., *Beno v. Shalala*, 30 F.3d 1057, 1063-64, fn 10 (9th Cir. 1994) (noting harm to beneficiaries from government benefit and medical care cuts); *Beltran v. Myers*, 677 F.2d 1317, 1322 (9th Cir. 1982) (finding irreparable harm to Medicaid recipients where enforcement of a state rule “may deny [plaintiffs] needed medical care”); *Edmonds v. Levine*, 417 F. Supp.2d 1323, 1342 (S.D. Fla. 2006) (summarizing eight different Medicaid cases finding irreparable harm or imminent risk of irreparable harm due to a variety of Medicaid cuts).

in even poorer health than the uninsured.²⁹ Such individuals, particularly older and disabled patients, are more likely to die from diseases and conditions that could be prevented or cured if they had adequate health care coverage.³⁰ The lack of preventive care or treatment due to lack of access to healthcare is the third leading cause of death for adults age 55-64, behind heart disease and cancer³¹ and the sixth-leading cause of death among adults ages 25 to 64, ahead of HIV/AIDS and diabetes.³²

Delayed access to health care also causes severe negative health outcomes.

Studies have shown that patients of facilities with average wait times of 31 days or

29 Although uninsured persons are in worse health than persons with private health insurance, national studies have shown that people covered by Medicaid are in significantly poorer health than those without any health insurance. Jack Hadley, Kaiser Comm'n on Medicaid and the Uninsured, *Sicker and Poorer: The Consequences of Being Uninsured*, 46 (2002), *available at* <<http://www.kff.org/uninsured/upload/Full-Report.pdf>>.

30 *Id.* at 16-34; Jack Hadley & John Holahan, Kaiser Comm'n on Medicaid and the Uninsured, *The Cost of Not Covering the Uninsured*, 3- 4 (2003), *available at* <<http://www.kff.org/uninsured/upload/Cost-of-Not-Covering-the-Uninsured-Project-Highlights.pdf>>.

31 Stan Dorn, Urban Institute, *Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality* at 4 (January 2008), *available at* <http://www.urban.org/UploadedPDF/411588_uninsured_dying.pdf>.

32 Karen Davis, The Commonwealth Fund, *Time for Change: The Hidden Cost of a Fragmented Health Insurance System 2* (2003), *available at* http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=21616 (Testimony given to U.S. Senate, Special Comm'n On Aging).

more had significantly higher odds of mortality than patients who attended medical facilities with wait times under 31 days.³³ Medi-Cal patients, whose medical problems will continue while they cannot get an appointment with a doctor, will suffer due to delayed and inaccessible care.

B. Low-Income Older People Disproportionately Suffer Grave Consequences As A Result Of Reduced Access To Medical Services

While the ten percent provider reimbursement rate cuts will have devastating consequences for low-income Californians of all ages, older people will suffer exceptional harm. Older individuals have an increased likelihood of developing multiple chronic illnesses and disabilities, and a greater need for extensive medical care than their younger counterparts.³⁴ The number of health care visits among the older population increases with age³⁵ and they are more likely to require health

³³ Julia C. Prentice & Steven D. Pizer, *Delayed Access to Health Care and Mortality*, 42.2 Health Services Research, 644-662 (Apr. 2007).

³⁴ Joanne Lynn & David M. Adamson, RAND Report, *Living Well at the End of Life: Adapting Health Care to Serious Chronic Illness in Old Age 4-5* (2003), available at <<http://www.medicaring.org/educate/download/wp137.pdf>>; Nat. Inst. On Aging, Behavioral and Social Research Program & U.S. Census, *65+ in the United States: 2005 1* (2005), available at <http://www.census.gov/Press-Release/www/releases/archives/aging_population/006544.html> (detailing the prevalence of selected chronic conditions and disabilities in people aged 65 and older) [hereinafter Nat. Inst. on Aging Report].

