No. _____

In the
Supreme Court of the United States

DAVID MAXWELL-JOLLY, Director of the Department of Health Care Services, State of California, et al.,

Petitioners,

v.

CALIFORNIA PHARMACISTS ASSOCIATION, et al.,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

Under 42 U.S.C. § 1396a(a)(30)(A) of the Medicaid Act, a state that accepts federal Medicaid funds must adopt a state plan containing methods and procedures to "safeguard against unnecessary utilization of . . . [Medicaid] services and . . . 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 . . . at least to the extent that such care and services are available to the general population." The Ninth Circuit, along with virtually all of the circuits to have considered the issue since this Court's decision in *Gonzaga University v. Doe*, 536 U.S. 273 (2002), concluded that this provision does not confer any "rights" on Medicaid providers or recipients that are enforceable under 42 U.S.C. § 1983, and respondents do not contend otherwise. Nonetheless, in the present cases, the Ninth Circuit held that § 1396a(a)(30)(A) preempted several state laws that could have the effect (either directly or indirectly) of reducing Medicaid reimbursement payments to providers, because the California Legislature failed to conduct a specific type of study that the Ninth Circuit said was required.

The questions presented are:

1. Whether Medicaid recipients and providers may maintain a cause of action under the Supremacy Clause to enforce § 1396a(a)(30)(A) by asserting that the provision preempts a state law that may reduce reimbursement rates.

QUESTIONS PRESENTED – Continued

2. Whether a state law that could result in reduced Medicaid reimbursement to providers may be held preempted by § 1396a(a)(30)(A) based on requirements that do not appear in the text of the statute.

LIST OF PARTIES

Petitioners are David Maxwell-Jolly, Director of the California Department of Health Care Services; John A. Wagner, Director of the California Department of Social Services; and Arnold Schwarzenegger, Governor of the State of California.

California Pharmacists respondents are California Pharmacists Association; California Medical Association; California Dental Association; California Hospital Association; California Association for Adult Day Services; Marin Apothecary, Inc., DBA Ross Valley Pharmacy; South Sacramento Pharmacy; Farmacia Remedios, Inc.; Acacia Adult Day Services; Sharp Memorial Hospital; Grossmont Hospital Corporation; Sharp Chula Vista Medical Center; Sharp Coronado Hospital and Healthcare Center; Fey Garcia; Charles Gallagher.

Independent Living respondents are Independent Living Center of Southern California, Inc.; Jerry Shapiro, Pharm. D., DBA Uptown Pharmacy & Gift Shoppe; Sharon Steen, DBA Central Pharmacy; Tran Pharmacy, Inc., a California Corporation.

Dominguez respondents are Lydia Dominguez; Patsy Miller; Alex Brown, by and through his mother and next friend Lisa Brown; Donna Brown; Chloe Lipton, by and through her conservator and next friend Julie Weissman-Steinbaugh; Herbert M. Meyer;

LIST OF PARTIES – Continued

Leslie Gordon; Charlene Ayers; Willie Beatrice Sheppard; Andy Martinez; Service Employees International Union United Healthcare Workers West; Service Employees International Union United Long-Term Care Workers; Service Employees International Union Local 521; and Service Employees International Union California State Council.

TABLE OF CONTENTS

TABLE OF CONTENTS – Continued

TABLE OF CONTENTS – Continued

TABLE OF AUTHORITIES

Page

CASES

TABLE OF AUTHORITIES – Continued

TABLE OF AUTHORITIES – Continued

Page

STATUTES

TABLE OF AUTHORITIES – Continued

Blank Page

PETITION FOR A WRIT OF CERTIORARI

The Attorney General of the State of California, on behalf of David Maxwell-Jolly, Director of the California Department of Health Care Services (DHCS), John A. Wagner, Director of the California Department of Social Services (DSS), and Arnold Schwarzenegger, Governor of the State of California, respectfully petitions for a writ of certiorari to review four judgments of the United States Court of Appeals for the Ninth Circuit.

OPINIONS BELOW

This petition seeks review of four opinions issued by a single panel of the Ninth Circuit Court of Appeals on March 3, 2010. Two of the opinions were designated for publication, App., *infra*, 1 (*Cal. Pharm. II*) and App., *infra*, 59 (*Dominguez*), but have not yet been reported, and two of the opinions were not designated for publication. App., *infra*, 37 (*Cal. Pharm. III*) and 53 (*Independent Living IV*). In one of the appeals (*Cal. Pharm. III*), the Ninth Circuit previously had issued an order granting an injunction pending appeal, App., *infra*, 42 (*Cal. Pharm. I*), which is reported at 563 F.3d 847. Three of the district court opinions that led to the Ninth Circuit decisions, App., *infra*, 84, 106, and 128, are reported at, respectively, 630 F. Supp. 2d 1144, 630 F. Supp. 2d 1154, and 603

F. Supp. 2d 1230, while the remainder are unreported. App. *infra*, 152, 161, 176, 178, 180.

STATEMENT OF JURISDICTION

The Ninth Circuit issued the four opinions on March 3, 2010. App., *infra*, at 1, 37, 53, 59. Petitioners have not petitioned for rehearing or rehearing en banc. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Supremacy Clause of the United States Constitution states:

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

U.S. Const. art. VI, cl. 2.

The Medicaid Act, 42 U.S.C. § 1396a(a)(30)(A), states in pertinent part:

(a) Contents

A State plan for medical assistance must –

* * *

(30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to 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. . . .

INTRODUCTION

The present petition raises substantially the same legal issues as the petition for certiorari pending in *Maxwell-Jolly v. Independent Living Center of Southern California*, No. 09-958 (*Independent Living*). Those issues are (1) whether 42 U.S.C. § 1396a(a)(30)(A), a federal Medicaid statute that does not meet the criteria for private enforcement under 42 U.S.C. § 1983, may nonetheless be enforced against a state by private parties under a Supremacy Clause theory; and (2) whether a state statute that reduces Medicaid reimbursement to providers may be held preempted by § 1396a(a)(30)(A) based on criteria that do not appear anywhere in the statute.

In *Independent Living*, the primary basis for the Ninth's Circuit's preemption holding was the State's purported failure, before implementing a rate reduction, to conduct a study of the potential impact of Medicaid reimbursement reductions in light of the § 1396a(a)(30)(A) factors, and to study providers' costs in order to ensure that the reduced rates would bear a reasonable relationship to those costs. *Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly*, 572 F.3d 644 (9th Cir. 2009) (*Indep. Living II*), *petition for cert. filed* (U.S. Feb. 16, 2010) (No. 09-958); *see also Indep. Living Ctr. of S. Cal., Inc. v. Shewry*, 543 F.3d 1050 (9th Cir. 2008) (*Indep. Living I*), *cert. denied*, 129 S. Ct. 2828 (2009) (holding that such claims could proceed under the Supremacy Clause). However, § 1396a(a)(30)(A) and its implementing regulations do not mention (let alone require) such a study, nor do they require any specific relationship between reimbursement payments and providers' costs. Moreover, the Ninth Circuit's analysis and holdings conflict with those of virtually every other circuit to have addressed these issues, namely, the First, Third, Fifth, Seventh, and Eighth Circuits.

