No. 09-1158

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

BRIEF OF RESPONDENTS IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether Medicaid recipients and providers who face imminent injury from a state statute that reduces Medicaid reimbursement rates may maintain a cause of action for injunctive relief under the Supremacy Clause on the ground that 42 U.S.C. § 1396a(a)(30)(A) preempts the state statute.

2. Whether a statute that reduces Medicaid reimbursement rates, for purely budgetary reasons and without any consideration of the effect of the reduction upon access to or the quality of Medicaid services, is preempted by the requirement of 42 U.S.C. § 1396a(a)(30)(A) that state Medicaid plans must "provide such methods and procedures relating to . . . the payment for . . . care and services available under the plan . . . as may be necessary . . . to assure that payments are consistent with efficiency, economy, and quality of care 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."

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.[a]

Respondents in this Opposition Brief 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; 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, who are plaintiffs-appellees in Ninth Circuit Case No. 09-16359, *Lydia Dominguez, et al. v. Arnold Schwarzenegger, et al.*

CORPORATE DISCLOSURE

Respondents have no parent corporations and no publicly held company owns any stock in these respondents.

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[a] Defendent-Appellant John Chiang, California State Controller, did not seek certiorari from the Court of Appeals decision. That not all the defendants bound by the preliminary injuction have petitioned for certiorari is an additional reason the petition should be denied.

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BRIEF OF RESPONDENTS IN OPPOSITION

INTRODUCTION

According to Petitioners, the issues they raise are important enough to warrant a grant of certiorari because the Court of Appeals decisions at issue "ha[ve] made it virtually impossible" for States to curtail Medicaid expenditures by reducing provider rates. Pet. 35. To the contrary, however, the Court of Appeals has read the Medicaid Act correctly to impose a modest obligation upon participating States: that before reducing the rates paid to Medicaid providers, the relevant decision-maker must consider the impact such reductions will have upon Medicaid recipients' equal access to care and quality of care. That obligation does not prevent States from reducing Medicaid provider rates. The requirement in 42 U.S.C.

§1396a(a)(30)(A) that States must have "methods and procedures" to "assure" that Medicaid payments are sufficient to ensure equal access to care and quality of care necessarily precludes States from reducing payment rates solely for budgetary reasons and without consideration of the impact of those reductions.

As explained in further detail later in this brief, it is simply not true that the Court of Appeals decisions below require the legislature itself to conduct rate studies, to reference expressly any particular statutes, or to study non-existent provider costs. Moreover, Petitioners fail to acknowledge that the Court of Appeals did not simply find that their efforts in this case had fallen short, but that they had not *given any consideration whatsoever* to the impact of the cuts at issue before adopting them – and that they had waived any argument otherwise by failing to present it to the District Court. App. 79 (finding that "the State conceded that the legislature did not consider any analysis of the § 30(A) factors prior to enacting" SBX3 6 and so "waiv[ed] the issue").

Additional reasons counsel against certiorari in this case, including the interlocutory posture, the existence of substantial questions regarding whether factual and legal arguments were preserved below, and the fact that even without a federal cause of action Respondents could assert the same Medicaid claims at issue in state or federal court and obtain the same relief. The *Dominguez* Respondents also agree with the reasons for denying certiorari set forth in the briefs in opposition by the *California Pharmacists* and *Independent Living Center* Respondents.

STATEMENT

1. The In-Home Supportive Services ("IHSS") program provides assistance to enable low-income elderly, blind,

or disabled individuals to remain in the community rather than be forced into more costly nursing homes or other institutional settings. Cal. Welf. & Inst. Code § 12300(a); App. 63. Individuals are eligible for IHSS only if they "cannot safely remain in their homes or abodes of their own choosing unless these services are provided." Cal. Welf. & Inst. Code §12300(a); App. 162.