³⁵ Natl. Inst. On Aging Report, *supra* note 34, at 64.

care attention from medical specialists, who are increasingly unwilling to accept Medicaid reimbursement for services.³⁶ Moreover, coordination of care, which is an essential element of the quality of care, especially for older patients with numerous chronic problems, becomes more difficult as increasing numbers of physicians providing primary and specialist care refuse to treat Medi-Cal patients.³⁷

Further cuts in Medi-Cal reimbursement rates will especially impact the demographic of aging, low-income individuals aged 50 to 64 who have increasing health care needs but cannot afford private insurance and are not yet eligible for Medicare.³⁸ Among older persons, “those in the lowest income quartile are almost three times as likely to experience a disability as those in the highest income

³⁶ AARP, *Beyond 50.02: A Report to the Nation on Trends in Health Security*, 62-63 (2002), *available at* <http://assets.aarp.org/rgcenter/health/beyond_50_health.pdf> [hereinafter *Beyond 50.02*]; Cal. HealthCare Found., *Medi-Cal Facts and Figures: A Look at California’s Medicaid Program* 49 (May 2007), *available at* <<http://www.chcf.org/documents/policy/MediCalFactsAndNat.Inst.onAgingReportFigures2007.pdf>>.

³⁷ AARP, *Testimony Before the Subcommittee on Health, Exploring Options for Improving the Medicare Physician Payment System* 17 (March 6, 2007), *available at* <http://energycommerce.house.gov/cmte_mtgs/110-he-hrg.030607.Thames-Testimony.pdf>.

³⁸ *Id.* at 49.

quartile.”³⁹ These patients are the ones who need more medical attention, not less. Older Californians whose health depends on primary care doctors and specialists accepting Medi-Cal will have nowhere to turn if rate cuts cause a mass exodus of physicians from the program.⁴⁰

Another group of low-income older people, known as dual eligibles because they qualify for both Medicare and Medi-Cal,⁴¹ will also be adversely impacted by the ten percent reimbursement cuts. One-fourth of California’s 4.2 million Medicare beneficiaries are dual-eligibles.⁴² This impoverished older population will suffer harm as a result of the cuts because they rely on Medi-Cal for several medically necessary services that the Medicare program does not provide. These services include Adult Day Health Centers, eyeglasses, hearing aids, medical equipment needed for functioning outside the home, and rehabilitative services.⁴³

39 AARP, *Beyond 50.03: A Report to the Nation on Independent Living and Disability 44-45* (2003), *available at* <http://assets.aarp.org/rgcenter/il/beyond_50_il_2.pdf> [hereinafter *Beyond 50.03*].

40 Physicians’ rates are so low that some doctors lose money serving Medi-Cal recipients. *See e.g.*, Hapler, *supra* note 21; Gang, *supra* note 21.

41 Centers for Medicare and Medicaid Services, *Dual Eligibility: Overview* (Feb. 27, 2008), *available at* <http://www.cms.hhs.gov/DualEligible/01_Overview.asp#TopOfPage>.

42 The Kaiser Commission on Medicaid and the Uninsured, *Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2003 at 5* (July 2005).

43 *Beyond 50.03, supra* at 39.

Individuals losing any of these services will face significant obstacles to living independently and accessing quality health care.

IV. REDUCING MEDI-CAL PATIENTS' ACCESS TO HEALTH CARE WILL LEAD TO INCREASED STATE SPENDING IN THE FUTURE

Even if the state may realize some short term savings from reducing Medi-Cal provider rates, in the long term the savings will diminish from the cost of providing acute hospitalization or institutionalization for those people whose health deteriorates as a result of diminished access to care.⁴⁴

In the case of Adult Day Health Centers, it is estimated that the combined impact of the ten percent cuts and an additional plan to defer payments⁴⁵ could eventually force approximately 28 facilities to close.⁴⁶ In California, there are 34,500 elderly who use adult day services.⁴⁷ The typical Adult Day Health Center participant “is a low-income frail elderly female who does not require 24-hour institutional care, but does need skilled health services and care coordination

⁴⁴ *See Id.* at 13.

⁴⁵ Assem. B. 5, X3 S. (Ca. 2008); Midyear Cuts, *supra* note 11.

⁴⁶ Nolcox, *supra* note 25.