In the present cases, the Ninth Circuit expanded its already atextual requirement of a study, holding, *inter alia*, that (1) a state must conduct a study of any reimbursement reduction not merely before implementing it, but also before *enacting* it (even though prior Ninth Circuit case law had permitted a reduction to be implemented while the requisite study was being conducted, *see Orthopaedic Hosp. v. Belshe*, 103

F.3d 1491, 1494 (9th Cir. 1997), *cert. denied*, 522 U.S. 1044 (1998)); (2) the state *legislature*, rather than the relevant state agency, must conduct the study if the legislature was the entity responsible for imposing the reduction (so that formal, pre-enforcement studies conducted by DHCS could not discharge the State's purported duties under § 1396a(a)(30)(A)); (3) the study must *expressly reference both § 1396a(a)(30)(A) and the specific statutory enactment* at issue (so that a study prepared expressly for the state legislature that provides data from which the legislature could make an informed decision about a reduction, but that does not include the purportedly necessary express references, does not suffice); (4) a study prepared specifically for a state legislature does not suffice unless the state *produces evidence that the legislature actually considered it*, and that evidence must consist of more than a reference to the study in a legislative committee agenda; and (5) a state must study providers' costs prior to implementing any reduction even if a particular class of providers does not incur costs in providing their services, and must create a means for obtaining cost data if no such means already exists; however, if no provider cost data exists, a state may use a proxy, but the court may second-guess (and reject) the choice of proxy.

The Ninth Circuit issued these holdings in the context of challenges to two statutory enactments that occurred subsequent to the enactment at issue in *Independent Living*. *Independent Living* involves the Assembly Bill ("AB") 5 reductions: ten percent

across-the-board reductions in Medicaid reimbursement payments enacted in February 2008 to apply to services provided under Medi-Cal's[1] fee-for-service program on or after July 1, 2008 (the "AB5" reductions). App., *infra*, 190. As described below, the present petition involves two later enactments: (1) the "AB1183" reductions, enacted in September 2008 to replace the AB5 reductions, App., *infra*, 198; and (2) Senate Bill X3 6 ("SB6"), which concerns the State's contribution toward the hourly wage and benefits paid by counties to providers of In-Home Supportive Services (IHSS). App., *infra*, 218. On March 3, 2010, the Ninth Circuit panel that previously affirmed the injunctions in *Independent Living* also affirmed all the injunctions sought here (and in one case, *California Pharmacists III*, reversed the district court by ordering entry of an injunction that the court had declined to grant). App., *infra*, 1, 37, 53, 59.

As petitioner Maxwell-Jolly demonstrated in the *Independent Living* petition, the Ninth Circuit's decision to allow private enforcement of § 1396a(a)(30)(A), coupled with its willingness to impose ever-expanding atextual requirements, has created a new class of lawsuits that is wreaking havoc with California's ability to manage its $40 billion Medicaid budget and its ability to plan its way out of its budget crisis through sensible Medicaid reform. Untethered from

[1] California's Medicaid program is known as Medi-Cal.

any statutory or regulatory language, the rules announced by the Ninth Circuit keep changing, and they become more onerous with each iteration. Congress put an administrative agency, rather than the courts, in charge of Medicaid for a reason: to work with the states on an ongoing basis, with regular communication and guidance, to ensure that they understand and comply with Medicaid requirements. Court-imposed injunctions, issued in private suits based on judicially-created, atextual requirements, that subject the States to massive liability, undermine Congressional intent and the cooperative federalism that is supposed to animate the program. These issues are important, recurring, national in scope, and the subject of conflicting and erroneous decisions among the circuits (as demonstrated in the *Independent Living* petition), and therefore merit review.

STATEMENT OF THE CASE

On September 30, 2008, the Governor signed the AB1183 reductions into law. App., *infra*, 198. AB1183 enacted a new, substitute set of smaller reductions to take the place of the AB5 reductions starting on March 1, 2009. Specifically, it, *inter alia*, (1) replaced the prior 10% reduction applicable to payments to physicians, dentists, optometrists, and clinics under Medi-Cal's fee-for-service program with a smaller, 1% reduction for dates of service on or after March 1, 2009; (2) replaced the prior 10% reduction for

payments to Adult Day Health Centers (ADHCs) and pharmacies under Medi-Cal's fee-for-service program with a smaller, 5% reduction for dates of service on or after March 1, 2009; (3) replaced the prior 10% reduction applicable to payments to hospitals for outpatient services with a smaller, 1% reduction for dates of service on or after March 1, 2009; and (4) replaced the prior 10% reduction applicable to payments to hospital-based nursing facility services and hospital-based subacute care services with a smaller, 5% reduction for dates of service on or after March 1, 2009. AB1183 also repealed all payment reductions for small and rural hospitals effective November 1, 2008, and enacted a new reimbursement cap on payments to some noncontract hospitals for inpatient services provided on or after October 1, 2008. App., *infra*, 201-16; Cal. Welf. & Inst. Code §§ 14105.191(b)(1)-(3), 14166.245(b), (c).[2]

The Legislature directed DHCS to "promptly seek any necessary federal approvals for the implementation" of the reductions. App., *infra*, 205, 210, 215; Cal. Welf. & Inst. Code §§ 14105.19(g), 14105.191(h),

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[2] Specifically, payments for inpatient services provided by noncontract hospitals, other than small and rural hospitals, are subject to a 10% reduction under AB1183; in addition, those noncontract hospitals located in a Health Facility Planning Area (HFPA) with a specified minimum number of general acute care hospitals have their reimbursements capped at an average of rates paid to hospitals under contract with the State minus 5% ("CMAC-5%"). App., *infra*, 211, 214; Cal. Welf. & Inst. Code §§ 14166.245(b)(2)(A), (c)(3)(B).

14166.245(f). However, it authorized DHCS to "elect not to implement" the reductions on payments to fee-for-service providers if "federal financial participation is not available with respect to any payment" subject to the reductions. App., *infra*, 210; Cal. Welf. & Inst. Code § 14105.191(h). And it ordered DHCS and the California Medical Assistance Commission (CMAC) to report annually regarding the implementation and impact of the reductions on payments for inpatient services provided by noncontract hospitals. App., *infra,* 215-16; Cal. Welf. & Inst. Code § 14105.191(i).