IHSS providers, who are paid by the State, deliver personal care services like bowel and bladder care, ambulation, bathing, oral hygiene, and feeding, as well as domestic and related services that permit IHSS recipients to live independently without compromising their health and safety. Cal. Welf. & Inst. Code § 12300(b)-(c); App. 63, 162-63. In some cases, the IHSS program also authorizes protective supervision for mentally impaired individuals and paramedical services such as the administration of medication and injections. Cal. Welf. & Inst. Code §§ 12300(b), 12300.1.

IHSS is provided through California's Medicaid program ("Medi-Cal"), and so program costs are shared by the federal government (which ordinarily is responsible for 50% of the costs but currently, pursuant to the federal stimulus legislation, covers 62%), state government (which pays two-thirds of the non-federal share), and county governments (which are responsible for the remaining one-third of the non-federal share). Cal. Welf. & Inst. Code §§ 12306(a)-(b), 12306.1(c); App. 62-63, 65 & n.2, 163-64.

The State has, by statute, established a system under which counties administer the IHSS program at the local level, and provider rates (wages and benefits) vary by county. Cal. Welf. & Inst. Code §§ 12301.6, 12302; App. 63-64. The state legislature sets a maximum rate toward which it will contribute ("rate cap"), counties submit proposed rates to the relevant state agencies, and the state

agencies approve those rates if they comply with federal and state law. Cal. Welf. & Inst. Code §§ 12306.1(a)-(d); App. 64-65.[1] State approval of county rates is contingent upon the State's maintenance of current funding levels (and so, according to prior communications by state officials, a reduction in the state cap automatically rescinds approval of all rates above that cap). Cal. Welf. & Inst. Code § 12306.1(b); App. 74.

IHSS recipients are responsible for finding and hiring their own providers. Cal. Welf. & Inst. Code § 12301.6(c). Some IHSS providers are related to their clients, but many consumers employ unrelated providers. Finding IHSS providers can be extremely difficult, given the nature of the work, which is often difficult and can be unpleasant. Some IHSS consumers are incontinent or unable to reach the bathroom when necessary. Others have mobility impairments and must be lifted and transferred by their providers. Still others have behavioral or mental health issues that make providing even basic services extremely challenging.

The California state legislature and state agencies have "recognize[d] that reimbursement rates – that is, providers' wages and benefits – are directly correlated to ensuring that services are consistent with efficiency, economy, and quality of care, and sufficient to ensure access to services under the IHSS program." App. 69; *see also* App. 73 & n.5. In other words, the relevant state officials have acknowledged that, the lower the reimbursement rates, the more difficult it is for IHSS recipients to find providers.

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[1] State law does not require counties to keep their rates at or below the rate cap. App. 66. Counties are, however, solely responsible for the full amount of the non-federal share of any amount above the rate cap. Cal. Welf. & Inst. Code § 12306.1(a); App. 66.

2. As a condition of participating in the Medicaid program, and thereby receiving federal Medicaid funds, the State of California has agreed to be bound by the provisions of the Medicaid Act, 42 U.S.C. §§ 1396a-1396v. Among the requirements imposed by that Act is that participating States adopt state Medicaid plans. *Id.*, § 1396. Those plans are themselves subject to a number of requirements, including that they must

> provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary . . . to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area . . . .

42 U.S.C. § 1396a(a)(30)(A) (hereinafter "Section 30(A)").

3. On February 20, 2009, the Governor signed SBX3 6 into law. App. 65, 218-27; S.B. 6, 2009-2010 Leg., 3d Extraordinary Sess. (Cal. 2009) (hereinafter "SBX3 6"). SBX3 6, which was enacted on an urgency basis and purely for budgetary reasons, would have reduced the IHSS rate cap by almost twenty percent, from $12.10 per hour to $10.10 per hour, effective July 1, 2009. App. 65, 219, 224, 227; SBX3 6 §9. Despite the commands of Section 30(A), the legislature decided to reduce the IHSS rate cap without any consideration of the Section 30(A) factors, including the impact that the reduction would have upon Medicaid recipients' equal access to IHSS services and the quality of those services. App. 79-80, 171.