⁴⁷ Tanya Alteras, Health Management Associates, *Adult Day Health Care Services: Serving the Chronic Health Needs of Frail Elderly Through Cost-Effective, Non-Institutional Care*, at 8 (2007), available at <http://www.caads.org/pdf/pdf/hma_adhc_report_final_2007_07_23.pdf>. In addition to serving the elderly, 21 percent of the ADHC population in California

related to managing her health, cognitive and/or mental conditions.”⁴⁸ Closing any of these centers would force older and disabled individuals almost immediately into nursing homes, costing the state more money in the future, due to the higher cost of nursing home care.⁴⁹

V. IT IS WELL ESTABLISHED THAT PREEMPTION IS A VIABLE ALTERNATIVE TO SUIT UNDER § 1983

Respondent incorrectly argues that whether a claim is brought under the Supremacy Clause or under § 1983 is simply a matter of “a party chang[ing] the label on his claim” (Resp’t Br. 23). It is well established that the “distinction between a statutory claim and a Supremacy Clause claim ... is important and is not a trifling formalism,” *Air Transport Ass’n of America, Inc. v. Cuomo*, 520 F.3d 218, 221 (2d Cir. 2008).

The Supreme Court has observed that “it would obviously be incorrect to assume” that a preemption claim under the Supremacy Clause was interchangeable with a claim under § 1983. *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 108 (1989). While Chief Justice Rehnquist and Justices O’Connor and Kennedy dissented in *Golden State* on the grounds that they believed there was no

is under 64; *Id.*

⁴⁸ *Id.* at 7.

⁴⁹ *Id.*; *Home and Community Based Care*, *supra* note 27, at 10.

basis for damages under § 1983, they had previously reached the merits of the preemption claim in the same case.⁵⁰ Justice Kennedy explained on behalf of the dissenters: “The injured party does not need § 1983 to vest in him a right to assert that an attempted exercise of jurisdiction or control violates the proper distribution of powers within the federal system.” *Id.* at 114 (Kennedy, J. dissenting).

There has been longstanding consensus among the Justices that federal preemption is a viable alternative to § 1983. As early as 1974, then-Associate Justice Rehnquist observed that federal question jurisdiction provides an avenue for federal courts to address whether state welfare law conflicts with federal law and therefore “is invalid under the Supremacy Clause of the United States Constitution.” *Hagans v. Lavine*, 415 U.S. 528, 553 (Rehnquist, J., dissenting). As recently as 2002, the Court summarily dismissed the argument that the lack of a cause of action could affect a court’s power to adjudicate the plaintiff’s preemption claim. *Verizon Maryland Inc. v. Public Service Commission*, 535 U.S. 635 (2002). Then in 2003, seven Supreme Court Justices reached the merits of whether a state law regarding prescription drug rebates was preempted by federal Medicaid law, without discussing the plaintiff’s cause of action. *Pharmaceutical Research & Manufacturers v. Walsh*, 538 U.S. 644 (2003). See Rochelle Bobroff, *Section*

⁵⁰ See *Golden State Transit Corp. v. City of Los Angeles*, 475 U.S. 608 (1986). Chief Justice Rehnquist dissented on the merits.

1983 and Preemption: Alternative Means of Court Access for Safety Net Statutes, LOY. J. OF PUB. INT. L., forthcoming 2009. http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1273664) (tracing the history of the two doctrines).

Indeed, the only Supreme Court opinions even suggesting that federal question jurisdiction does not provide an alternative to § 1983 in the context of Medicaid have been the separate concurrences of Justices Scalia and Thomas in *Pharmaceutical Research & Manufacturers v. Walsh*, 362 F.3d 817 (D.C. Cir. 2004). Petitioners do not and cannot rely upon these concurrences, because as Judge Higginbotham of the Fifth Circuit commented, the “persuasive force [of the Scalia/Thomas concurrences] is wasted on the inferior courts. Rather, they must persuade at least three other Justices.”⁵¹

For a claim under the Supremacy Clause, the cause of action is implied in the Constitution.⁵² Plaintiffs may invoke federal question jurisdiction to determine whether state law is preempted even though there is no explicit cause of action under § 1983. Preemption claims vindicate “the proper distribution of powers within the federal system” by enjoining states from taking actions inconsistent with federal law. *Golden State*, 493 U.S. at 114 (Kennedy, J., dissenting). Section

⁵¹ *Planned Parenthood of Houston & Southeast Tex. v. Sanchez*, 403 F.3d 324, 332 n.34 (5th Cir. 2005). See also *Local Union No. 12004, United Steelworkers of America v. Massachusetts*, 377 F.3d 64, 75 n.8 (1st Cir. 2004); *Pharmaceutical*, 362 F.3d at 819 n.3.