On September 30, 2008, DHCS submitted a State Plan Amendment (SPA) to the federal Centers for Medicare and Medicaid Services (CMS), which remains pending. That SPA encompassed the AB5 reductions and most of the superseding AB1183 reductions. *See* App., *infra*, 27.[3]

AB1183 prompted two of the lawsuits at issue, which were brought by different sets of providers: *California Pharmacists Association v. Maxwell-Jolly* and *Independent Living Center of Southern California v. Maxwell-Jolly* (*Independent Living IV*). A separate enactment, SB6, prompted a third lawsuit, *Dominguez v. Schwarzenegger*. Each is described in turn.

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[3] In response to a request from CMS, DHCS subsequently split the September 30, 2008 SPA into four separate SPAs that it submitted on October 29, 2008. DHCS submitted a separate SPA to encompass the AB1183 reductions for noncontract hospital inpatient services on December 31, 2008.

California Pharmacists v. Maxwell-Jolly

On January 29, 2009, Medicaid provider groups and beneficiaries filed *California Pharmacists Association v. Maxwell-Jolly* to enjoin the 1% and 5% reductions applicable to fee-for-service providers, including pharmacies, ADHCs, and hospital-based nursing facilities and subacute care facilities, and the new (CMAC-5%) reimbursement cap on inpatient services provided by certain noncontract hospitals. *See* App., *infra*, 205-06, 211, 214; Cal. Welf. & Inst. Code §§ 14105.191(b)(1)-(3), 14166.245(b)(2)(A), (c)(3)(B). Respondents moved for preliminary injunctions shortly thereafter. In opposing the motions, DHCS submitted a broad array of evidence concerning the legislative process that led to the enactments and analyzing the adequacy of the reduced rates.

Declarations described the California Legislature's deliberative process in enacting AB1183. Starting in January 2008, top-ranking DHCS officials in charge of Medi-Cal met with the Governor's Office and members of the Legislature to discuss the options available for reducing the ever-increasing costs of the Medi-Cal program. The more moderate proposed reductions ultimately enacted by AB1183 were considered and discussed in legislative committee meetings in May, June, and July 2008, as documented in committee reports and agendas. App., *infra*, 18-20, 98, 119. A sworn declaration from DHCS's Deputy Director for Legislative and Governmental Affairs described how DHCS staff members provided information, technical assistance, and responses to numerous

inquiries from legislative staff members concerning the reductions from May 2008 until AB1183 was enacted in September 2008. App., *infra*, 18. Ultimately, the Legislature and Governor were able to avoid taking more draconian measures, such as eliminating all optional Medi-Cal benefits including pharmacy services (which cost Medi-Cal in excess of $3 billion per year)[4] or restricting beneficiaries' eligibility for Medi-Cal.

Cognizant of the Ninth Circuit's prior rulings in *Independent Living I* and *Orthopaedic*, following AB1183's enactment but before its implementation, DHCS conducted formal cost-based evaluations with respect to those services for which it could obtain relevant cost data. Based in part on these evaluations, DHCS prepared a series of formal reports analyzing the potential impact of each of the AB1183 reductions, which it released in February 2009, before most of the AB1183 reductions took effect on March 1, 2009.[5] DHCS concluded in these reports, based on its

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[4] "Optional" benefits are those that, under the Medicaid Act, a state may, but is not required, to provide. California eliminated coverage for some optional benefits effective July 1, 2009, but preserved coverage for ADHC services, prescription drugs, substance abuse treatment services, licensed midwife services, hearing aids, Personal Care Services Program, and other services.

[5] By statute, the AB1183 reduction applicable to certain noncontract hospitals' inpatient services was implemented in October 2008, before the other AB1183 reductions. Therefore, one study, "Amended Analysis: Impact of Welfare and Institutions Code Section 14166.245 Concerning Medi-Cal Reimbursement

(Continued on following page)

analysis and the data available to it, that the reduced payments would comply with federal law, reasonably compensate providers' costs, increase efficiency in Medi-Cal, and not impair beneficiaries' access to services. Although the methods and data used in each analysis varied, DHCS noted in *all* the reports that, during the period in which the higher 10% reductions were in effect, there were no material declines in either claims paid or the number of providers participating in Medicaid, supporting the conclusion that the new, far-smaller reductions were unlikely to disrupt the system. *See, e.g.,* App., *infra*, 100.

ADHCs. DHCS submitted a February 24, 2009 report entitled "Analysis of Assembly Bill 1183 Medi-Cal Reimbursement for Adult Day Health Care Centers." *See* App., *infra*, 96-97, 99-100. In the report, DHCS concluded that reimbursement to ADHCs, as reduced by AB1183, would be sufficient to cover at least 100% of their necessary and reasonable costs and would not result in any access problem. *See* App., *infra*, 97, 99. DHCS based its analysis in part on cost data for nursing (level A) facilities (NF-As) because, as it explained, it does not have access to reliable cost data for ADHCs.[6] App., *infra*, 99 n.6. Instead,

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for Non-Contract Hospital Inpatient Services," described in more detail below, was issued after the implementation date for the relevant reduction.

[6] Due to recent state legislation, DHCS is developing a cost-based reimbursement methodology for such entities that will be effective August 1, 2012. *See* Cal. Welf. & Inst. Code §14571.2; App., *infra*, 99 n.6

pursuant to a court settlement to which ADHCs were a party, on August 1, 1997, the Medi-Cal reimbursement daily rate for ADHCs was set at 90% of the statewide weighted average of the Medi-Cal daily rate for NF-As (who are reimbursed at least 100% of their costs), although due to subsequent adjustments, the relationship is now closer to 87%. For context, ADHCs typically provide only four hours of services a day to a population that is far more ambulatory and independent than the population served by NF-As, which generally requires 24-hour nursing care in an institutional setting. Moreover, there has been a threefold increase in ADHCs since 1997, when their reimbursement rates were linked to NF-As.

Hospital-Based Nursing Facility and Subacute Care Services. DHCS submitted a February 24, 2009 Report, entitled "Analysis of Assembly Bill 1183 Medi-Cal Reimbursement for Various Nursing Facility Services." This was a 12-page report with supporting material. Based on a study of costs incurred by these providers, DHCS determined that, after a 5% reduction, reimbursement would compensate in the aggregate 86-92% of costs incurred by adult subacute care providers, 104-109% of the costs incurred by pediatric subacute care providers, and 83-85% of costs incurred by hospital-based nursing facility (level B, or NF-B) providers. DHCS noted that, with respect to NF-B services, other providers that are not subject to the AB1183 reductions (i.e., freestanding nursing facilities) currently provide 94% of such services at about half the expense.