Based on their position that SBX3 6 invalidated all existing rates above the new rate cap, state officials required all counties paying above $10.10 per hour to sub-

mit rate change requests for state approval. All county requests to reduce IHSS rates in response to SBX3 6 were approved. App. 66 & n.3, 74.

4. Respondents filed an action challenging SBX3 6 on May 26, 2009, asserting that the statute is preempted by Section 30(A) and violates the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. App. 66-67 & n.4.

Respondents moved immediately for a preliminary injunction, and submitted substantial evidence that SBX3 6 would cause many providers who would be unable or unwilling to work for reduced wages to leave their jobs, and that many IHSS recipients would be unable to find replacement providers. For example, Respondent Leslie Gordon has severe cerebral palsy but is able to maintain an active and independent life in the community with the help of several IHSS providers, who lift her, assist her with bathing and toileting, and provide overnight care. Her providers submitted declarations that they would be forced to obtain other employment if their wages were reduced and that, given the difficulty of the tasks with which she needs assistance, Ms. Gordon would be unlikely to find providers to replace them at the lower wage. If she were unable to find a replacement provider, Ms. Gordon would be forced into a nursing home. Declarations of Leslie Gordon, Brittany Calhoun, and Natalie Hunter (D. Ct. Dkt. Nos. 14, 20, 24). Respondents also submitted expert testimony by, among others, labor economist Dr. Candace Howes, who used an economic model based on past documented responsiveness of provider turnover to wage fluctuations in order to estimate the increased turnover that would result from the rate reduction. She concluded that at least 4,000 IHSS recipients would lose their providers due to SBX3 6, 1,400 of whom would be forced into nursing homes due to inability

to find replacement providers, costing the State tens of millions of dollars in increased expenditures. Declaration of Dr. Candace Howes (D. Ct. Dkt. No. 22).

On June 25, 2009, the District Court enjoined implementation of SBX3 6's rate cap reduction on the ground that Respondents had shown a likelihood of success on the claim that the State had violated the procedural requirements of the Medicaid Act. App. 162. The court found that Petitioners had "concede[d] that the California legislature did not consider the Section 30(A) factors" – that is, "the impact of the provision on access to care or the quality of care" – when it adopted SBX3 6. App. 171. And the court rejected Petitioners' contention that the State was not responsible for Section 30(A) compliance with respect to the IHSS program. App. 168-172.

The District Court also concluded that IHSS recipients would "suffer immediate and irreparable harm" without an injunction, and that the challenged statute would "greatly diminish[]" IHSS recipients' quality of life. App. 172-73. Specifically, the District Court concluded that "[t]he wage reductions w[ould] cause many IHSS providers to leave employment, which in turn w[ould] leave consumers without IHSS assistance," and cited expert testimony as well as other evidence that without IHSS recipients would go hungry; suffer dehydration, falls, and burns; be unable to leave their homes; and/or face unnecessary institutionalization.

The District Court also found "persuasive evidence that the wage cuts will actually *cost* the State *tens of millions of additional dollars* because in-home care is considerably less expensive than institutionalized care and IHSS providers reduce the need for expensive emergency room visits." App. 174 (emphasis added). That is, although the State refers repeatedly to budget issues, the evidence before the District Court established that implementation

of the state statute at issue actually would have required greater State expenditures.

Both the District Court and the Court of Appeals denied Petitioners' requests for stays pending appeal. Supp. App. 1a, 8a. After Petitioners repeatedly refused to restore rates to pre-SBX3 6 levels, the District Court issued two further injunctions prohibiting Petitioners from putting into effect wage reductions based on SBX3 6. Supp. App. 2a-7a; App. 180-189.