1983, by contrast, protects individual rights by enforcing substantive federal law and providing additional remedies, such as damages and attorneys fees. There has been unanimous agreement among courts of appeals that claims may be brought under the Supremacy Clause to enforce federal statutory provisions which are not enforceable under § 1983.⁵³

VI. PREEMPTION BY 42 U.S.C. § 1396A(30)(A) IS CONSISTENT WITH REPEAL OF THE BOREN AMENDMENT

The purpose and effect of the Boren Amendment repeal was to change a specific provision that entitled institutional providers to rates adequate to meet their costs. *Alaska Dept. of Health & Soc. Servs. v. CMS*, 424 F.3d 931, 941 (9th Cir. 2005). This repeal had no impact on enforcement of other remaining provisions designed to protect beneficiaries and is completely irrelevant to the existence of a cause of action under the Supremacy Clause. The preemption cause of action is implied in the Constitution, and does not depend on Congressional intent. *See Green v. Mansour*, 474 U.S. 64, 68 (1985) (“the availability of prospective relief of the sort awarded in *Ex parte Young* gives life to the Supremacy Clause”).

⁵² *Planned Parenthood*, 403 F.3d at 333; *Local Union No. 12004*, 377 F.3d at 75.

⁵³ *Lankford v. Sherman*, 451 F.3d 496, 509 (8th Cir. 2006); *Planned Parenthood*, 403 F.3d at 335; *Qwest Corp. v. City of Santa Fe*, 380 F.3d 1258 (10th Cir. 2004). *See also Day v. Bond*, 511 F.3d 1030, 1034 (10th Cir. 2007).

Moreover, as the Third Circuit recently noted, *Penn. Pharm. Ass'n v. Houstoun*, 283 F.3d 531, 541 (3d Cir. 2002), the legislative history of 42 U.S.C. § 1396a(30)(A) (§ 30(A)) explicitly states that that “in instances where the States or the Secretary fail to observe these statutory requirements, the courts would be expected to take appropriate remedial action.” H.R.REP. NO. 97-158, pt. 2, at 301(1981). Thus, Congress anticipated judicial enforcement of § 30(A). A single statement about hospital suits in a later House report concerning a different Medicaid provision, which does not even mention § 30(A), cannot be inferred to bar its enforcement.

Respondent’s claim that the Boren repeal rendered all of § 1396a unenforceable (Resp’t Br. at 20) is similarly contrary to this Court’s precedent. This circuit’s Medicaid jurisprudence makes clear that Congress has never prohibited enforcement of § 1396a *in its entirety*, irrespective of the source of plaintiffs’ cause of action. *See, e.g., Ball v. Rodgers*, 492 F.3d 1094 (9th Cir. 2007); *Watson v. Weeks*, 436 F.3d 1152 (9th Cir. 2006).

CONCLUSION

For the reasons stated above, *Amici Curiae* respectfully request that this Court affirm the district court’s order granting, in part, Petitioners’ motion for preliminary injunction.

Dated: November 18, 2008

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STATEMENT OF RELATED CASES

The following Ninth Circuit case appeals are related cases to the Ind. Living case: U.S. Court of Appeal, *Tran Pharmacy, et al. v. Sandra Shewry*, case no. 08-56551 and *Independent Living Center of Southern California v. Shewry*, case no. 08-56554.

Dated: November 18, 2008

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CERTIFICATE OF COMPLIANCE WITH TYPEFACE & LENGTH

Pursuant to Fed. R. App P. 29(d) and 9th Cir. R. 32-1, the attached *amici* brief is proportionally spaced, has a typeface of 14 points or more and contains 7000 words or less. The word processing system software used to prepare this brief was Microsoft Word.

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