Noncontract Hospitals Inpatient Services. DHCS produced a February 19, 2009 report entitled "Amended Analysis Impact of Welfare and Institutions Code Section 14166.245 Concerning Medi-Cal Reimbursement for Non-Contract Hospital Inpatient Services." App., *infra*, 117. This was a 16-page report with 130 pages of supporting material.[7] In the report, DHCS concluded that, after the AB1183 reductions, Medi-Cal reimbursement would compensate in the aggregate 91% of the costs incurred by all noncontract hospitals, with many noncontract hospitals being reimbursed 100% or more of their costs.[8] DHCS explained, further, that the reductions would incentivize noncontract hospitals to enter into contracts with the State, resulting in tremendous cost efficiencies. While noncontract hospitals provide approximately 11% of inpatient days, they receive 21.9% of Medi-Cal reimbursement for hospital inpatient services. The State saved $572 million in the 2007-2008 fiscal year due to the reduced rates it pays to contract hospitals, and has saved over $10.3 billion in general fund expenditures since 1983. DHCS also concluded that the reductions would not create patient access problems, in part because contract hospitals that are

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[7] The February 19, 2009 report corrected errors in the original report issued on January 29, 2009.

[8] Many noncontract hospitals receive, in addition to the reimbursement paid pursuant to AB1183, supplemental Medi-Cal reimbursement under the disproportionate share hospital (DSH) program. AB1183 did not reduce Medi-Cal money paid to noncontract hospitals under the DSH program.

not subject to the AB1183 reductions on inpatient services provide 89-90% of those services under Medi-Cal. *See* App., *infra*, 125-26.

Hospital Outpatient Services. DHCS did not prepare a formal report analyzing AB1183's impact on outpatient services, instead submitting declarations and supporting documents. Based on historical claims data (including the claims and participation data for when the 10% reduction was in effect), DHCS demonstrated that the 1% reduction mandated by AB1183 would not reduce Medicaid beneficiaries' access to such services.

DHCS did not analyze how the reduced rates would compare to providers' costs in providing outpatient services because, as it explained, there is no feasible mechanism for collecting reliable cost data for each of the 20,000-plus outpatient services covered by Medi-Cal. Following the Ninth Circuit's decision in *Orthopaedic*, DHCS commissioned a consulting firm, Tucker-Alan, Inc., to develop a methodology. After two failed attempts, the outside consultant advised that development of a sufficiently reliable cost model would take 5-7 years to establish and implement. Ultimately, rather than develop a cost model, DHCS entered into a settlement agreement with the hospitals under which their outpatient reimbursement increased substantially (e.g., by 44.34% in July 2004 above what was in effect in June 2001). *See* App., *infra*, 125.

DHCS also submitted a Legislative Analyst's Office (LAO) report, "Analysis of the 2008-09 Budget Bill" (2008-09 Analysis),[9] which evaluated the 10% reduction enacted by AB5 and, *inter alia*, recommended more moderate reductions for some services (a recommendation that the Legislature ultimately followed when it enacted AB1183). The LAO is a nonpartisan entity, operating under the oversight of the Joint Legislative Budget Committee, to "provid[e] fiscal and policy advice to the Legislature." *See* http://www.lao.ca.gov/laoapp/laomenus/lao_menu_aboutlao.aspx. The LAO report recommended increased reductions for hospitals on the ground that they have "received significant rate increases relative to other provider types in recent years, and hospitals are generally among the most expensive settings to provide care." App., *infra*, 125. The Legislature followed that recommendation by enacting lower rates for some noncontract hospitals, although it eliminated any reduction for small and rural hospitals.

On March 9, 2009, in *California Pharmacists*, the district court enjoined the 5% reduction on ADHCs, App., *infra*, 84, but refused to enjoin the AB1183 reductions as to inpatient, outpatient, and other services provided by hospitals, holding that plaintiffs had failed to carry their burden on irreparable harm. App., *infra*, 106. The district court held that plaintiffs

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[9] The LAO's 2008-09 Analysis is available at http://www.lao.ca.gov/analysis_2008/health_ss/healthss_anl08.pdf.

had demonstrated a likelihood of success on *all* their claims based on the State's failure to discharge a purported duty under § 1396a(a)(30)(A), as interpreted by the Ninth Circuit, to study the impact of any rate reduction before the reduction is enacted. App., *infra*, at 98-99, 120. The district court specifically faulted DHCS's formal study on ADHCs for utilizing NF-A data, "which may not be an adequate proxy for ADHC costs." App., *infra*, 99. While the court recognized that the LAO report supported the reductions for noncontract hospitals, the court held it was insufficient because "defendant presents no evidence to indicate that the Legislature actually reviewed or considered the LAO's report in passing AB1183." App., *infra*, at 119 n.8.

After the district court denied their motion for a preliminary injunction based on their failure to demonstrate irreparable harm, the hospital plaintiffs filed an emergency motion for a preliminary injunction pending appeal in the Ninth Circuit. On April 6, 2009, the Ninth Circuit granted an injunction pending appeal. App., *infra*, 42 (*Cal. Pharm. I*). It agreed that the hospitals had demonstrated a likelihood of success on the merits given the State's failure to show that the Legislature considered the § 1396a(a)(30)(A) factors before passing AB1183. App., *infra*, 44-45. Specifically, it found no abuse of discretion in the district court's holdings that (1) DHCS's formal studies were impermissibly post hoc; and (2) evidence that the LAO had recommended enactment of the rate reductions was inadequate because "there was

no evidence that the Legislature actually considered the report before enacting AB1183." App., *infra*, 44-45. In addition, the court found that respondents had demonstrated irreparable injury given that the Eleventh Amendment would bar them from obtaining retroactive monetary damages were they ultimately to prevail in the case. App., *infra*, 50.

On March 3, 2010, the Ninth Circuit issued opinions affirming the injunctions of the payment reductions for ADHCs (*Cal. Pharm. II*), and reversing the denial of an injunction of payment reductions for noncontract hospitals (*Cal. Pharm. III*). App., *infra,* 1, 37. The Ninth Circuit emphasized that, under *Independent Living II*, the State must produce evidence that it studied the impact of any rate reduction on the § 1396a(a)(30)(A) factors *before* the reduction either is enacted *or* implemented, and that the State relied upon responsible cost data in setting rates. App., *infra*, 3, 15-17, 36. Further, the court held that, because the California Legislature was the entity that mandated the payment reductions, it, rather than DHCS, was the entity that "must engage in the same principled analysis we required of the Director in *Orthopaedic II*." App., *infra*, 13-14; *see also* App., *infra*, 16-17 ("[W]e find nothing remarkable in holding that the final body responsible for setting Medicaid reimbursement rates must study the impact of the contemplated rate reduction on the statutory factors . . . *prior* to setting or adjusting payment rates.").

Despite uncontroverted evidence that the California Legislature had considered and discussed the AB1183 rate reductions before enacting them, the court held that the State failed to demonstrate that the Legislature had discharged its obligations under § 1396a(a)(30)(A). The court noted that, while the agendas and other legislative documents provided by DHCS referenced the specific rate reductions, they did not expressly reference the § 1396a(a)(30)(A) factors, and therefore could not serve as evidence that the Legislature expressly considered those factors. App., *infra*, 20 ("[T]he legislative history nowhere mentions any of the § 30(A) factors."). In addition, according to the panel, there was no evidence that the Legislature relied on "'"responsible cost studies, its own or others,"'" as a basis for its rate-setting. App., *infra,* 20-21 (quoting *Independent Living II* and *Orthopaedic*).