Petitioners appealed, and the Court of Appeals affirmed in a unanimous decision. The Court of Appeals found that Petitioners had conceded, in the District Court, "that the legislature did not consider any analysis of the § 30(A) factors prior to enacting" SBX3 6, and had waived any claim to the contrary. App. 79. In any event, the court concluded, the annual report that Petitioners now asserted fulfilled the State's Section 30(A) obligation did not purport to analyze the effect of any rate decrease, and in fact had documented a "'critical shortage of available providers'" for groups of IHSS recipients in almost half of all counties. App. 80.[2] And the Court of Appeals rejected Petitioners' various arguments as to why the Section 30(A) obligation would not apply in the IHSS context. App. 70-75, 76-79.

The Court of Appeals also affirmed the District Court's findings of irreparable harm and that equitable factors favored an injunction, "especially in light of evidence in the record that suggests that reductions in providers' wages and benefits may have an adverse, rather than beneficial, effect on the State's budget, such that it would

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[2] That report was in the District Court record but had been cited for other purposes; Petitioners had not argued, before the appeal, that the legislature had considered the report in connection with the enactment of SBX3 6.

actually *save the State money* if it maintained its current level of funding of the IHSS program." App. 80-83 (emphasis added). And it emphasized that the State remains free to "make[] a policy decision to decrease providers' reimbursement rates" so long as it complies with the requirements of the Medicaid Act in doing so. App. 82-83.

REASONS THE PETITION SHOULD BE DENIED

The *Dominguez* Respondents agree with the discussion in the briefs in opposition filed by the *Independent Living Center* and *California Pharmacists* Respondents as to why the Court of Appeals correctly decided the cases below, and why the Court of Appeals decisions present no conflict with those by other circuits or state courts. Rather than repeating those arguments, Respondents join in them fully, and set forth herein the following additional reasons why certiorari should be denied.

1. The Petition's Characterization of the Proceedings and Holdings Below Is Inaccurate, and Fails to Acknowledge Petitioners' Concession that the State Gave No Consideration to the Section 30(A) Factors Before the Decision to Reduce Rates.

Petitioners contend that,"[b]y adopting inconsistent, ever-expanding, ever-more-detailed rules, the Ninth Circuit has made it virtually impossible for California to enact a statute that . . . may reduce reimbursements to Medicaid providers." App. 35. This misreads the relevant decisions below.[3]

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[3] Petitioners also omit mention of the Court of Appeals' and District Court's findings, on the record established at the time of the preliminary injunction, that the reduction of IHSS provider rates would cost the State more money than it would save because of increased institutionalization costs. *See supra* at 7, 8-9.

It is not the case that Petitioners have repeatedly attempted to comply with the obligations of Section 30(A) but been thwarted by increasingly specific and unreasonable judicial rejections of those efforts. Rather, as the Court of Appeals explained, Petitioners have "conceded that the legislature did not consider *any analysis of the § 30(A) factors* prior to enacting § 12306.1(d)(6)," and waived any argument otherwise. App. 79 (emphasis added).[4] The Court of Appeals did go on to reject Petitioners' *post hoc* explanation that the legislature might have relied upon an annual report produced by the California Department of Social Services regarding the state of the IHSS program, but not because that report failed to meet technical or detailed requirements. Rather, the Court of Appeals accurately observed that the report did not even mention, much less purport to analyze the effect of, any rate reduction. App. 80. Further, the court noted that the report documented critical shortages of IHSS providers – and so inconsistency with the Section 30(A) factors – in certain counties even at the higher, pre-SBX3 6 rates. App. 80; *compare* App. 20-21.

Petitioners erroneously contend that the Court of Appeals held that the state legislature itself, rather than a state agency, must conduct the study of the Section 30(A) factors when the legislature acts to reduce rates. Pet. 5, 31 (citing App. 13-14, 16, 54). In fact, in rejecting Petitioners' arguments that the legislature had relied on studies commissioned or conducted by a state agency, the Court of Appeals did *not* say that the legislature itself must conduct the study. *See also Orthopaedic Hospital*, 103 F.3d at 1496 (holding that state agency – which set the

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[4] Over a decade ago, the Court of Appeals rejected the State's argument that Section 30(A) did not require consideration of the impact of a rate reduction upon access to or quality of Medicaid services. *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491, 1496 (9th Cir. 1997).