The court rejected as inadequate the post-enactment, but largely pre-implementation, formal studies that DHCS released in February 2009. It explained that, "[t]o satisfy § 30(A), any analysis of reimbursement rates . . . must have the potential to influence the rate-setting process." App., *infra*, at 22. The post-enactment studies could not suffice because, according to the court, AB1183 was phrased in mandatory terms and did not give DHCS discretion *not* to implement the rates based on the results of its analysis. App., *infra*, 22. The court rejected DHCS's arguments that, under federal and state law, as the designated "single state agency" entrusted with

implementing Medicaid, it could have declined to implement the reductions pursuant to California Welfare and Institutions Code sections 14105(a) and 14105.191(i). App., *infra*, 22-26; *see also* 42 U.S.C. § 1396a(a)(5).

With respect to ADHCs, the panel held that the district court did not abuse its discretion in rejecting NF-A cost data as a proxy for ADHC cost data, App., *infra*, 29, even though reliable ADHC cost data was not available to DHCS when it conducted its analysis, and even though ADHCs reimbursement rates have been tied to NF-A reimbursement rates since 1997.

***Independent Living v. Maxwell-Jolly* (*Independent Living IV*)**

On January 16, 2009, a group of pharmacy plaintiffs filed a lawsuit, *Managed Pharmacy Care v. Maxwell-Jolly*, to enjoin a 5% rate reduction for pharmacy services rendered on or after March 1, 2009 under Medi-Cal's fee-for-service program, pursuant to AB1183. *See* App., *infra*, 206; Cal. Welf. & Inst. Code § 14105.191(b)(3). Shortly thereafter, respondents moved for a preliminary injunction.

DHCS produced a wide array of evidence to oppose this injunction, including much of the same legislative material it provided in *California Pharmacists*. Of particular relevance to the pharmacy reductions, DHCS produced an agenda for a May 30, 2008 meeting of the Assembly Budget Subcommittee No. 1 on Health and Human Services that expressly

referenced a pharmaceutical cost-data study (the "Myers and Stauffer" study). App., *infra*, 55.

In addition, DHCS produced its February 8, 2009 report entitled "Analysis of Assembly Bill 1183 Medi-Cal Reimbursement for Pharmacies." App., *infra*, 141. This was a 13-page report with over 150 pages of supporting material. Included among them was the above-referenced Myers and Stauffer report, an analysis of drug dispensing and acquisition costs incurred in California prepared by an outside accounting firm that specializes in Medicaid issues. Based on this report, and adjusting for inflation, DHCS concluded that, as of March 1, 2009, Medi-Cal would reimburse drugs in the aggregate (i.e., single source drugs and multisource drugs) at 108.7% of costs without the AB1183 reductions, and at 103% of costs after the reductions were imposed (98.9% of costs for single source drugs, and up to 137% of costs for multisource drugs). *See* App., *infra*, 147, 159. More efficient pharmacies would do even better. There would be no access problem, as 5,772 of the 6,078 pharmacies in California with active licenses are actively enrolled in Medi-Cal.

On February 27, 2009, the district court enjoined the 5% reduction on payments for prescription drugs. App., *infra*, 128; *see also* App., *infra*, 152 (denying motion to alter or amend, and clarify prior order). The district court's analysis was substantially the same as that in its *California Pharmacists* decision described above.

On March 3, 2010, the Ninth Circuit affirmed the district court's order enjoining the AB1183 reduction for pharmacies. App., *infra*, 53. It reiterated much of the reasoning from its *California Pharmacists* opinion with respect to the purported requirement of a *pre-enactment* study conducted by the state *legislature*. App., *infra*, 54, 57. Although it acknowledged the express mention of the Myers and Stauffer report in the budget committee agenda, the court rejected this evidence as inadequate under § 1396a(a)(30)(A): "the one-sentence citation to the May 30, 2008 agenda does not show adequate consideration of the § 30(A) factors." App., *infra*, 55-56. The court also found the Myers and Stauffer report inadequate because "it is bereft of any analysis of the remaining § 30(A) factors – efficiency, economy, quality, and access to care." App., *infra,* 56.

Dominguez v. Schwarzenegger

In February 2009, the Governor signed the SB6 reductions into law. App., *infra*, 218. Effective July 1, 2009, SB6 would have reduced an existing cap on the State's maximum contribution to wages and benefits paid by the counties to IHSS providers as part of Medi-Cal. App., *infra*, 224; Cal. Welf. & Inst. Code § 12306.1(d)(6).

The IHSS program provides payment for services such as cleaning, personal care services, accompaniment for necessary travel to health-related appointments, and protective supervision, to low-income,

aged, blind and disabled persons. *See* Cal. Welf. & Inst. Code § 12300. The IHSS program is administered by the California counties, and the wages paid to IHSS providers are generally governed by collective bargaining agreements negotiated by the counties with unions representing IHSS providers, to which the State is not a party. App., *infra*, 63-64, 163-64. Because they are separately negotiated, the rates paid for IHSS wages vary from county to county. The State contributes 65% of the nonfederal share of wage and benefits paid to IHSS providers, up to a statutory cap, which was $12.10 per hour before SB6 was enacted (the counties pay the remaining 35% of the nonfederal share). App., *infra*, 65, 163-64.

Under SB6, the statutory cap toward which the State was to contribute would have been reduced from $12.10 to $10.10 per hour effective July 1, 2009. App., *infra*, 65, 224; Cal. Welf. & Inst. Code § 12306.1(d)(6). This amendment would not have affected the majority of counties or the majority of IHSS providers: before the Legislature enacted SB6, 36 of the State's 58 counties already paid IHSS providers $10.10 or less per hour in wages and benefits, including Los Angeles County, where 42% of all IHSS services are provided. *See* App., *infra*, 66, 164-65. Further, counties always have had the option of paying more than the maximum amount to which the State will contribute, and would have been free to do so in this instance, using their own funds as necessary to pay the nonfederal share. App., *infra*, 66, 164.

Respondent unions and Medi-Cal beneficiaries filed *Martinez v. Maxwell-Jolly*, on May 26, 2009, challenging implementation of the new cap. They contended that the new cap was preempted by § 1396a(a)(30)(A) because the State purportedly failed to study its impact before enacting it.

Petitioners conceded that the Legislature had not specifically conducted a study analyzing the impact of SB6 on the § 1396a(a)(30)(A) factors before the reductions were enacted. The new participation cap was, after all, equal to or higher than the wages and benefits already in effect in most of the State. Petitioners noted, however, that when the Legislature enacted SB6, it had access to the "July 2008 Report to the Legislature, Public Authorities and Nonprofit Consortia in the Delivery of In-Home Supportive Services, SFY 2006/2007" (July 2008 report), a type of report that the Department of Social Services (DSS) must submit on an annual basis. App., *infra*, 78, 80. In the words of the Ninth Circuit, this report contained "extensive data regarding quality and access in the IHSS system," App., *infra*, 78, including data on the number of providers available to work in the provider registries in each county; data on service shortages and the availability of emergency back-up providers; and data on wages and benefits paid by each county.

On June 25, 2009, the district court enjoined the reduced cap imposed by SB6. App., *infra*, 161, 176; *see also* App., *infra*, 178, 180 (amended injunction, order clarifying injunction). It, too, cited petitioners' failure

to produce evidence demonstrating that the California Legislature considered the § 1396a(a)(30)(A) factors when it adopted the new cap. App., *infra*, 171-72. The district court also found that respondents met their burden to show irreparable harm based on evidence that, were the rates reduced, IHSS providers might leave the program, possibly leaving some beneficiaries with reduced services. App., *infra*, 172-73.

On March 3, 2010, the Ninth Circuit affirmed the injunction in an opinion at issue here. App., *infra*, 59 (*Dominguez*). The court recognized that SB6 does not directly reduce IHSS wages, but merely may lower the State's contribution to those wages. App., *infra*, 70. Nonetheless, the court held that, "before enacting legislation that has the effect of lowering payments to providers . . . the State must study the impact of the decision on the statutory factors set forth in §30(A)." App., *infra*, 70 (citing *Cal. Pharm. II*). The court rejected petitioners' arguments that they could not study IHSS providers' costs because such providers do not incur costs. The court held that, where the court has previously required a cost study, the State is not immunized from liability simply because it has no mechanism for collecting such costs (or, apparently, even though such costs do not exist). App., *infra*, 77. Instead, the court said the state "must rely on something." App., *infra*, 78. It therefore suggested that the State "look to what it costs providers of analogous services, such as in-home nursing care, as a means of considering providers' costs." App., *infra*,

78-79. Although the State demonstrably did rely on "something" in defending SB6 in its Ninth Circuit briefing – specifically the July 2008 report to the Legislature – the court held that this too was inadequate to discharge the State's duties under § 1396a(a)(30)(A) because it did not specifically reference SB6, "let alone 'study the impact of the contemplated rate change(s) on the statutory factors *prior to* setting rates, or in a manner that allows those studies to have a meaningful impact on rates before they are finalized.'" App., *infra*, 80 (quoting *Cal. Pharm. II*).

The court also rejected petitioners' arguments that SB6 would not result in an access problem, noting that under its prior decisions, the obligations under § 1396a(a)(30)(A) are purely "procedural." App., *infra*, 76. It thereby reaffirmed its holding in *Independent Living II* that a state law may be enjoined solely because the State failed to conduct a particular kind of study, regardless of whether the measure complies "substantively" with federal law, and despite the fact that neither § 1396a(a)(30)(A) nor its implementing regulations requires such a study.

REASONS FOR GRANTING THE PETITION

1. The Court should grant the petition to consider whether a private party may bring a preemption challenge under a Spending Clause statute, 42 U.S.C. § 1396a(a)(30)(A), that is not otherwise

enforceable by private parties under 42 U.S.C. § 1983. This issue is already pending before this Court in the petition for certiorari filed in *Independent Living II* and *III*, No. 09-958.

Under the reasoning adopted by the Ninth Circuit, a private party may seek to enforce any federal statute, and enjoin state conduct, merely by invoking the Supremacy Clause and alleging a conflict between state and federal law. A party pursuing such a theory need not satisfy any of the requirements for private enforcement of federal statutes that this Court has carefully crafted and applied over several decades, such as the requirement that the party demonstrate that Congress intended to create a privately enforceable federal "right," and that the provision to be enforced is not so "vague and amorphous" as to strain judicial competence. *See, e.g., Cort v. Ash*, 422 U.S. 66 (1975); *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1 (1981); *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002).

The Ninth Circuit's theory (which the D.C., Fifth, and Eighth Circuits also have accepted[10]) has opened the door to a flood of lawsuits seeking to enjoin state action based on federal Spending Clause provisions

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[10] *See Planned Parenthood of Houston & Se. Tex. v. Sanchez*, 403 F.3d 324, 330-35 (5th Cir. 2005); *Lankford v. Sherman*, 451 F.3d 496, 509-13 (8th Cir. 2006); *see also Pharmaceutical Res. & Mfrs. of Am. (PhRMA) v. Thompson*, 362 F.3d 817, 819 n.3 (D.C. Cir. 2004); *cf. PhRMA v. Concannon*, 249 F.3d 66, 73 (1st Cir. 2001).

that previously have been held by the courts to be unenforceable by private parties under § 1983, including 42 U.S.C. §§ 1396a(a)(17) and 1396a(a)(30)(A). *See* App., *infra*, 228. One recent lawsuit even sought to invoke *Independent Living* and the Supremacy Clause to state a claim under a purely hortatory "purposes" provision of the American Recovery and Reinvestment Act of 2009, H.R. 1, 111th Cong., Pub. L. No. 111-5 (1st Sess. 2009), § 5000(a). *Gray Panthers of San Francisco v. Schwarzenegger,* No. C 09-2307 PJH, 2009 WL 2880555 (N.D. Cal. Sept. 01, 2009).

Recent developments, including the four new opinions at issue here, confirm both the recurring nature and national importance of the question presented. As reflected in the updated information included in the Appendix, App., *infra*, 228, the Ninth Circuit's *Independent Living* decisions have generated almost 40 new lawsuits across the country, including in Arizona, Connecticut, Delaware, Hawai'i, Idaho, Kansas, Louisiana, Maine, Minnesota, New York, Pennsylvania, and Washington. California's liability under existing injunctions is fast approaching $1 billion, consisting of over $735 million in lost Medicaid savings to date, and more than $250 million in additional retroactive relief to which providers in *Independent Living* contend they are entitled. App., *infra*, 228-32. The existing injunctions are costing over $35 million in additional lost Medicaid savings each month that they remain in place. App., *infra*, 228-32. More can be expected: in the short time since

petitioner Maxwell-Jolly filed the petition for certiorari in *Independent Living* in February 2010, two more courts in California have issued injunctions based on the Ninth Circuit's interpretation of the Supremacy Clause. App., *infra*, 228, 229.