rates at issue in that case – was required to consider cost studies, "its own or others'"). Rather, the court said that the studies at issue were inadequate because they did not analyze the effect of the rate reductions at issue upon access or quality, and that there was no evidence the legislature had considered the studies in enacting those rate reductions. App. 55-56, 80. Consideration of the impact of a rate reduction by someone other than the entity that is actually making the decision to reduce rates would carry out neither the mandate nor the purposes of Section 30(A).[5]

Petitioners go on to assert that under the Court of Appeals' rulings a study of the Section 30(A) factors "must *expressly reference both § 1396a(a)(30)(A) and the specific statutory enactment* at issue," so that a study upon which the legislature could otherwise rely, but that fails to make those express references, would not suffice. Pet. 5, 32 (citing App. 20, 56, 80) (emphasis in original). But the Court of Appeals held no such thing; rather, it rejected Petitioners' attempt to rely upon studies or reports that did not address the contemplated rate reduction and either did not analyze the relevant factors or con-

[5] Similarly, consideration of the impact of a rate reduction upon access and quality *after* the final decision to reduce rates has been made would be an empty exercise. Petitioners complain that the Court of Appeals held that the required analysis must be conducted before enacting the reduction, rather than post-enactment but prior to implementation. Pet. 4, 31 (citing App. 15, 54, 57, 80). But the Court of Appeals did not reject Petitioners' contention that, if the implementing agency had the authority to decline to implement the rate reduction based on a study of the Section 30(A) factors, then a post-enactment but pre-implementation study would fulfill the State's obligations; rather, it concluded that the agency had no authority but to implement the rate reduction at issue unless the federal government actually withheld funds from the State. App. 21-29. Since the legislature was the body that decided to reduce rates, it was required to consider the Section 30(A) factors. App. 22, 28.

cluded that *current* rates, prior to a contemplated reduction, produced significant problems with access and quality. For example, in *Dominguez*, the Court of Appeals found that the annual report that Petitioners asserted fulfilled the Section 30(A) obligation "contains no discussion of a contemplated rate change that would either increase or decrease payment rates," and in fact documents a "'critical shortage of available providers that affected a specific subpopulation of IHSS consumers'" in almost half of the counties statewide. App. 80; *see also* App. 20 (in *California Pharmacists*, noting one analysis "is concerned solely with budgetary matters" and does not mention Section 30(A) factors at all, and that other finds that greater rate reduction would limit recipient access to services); App. 55-56 (in *Independent Living Center*, noting report does not analyze access or quality at all, and that it recommends further analysis in light of its conclusions about provider costs).[6]

Finally, Petitioners contend that the Court of Appeals held that even when a group of providers does not incur costs the State must study provider costs. Pet. 5, 32 (App. 78-79). That is not true. The Court of Appeals held merely that the State "must rely on something" to determine the impact of a rate reduction upon access

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[6] Relatedly, Petitioners contend that, under the Court of Appeals decisions, a mention on a legislative committee agenda does not suffice to show that the legislature considered a study. Pet. 5, 32 (citing App. 55-56). In fact, however, Petitioners had not argued, in the District Court or in their appellate briefs, that the legislature had considered the study at issue – rather, they waited until the appellate oral argument to make this assertion. App. 54-55. Moreover, the Court of Appeals noted that the study at issue did not analyze the impact of a rate reduction upon access or quality, and found no clear error in the District Court's finding that the Section 30(A) factors were not considered by the legislature prior to its decision to reduce rates. App. 55-56.

to and quality of care, and suggested that the State could consider factors like those presented in an annual report issued by the relevant state agency. App. 78.[7] Then, the court went on to note that, in addition, the State "may" look at costs for providers of analogous services, or to the market rate for similar work in the local area. App. 79. In no way did the court require analysis of non-existent costs.[8]

Despite Section 30(A)'s requirements, for the past two years, the State of California has repeatedly made across-the-board reductions in Medicaid provider rates based solely upon budgetary considerations, and without any (much less adequate) consideration of the impact of such reductions upon the Section 30(A) factors. Petitioners

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[7] That annual report was held inadequate to satisfy the State's Section 30(A) obligations not because it failed to consider provider costs, but because it did not analyze the effect of the rate change at issue and found substantial access problems even before the reduction in rates. App. 80. Moreover, Petitioners had waived any argument that the legislature had actually considered the annual report in enacting the rate reduction. App. 79.