Petitioners believe that *Independent Living* is a suitable vehicle for deciding this first question presented, as the Ninth Circuit chose that opinion to announce its holding and analysis. Moreover, the Ninth Circuit declined to revisit this issue in the four March 3, 2010 opinions at issue here, apparently believing that its earlier decisions in *Independent Living I, II,* and *III* resolved it. However, as DHCS has noted, while the petition for certiorari in *Independent Living* presents a live case or controversy, the state statute at issue in those decisions is no longer in effect, having been replaced with the lower (AB1183) reductions at issue here.[11] Therefore, if this Court would prefer to decide the question presented with respect to reductions that are still in effect, the present petition presents an excellent vehicle for doing so. Petitioners properly preserved this first

[11] The petition in *Independent Living* presents a live controversy because, if the State prevails, it will be entitled to retroactive reimbursement of excess Medicaid reimbursements that it was required to pay providers as a result of the injunctions at issue in that case.

question presented in both *Dominguez* and *Independent Living IV*.[12]

2. The Court also should grant the petition to consider whether state statutes that directly (or, at best, indirectly in the case of SB6) reduce Medicaid reimbursement payments to certain providers may be preempted based on requirements that do not appear in the text of the preempting federal statute, § 1396a(a)(30)(A). This issue, too, is already pending before this Court in the *Independent Living* petition for certiorari, No. 09-958.

In *Independent Living*, the Ninth Circuit held that the AB5 reductions were preempted because California failed to provide evidence that, "before implementing those cuts," it (1) studied the impact of

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[12] In *Dominguez*, petitioners preserved this issue as presented here. In *Independent Living IV*, petitioners included this argument in a discussion in their opening brief of "prudential standing," expressly stating: "It is the Department's position that *ILC* was wrongly decided because it conflicts with numerous Supreme Court precedents, including *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002), and because the Supremacy Clause does not itself create any substantive rights. *See Dennis v. Higgins*, 498 U.S. 439, 450 (1991); *Golden State Transit Corp. v. City of Los Angeles,* 493 U.S. 33 103, 107 (1989); *Chapman v. Houston Welfare Rights Org.*, 441 U.S. 600, 615 (1979). The Department recognizes, however, that *ILC* is controlling here, and therefore raises these arguments to preserve them for later appellate proceedings." Defendant-Appellant David Maxwell-Jolly's Opening Brief and Request for Oral Argument at 32-33, *Indep. Living IV*, No. 09-55692 (9th Cir. June 19, 2009) (footnote omitted); *see also* App., *infra*, 138 n.6 & 171 n.5.

the reductions on the § 1396a(a)(30)(A) factors of efficiency, economy, quality, and access to care; and (2) considered responsible studies of providers' costs, to ensure that the reduced rates would bear a reasonable relationship to those costs. *Indep. Living II*, 572 F.3d at 648, 651-52. However, neither §1396a(a)(30)(A), nor any of its implementing regulations, requires any sort of study, let alone a pre-enactment or pre-implementation study; and neither §1396a(a)(30)(A), nor any of its implementing regulations, requires that reimbursement rates bear any relation to providers' costs. The Ninth Circuit also held that the rate reduction could be preempted because it was motivated "solely" by "budgetary concerns." *Id.* at 655-56. But § 1396a(a)(30)(A) does not preclude a state from reducing rates to address a budgetary crisis, so long as the substantive requirements of the statute are met.

In the present cases, the Ninth Circuit reaffirmed this basic framework, and then added to it. Based on the new decisions:

(1) Any study must be concluded not merely pre-implementation, but also pre-enactment (resolving an ambiguity in *Independent Living II* and *III*). App., *infra*, 15, 54, 57, 80.

(2) The actual entity that mandates the payment reductions – in this case, the California Legislature – must conduct the required study. App., *infra*, 13-14, 16, 54.

(3) Where the obligation to conduct the study falls on a state legislature rather than a state agency, there must be evidence that the legislature actually considered the requisite study. Something more than an agenda item reflecting that a budget committee studied the issue is required. App., *infra*, 55-56. A report issued by a nonpartisan entity convened by the state legislature to assist in fiscal and budgeting matters also does not suffice, absent additional evidence that the legislature considered the report. App., *infra*, 45. While the Ninth Circuit rejected this evidence, it did not indicate what *would* be adequate evidence that the Legislature had discharged its duty under § 1396a(a)(30)(A) as interpreted.

(4) Any study must expressly reference both the state enactment being analyzed (e.g., SB6, AB1183) *and* the § 1396a(a)(30)(A) factors. App., *infra*, 20, 56, 80. Thus, evidence that a state legislature considered reports or data that did not specifically reference either the reductions or § 1396a(a)(30)(A), but from which the legislature reasonably could have drawn the conclusion that the reductions would comply with federal law, does not suffice.

(5) If a state does not have a feasible means for obtaining cost data with respect to a specific type of cut, it must obtain such data or possibly rely on a reasonable proxy. App., *infra*, 78-79 (suggesting that State use in-home nursing care costs as proxy for IHSS providers, even though IHSS providers do not incur costs). However, the court may second-guess (and reject) the proxy chosen by the state. App., *infra*,

29 (suggesting that DHCS should not have used NF-A cost data as a proxy in the ADHC study, even though ADHC reimbursement rates have been tied to NF-A reimbursement rates since 1997).

In addition, the Ninth Circuit reaffirmed that, even if there is evidence that rates under the challenged state statute will remain substantively adequate under § 1396a(a)(30)(A), such evidence may be irrelevant: the statute still may be enjoined if the State failed to comply with a "procedural" requirement to produce a pre-enactment study that contains all the features set forth above. App., *infra*, 76; *see also* App., *infra*, 22.

In light of the ever-growing list of increasingly specific requirements that the Ninth Circuit has imposed under the guise of interpreting § 1396a(a)(30)(A), it is at best ironic that the court chose to "emphasize that the State need not follow 'any prescribed method of analyzing and considering [the § 30(a)] factors.'" App., *infra*, 17 (quoting *Minn. HomeCare Ass'n v. Gomez,* 108 F.3d 917, 918 (8th Cir. 1997) (per curiam)). Presumably cognizant that it is on the short side of a circuit split concerning whether states must conduct a § 1396a(a)(30)(A)-based study before implementing Medicaid rate reductions,[13] the court apparently

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[13] *Compare Long Term Care Pharmacy Alliance v. Ferguson,* 362 F.3d 50, 56 (1st Cir. 2004); *Rite Aid of Pa., Inc. v. Houstoun,* 171 F.3d 842, 851 (3d Cir. 1999); *Evergreen Presbyterian Ministries Inc. v. Hood,* 235 F.3d 908, 933 n.33 (5th Cir. 2000), *overruled in part on other grounds, Equal Access for El Paso, Inc. v.*

(Continued on following page)

sought thereby to characterize its approach as somewhere within the judicial mainstream. But, as DHCS demonstrated in its petition for certiorari in *Independent Living*, the Ninth Circuit's approach was already an outlier, in terms of the scope and onerous nature of the atextual requirements that it imposed, *before* it issued this latest series of decisions. These new decisions add yet more, increasingly detailed, requirements for a study that no federal statute or regulation requires. And no other Circuit has imposed duties directly on a state *legislature* under § 1396a(a)(30)(A). *See Minn. HomeCare*, 108 F.3d at 919 (Loken, J., concurring) ("Federal courts do not undertake administrative law review of legislative action, certainly not the action of a state legislature.").[14]

The Ninth Circuit's decisions in the present cases further underscore the need for this Court's intervention, whether in *Independent Living* or here. The decisions illustrate why preemption of state statutes

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Hawkins, 509 F.3d 697, 704 (5th Cir. 2007), *cert. denied*, 129 S. Ct. 34 (2008); *Methodist Hosps., Inc. v. Sullivan*, 91 F.3d 1026, 1030 (7th Cir. 1996); *Minn. HomeCare*, 108 F.3d at 918 *with Arkansas Med. Soc'y, Inc. v. Reynolds*, 6 F.3d 519, 531 (8th Cir. 1993).