[8] Petitioners also contend that the Court of Appeals held that the Section 30(A) obligation extends to any statute that could potentially affect provider rates. Pet. 38. That is a broad overreading of the Court of Appeals' holding. In relation to IHSS, the State, which is bound by its participation in Medicaid to ensure compliance with Section 30(A), has established a rate-setting system under which its role is to establish the rate cap and to approve individual county rates. *Supra* at 3-4. The Court of Appeals found not that the rate cap enacted by SBX3 6 might possibly affect rates in the future, but that it directly and immediately drove rate reductions in the affected counties. App. 72. State officials themselves had represented that the enactment of SBX3 6 automatically rescinded approval of existing rates above the new, lower rate cap, and so "the State explicitly invalidated its prior approval of [these] rates . . . as a result of" SBX3 6. App. 74. There can be no question that, if Section 30(A) requires consideration of access and quality in providing for the methods of payment, that obligation was implicated by SBX3 6.

have advanced varying and at times contrary views on whether the Section 30(A) factors were considered at all, and if so, by which entity and at which time.

In the instant case, for example, Petitioners conceded in the trial court that the legislature had given no consideration to the Section 30(A) factors before reducing provider payments. App. 79, 171. Then, on appeal, Petitioners asserted for the first time that the Section 30(A) obligation had been met by an annual report prepared by the state agency.[9] The Court of Appeals found that Petitioners' failure to make this argument below waived it, and so the court's explanation as to why the study did not fulfill the State's Section 30(A) obligations – that it documented serious access problems and did not purport to analyze the impact of reductions in provider payments – were in the nature of alternative holdings only. App. 80. Similarly, in *California Pharmacists*, Petitioners argued for the first time in their reply brief on appeal that the state agency's consideration of a study after the legislature's enactment of the rate reductions sufficed to fulfill the State's Section 30(A) obligation, because the agency had the discretion not to implement the rate reductions adopted by the state legislature, and the Court of Appeals found that argument had been waived. App. 22-24. The Court of Appeals went on to reject both the notion that the agency had such discretion, and Petitioners' argument that the study would have fulfilled the Section 30(A) obligation, but only as alternate grounds for its conclusion that the State had not met its obligation. App. 24-29 & nn. 4-5. And in *Independent Living Center*, Petitioners waited until their oral argument on appeal to assert that the *legislature* had relied upon that same cost study. App. 54-55.

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[9] The study was in the trial court record because Petitioners had relied upon it for a different point.

It is not the Court of Appeals' "onerous" requirements that have prevented the State from reducing Medicaid rates. Pet. 7; *see* App. 82-83 ("If the State makes a policy decision to decrease providers' reimbursement rates, and fully complies with the requirements of this and our other decisions, it will not be barred by current federal Medicaid law from doing so."). Rather, it is the State's own failure to consider the Section 30(A) factors at all when reducing Medicaid rates. Petitioners' failure to take any steps to evaluate the impact of the rate reductions at issue upon equal access to and quality of care before those rate reductions were enacted would make these cases poor vehicles for resolving the nature of any obligation under Medicaid Section 30(A) that does exist.

2. The Interlocutory Posture and Questions Regarding Issue Preservation Counsel Against Certiorari.

As is true of the other two cases at issue in the instant petition, the decision by the Court of Appeals affirms a preliminary injunction and is therefore necessarily interlocutory in nature, which itself is reason to deny certiorari. *See Brotherhood of Locomotive Firemen v. Bangor & Aroostock R. Co.*, 389 U.S. 327, 328 (1967); *Hamilton-Brown Shoe Co. v. Wolf Bros. & Co.*, 240 U.S. 251, 258 (1916); *American Constr. Co. v. Jacksonville, T. & K.W. Ry. Co.*, 148 U.S. 372, 384 (1893).