[14] The Ninth Circuit's citation to *Minnesota HomeCare* also is ironic because the Eighth Circuit there affirmed summary judgment in the State's favor despite the fact that "DHS did not provide any formal analysis of the equal access factors to the legislature" in connection with the rate change at issue. 108 F.3d at 918.

based on conflicts with judicially created funding conditions that have no textual support in the preempting federal statute is completely unworkable, in addition to conflicting with this Court's discussion in *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1 (1981) regarding the nature of Spending Clause legislation. *Id.* at 17 ("[I]f Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously."). By adopting inconsistent, ever-expanding, ever-more-detailed rules, the Ninth Circuit has made it virtually impossible for California to enact a statute that directly (or at best, indirectly) may reduce reimbursements to Medicaid providers.

To recap the relevant history, the first decision in the series, *Orthopaedic,* required the State to "rely on responsible cost studies, its own or others," in setting rates, but did not require any study to be completed pre-implementation; rather, the State was permitted to implement the rate reductions while its cost analysis was underway. *See* 103 F.3d at 1494. To comply with *Orthopaedic*, in *Independent Living*, DHCS submitted declarations that analyzed the impact of the rate reductions on the § 1396a(a)(30)(A) factors, and on providers' costs, including cost data where it was available. But this was held insufficient because the Ninth Circuit held in *Independent Living II* that any studies must occur "before implementing [any] cuts," 572 F.3d at 648, and suggested, in a footnote, that they must be prepared "in anticipation" of the rate reduction. *Id.* at 652 n.9.

At the time that the cases at issue here were briefed in the district court, *Independent Living II* had not yet been decided. But the State was aware of the *Orthopaedic* decision, and also knew, based on the district court's willingness to enter an injunction in *Independent Living*, that relying on post-implementation declarations probably would not suffice to support AB1183 and SB6. To comply with then-existing Ninth Circuit precedent, therefore, in opposing the injunctions, the State produced a variety of material to the district courts, including formal reports discussing the specific reductions in light of the § 1396a(a)(30)(A) factors, and materials available to the Legislature when it deliberated. It is fairly indisputable that these materials would have sufficed under *Orthopaedic* – or, if not, at least the State would have been permitted to conduct additional analysis while the reductions remained in place.

However, none of this was enough under the new, expanded parameters announced by the Ninth Circuit in the present cases. When DHCS, as *the single state agency* designated under federal and state law to implement Medicaid in California, performed *pre-implementation* formal studies analyzing the impact of the specific reductions on the § 1396a(a)(30)(A) factors, the court rejected such studies as untimely and because the wrong entity conducted them. When the State produced evidence that the *Legislature* considered a *pre-enactment* analysis of pharmacies' costs (the Myers and Stauffer report), the court rejected that evidence because the proof that the

Legislature considered the report consisted of only "one-sentence" in a budget committee agenda. When the State produced evidence of *pre-enactment* analyses *prepared specifically for the Legislature* (the IHSS report prepared by DSS, and the LAO report recommending reduction of hospital reimbursements), the court found there was insufficient evidence that the Legislature actually considered them, and also held the analyses inadequate because they did not specifically mention either the preempting statute (§ 1396a(a)(30)(A)) or the state reduction (AB1183, SB6).

This is not what Congress intended. A state cannot run a $40 billion Medicaid program where every decision is potentially subject to private enforcement through court-imposed injunctions. To the contrary, Congress envisioned a program of cooperative federalism, under which the States are in constant communication with a federal agency, CMS, to receive guidance and to ensure compliance with federal law. However, the Ninth Circuit has taken for itself, and the federal courts, effective oversight of at least the provider reimbursements portion of the Medicaid program, and in so doing, has subjected the States to inconsistent and atextual requirements, with the consequence of hundreds of millions of dollars in lost Medicaid efficiencies (and reductions in *other* Medicaid programs, such as optional services). This cannot be what Congress intended when it enacted the Medicaid Act, and more recently when it repealed the Boren Amendment in an effort to

underscore the need for State flexibility in administering Medicaid programs, without interference from private suits challenging the adequacy of provider reimbursements. *See Pa. Pharmacists Ass'n v. Houstoun*, 283 F.3d 531, 538-40 & n.15 (3d Cir. 2002); *Evergreen*, 235 F.3d at 919 n.12; *see also Sanchez v. Johnson,* 416 F.3d 1051, 1059-60 (9th Cir. 2005).

Finally, under the Ninth Circuit's ruling in *Dominguez*, these cases are no longer limited to challenges to state statutes that directly reduce Medicaid reimbursement rates to providers. Now, any state Medicaid reform effort may be enjoined on the theory that it may *potentially* impact provider payments. Thus, in *Dominguez*, SB6 was held preempted even though it did not reduce payments to IHSS providers, but merely changed a statutory cap according to which the State's contribution is calculated. The connection to Medicaid reimbursement rates is even more attenuated in *Putz v. Schwarzenegger*, a case filed in federal district court in California in January 2010: there, plaintiffs are invoking § 1396a(a)(30)(A) and the Supremacy Clause in an effort to challenge (and enjoin) a reduced appropriation to entities that provide purely administrative support in connection with the provision of IHSS services. *See* App., *infra*, 236. *But see National Ass'n of Chain Drug Stores v. Schwarzenegger,* No. CV 09-7097 CAS (MANx), ___ F. Supp. 2d ___, 2009 WL 5253371 (C.D. Cal. Dec. 22, 2009) (refusing to enter injunction where reduction in reimbursement rates to

pharmacies did not "result of any state law or policy mandating a change in reimbursement").

Petitioners believe that the earlier-filed *Independent Living* petition is a suitable vehicle for reaching the overarching issue of whether a state statute reducing Medicaid rates may be preempted based on judicially created funding criteria that lack any textual support whatsoever. The *Independent Living* decisions developed most of the framework for the Ninth Circuit's current analysis. However, if the Court would prefer to reach the issue with respect to reductions that are still in effect, or to reach the full panoply of requirements that the Ninth Circuit has now imposed, it should grant the present petition instead (and hold the *Independent Living* petition pending the disposition of this case).

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

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Respectfully submitted,

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