If this Court declines to review these interlocutory decisions, Petitioners will be able to seek review of final judgments in these proceedings at the appropriate time. In all three cases, proceedings in the District Court are ongoing. In the instant case, the hearing on dispositive motions is set for March 3, 2011 and trial is scheduled on June 6, 2011.[10] This Court will have ample opportunity to

[10] These proceedings will also adjudicate Respondents' claims under the Americans with Disabilities Act and the Rehabilitation Act that SBX3 6 will cause unnecessary institutionalization of IHSS

review the final judgment that results from those proceedings in the near future.

There are strong reasons to wait for a final judgment rather than reviewing the interlocutory decisions below. In the current cases, disputes abound as to which evidence and arguments were properly before the courts below when the preliminary injunctions at issue were entered and affirmed. For example, in the instant case, the District Court and Court of Appeals both found that Petitioners had conceded that the legislature did not give any consideration to the Section 30(A) factors before enacting SBX3 6. App. 79, 171. Yet Petitioners now seek to contest that fact. Similarly, in *California Pharmacists*, Petitioners waived the argument that the state agency rather than the state legislature was the relevant rate-setting entity, but have since changed their minds on that front. App. 22-24. Rather than attempt to sort out which factual and legal issues were properly raised and when, this Court should wait to determine whether certiorari is warranted until after final judgments have been rendered.

3. Resolution of the Questions Presented Will Not Affect the Result in this Case.

a. Resolution of the First Question Presented Would Not Affect the Authority of Federal or State Courts to Entertain Similar Preemption Claims.

Resolution of the first Question Presented will not have any real world impact upon Petitioners' obligation to com-

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recipients whose providers quit work and who cannot find replacement providers. *See Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 587 (1999). If the District Court grants judgment in favor of Respondents on these claims, the preliminary injunction affirmed by the Court of Appeals will be rendered moot, and the Court of Appeals decision regarding Respondents' likelihood of success on the Medicaid Act claim will become superfluous.

ply with Section 30(A). In California, California Code of Civil Procedure Section 1085 authorizes a private party to enforce state officials' obligations to comply with the Medicaid Act (or any other federal statute) through a petition for writ of mandate, regardless of whether the statutory provision is enforceable via 42 U.S.C. § 1983. *See Mission Hosp. Regional Med. Ctr. v. Shewry*, 168 Cal.App.4th 460, 478-79 (2008); *California Ass'n for Health Servs. at Home v. Department of Health Servs.*, 148 Cal.App.4th 696, 706 (2007); *Doctor's Med. Lab., Inc. v. Connell*, 69 Cal.App.4th 891,896 (1999).[11]

Thus, even if Petitioners were to prevail on their first Question Presented, Respondents could raise the same claims in state court via a mandamus action, or could potentially assert them in federal court to the extent that their disposition would turn upon the resolution of a contested and substantial question of federal law. *See Grable & Sons Metal Prods., Inc. v. Darue Eng'g & Mfg.*, 545 U.S. 308, 312-13 (2005).[12]

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[11] In support of a related certiorari petition, Petitioners suggested that a successful mandamus action in California requires the existence of a statutory "right" akin to the type of right that is enforceable under 42 U.S.C. § 1983. Reply Brief in Support of Petition for Writ of Certiorari, No. 09-958 (filed Apr. 30, 2010) at 9. They well know this is not true. California courts have made clear that any party with a beneficial interest may file a mandamus action to compel state officials to follow the law and that "[t]he beneficial interest standard is so broad, even citizen or taxpayer standing may be sufficient to obtain relief in mandamus." *Mission Hosp.*, 168 Cal.App.4th at 480. A writ of mandate to enforce a legal duty "is available not only to those who have enforceable private rights," but to anyone who is a "beneficially interested" party – meaning that they have an interest that is different from the public at large. *Id.* at 479-80 (internal quotation marks and citations omitted). All that is needed to establish such a beneficial interest is an injury akin to that required to establish Article III standing. *California Ass'n for Health Servs. at Home*, 148 Cal.App.4th at 706-07.

[12] In the instant case, Respondents could also rely upon supplemental federal jurisdiction, based on the Americans with Disabilities Act and Rehabilitation Act claims asserted in the case.

b. Resolution of the Second Question Presented Would Not Affect the Outcome of the Case Because Even Under Petitioners' Reading of Section 30(A) the State's Enactments Are Preempted.

Petitioners take the position that Section 30(A) establishes "substantive" rather than procedural obligations, and may require "that rates not be set . . . so low as to create an access or quality of care problem for beneficiaries." Reply Brief in Support of Petition for Writ of Certiorari, No. 09-958 (filed Apr. 30, 2010) at 9-10; Petition for Writ of Certiorari, No. 09-958 (filed Feb. 16, 2010) at 33; *see also id.* at 26 (Section 30(A) "arguably sets some substantive objectives – that rates not be set . . . so low as to create an access or quality of care problem for beneficiaries"); *id.* at 31 (criticizing Court of Appeals for failing to determine whether new rates meet "substantive requirements" of statute).[13]

The Court of Appeals' holding comports with the mandates of Section 30(A), which requires States to have "methods and procedures" to ensure that payments are consistent with, among other factors, access and quality. 42 U.S.C. § 1396a(a)(30)(A). But even if Section 30(A) were to impose a substantive rather than procedural obligation, the rate reduction at issue still would be invalid. The Court of Appeals found that "both the legislature and the Department recognize that reimbursement rates . . . are directly correlated to ensuring that services are consistent with . . . quality of care, and sufficient to ensure access to services under the IHSS program." App. 69.

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[13] The Court of Appeals has previously explained that the substantive approach favored by Petitioners accords *less* deference to the State in making decisions about provider rates than the procedural reading of Section 30(A). *See Independent Living Center of S. Cal. Inc. v. Shewry*, 572 F.3d 644, 657 (9th Cir. 2009).

And it observed that Petitioners themselves sought to rely on a report that documented a "critical shortage of available providers" affecting specific subgroups of IHSS recipients in almost half of the counties statewide, thus "bel[ying] the State's assertion that current wages and benefits – those in effect prior to passage of [SBX3 6] – are consistent with § 30(A)'s statutory factors." App. 80. Further, the Court of Appeal accepted the District Court's findings that reductions in provider rates would lead to institutionalization of Medicaid recipients whose providers would cease providing services and who would be unable to find replacements. App. 82; *see also* App. 172-74 (District Court findings that rate reductions "will cause many IHSS providers to leave employment, which in turn will leave consumers without IHSS assistance," reduce quality of care, and lead to institutionalization).

Accordingly, a ruling for Petitioners on the merits of the Second Question Presented would not affect the result in this case, because the SBX3 6 rates would not be valid under the Respondents' proposed reading of Section 30(a).[14] The Court of Appeals reached similar conclusions regarding the impact of the rate reduction at issue upon recipients' access to Medicaid services in the *California Pharmacists* and *Independent Living Center* cases as well. App. 33-34 ("[E]ven if we were to require a substantive violation of the statute to support a finding of irreparable harm, we would find that violation here" based on showing that recipients will lose access to adult day health services); App. 57-58 (affirming district court

[14] In addition, the findings of the District Court and Court of Appeals that the rate reductions would lead to unnecessary institutionalization would establish Respondents' entitlement to an injunction based on Petitioners' claims under the Americans with Disabilities Act and Rehabilitation Act. *See supra* at 7, 8-9.

findings that reduction in rates will limit Medi-Cal patients' access to pharmacy services).

CONCLUSION

For the reasons discussed, this Court should deny certiorari.