

09-16359

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

**MIKESHA MARTINEZ, by and through
her husband and next friend Carlos
Martinez, et al.,**

Plaintiffs and Appellees,

v.

**ARNOLD SCHWARZENEGGER,
Governor of the State of California, et al.,**

Defendants and Appellants.

On Appeal from the United States District Court
for the Northern District of California

No. CV 09-2306 CW
The Honorable Claudia Wilken, Judge

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INTRODUCTION

The district court misinterpreted this Court’s precedent on 42 U.S.C. § 1396a(a)(30)(A); misapplied this Court’s Medicaid standards; and improperly relied on fatally (and admittedly) flawed expert testimony as well as a cascade of improbabilities to erroneously conclude that Appellees were likely to prevail on the merits and would be irreparably harmed if the court did not enjoin the implementation of California Welfare and Institutions Code § 12306.1(d)(6).

The district court enjoined this State statute—which governs the State’s level of contribution to wages and benefits that counties pay to In-Home Supportive Services (IHSS) providers—until the State Defendants-Appellants (Appellants)¹ “conduct[] the analysis required by Section 30(A), as described in *Orthopaedic Hospital v. Belshe*, 103 F.3d 1491 (9th Cir. 1997).” In so holding, the district court committed reversible legal error because *Orthopaedic* has no application to § 12306.1(d)(6). *Orthopaedic*

¹ State Defendants-Appellants are: Arnold Schwarzenegger, Governor of the State of California; John A. Wagner, Director of the California Department of Social Services; and David Maxwell-Jolly, Director of the California Department of Health Care Services (collectively, Appellants). State Defendant John Chiang, California State Controller, has taken no position in this litigation. State Defendants-Appellants expressly reserve their right to immunity under the Eleventh Amendment of the United States Constitution.

requires states, in setting Medicaid reimbursement rates, to rely on cost studies or otherwise undertake procedures to ensure that those rates are consistent with efficiency, equality, and quality of care. But § 12306.1(d)(6) does not set any reimbursement rates, and thus no such “procedures” or “cost studies” are required under *Orthopaedic* or § 1396a(a)(30)(A).

Indeed, § 12306.1(d)(6) does not alter the extensive procedures already in place to ensure that the wages and benefits paid to IHSS providers are consistent with quality of care and access to care. Those wages and benefits are not set by the State, but rather are set at the individual county level through a collective bargaining process in which the IHSS providers, through their union, are directly involved in the negotiations. This collective bargaining process provides a far *greater* assurance of quality and access to care than the reliance on “cost studies” discussed in *Orthopaedic*.

Even if *Orthopaedic* applies, the district court nonetheless committed reversible error because Appellants—although not required to do so—in fact complied with *Orthopaedic* by conducting precisely the analysis that *Orthopaedic* requires in the rate-setting context. The district court ignored the clear evidence of this in the record, and accordingly erred in holding that Appellees were likely to prevail on the merits.

Finally, the district court compounded its error by finding that Appellees would suffer irreparable harm if the injunction were not granted. The record contains no probative evidence that the Appellees are likely to suffer irreparable harm, and Appellees' own expert essentially conceded as much in her reply declaration.

For each of these reasons, and for the additional reasons set forth herein, this Court should reverse the district court and vacate the preliminary injunction.

STATEMENT OF JURISDICTION

Appellees brought an action for injunctive relief under the Supremacy Clause of the United States Constitution, and the district court had jurisdiction over the action pursuant to 28 U.S.C. § 1331.

The orders of the district court granting and modifying the preliminary injunction are interlocutory orders appealable as of right, and this Court has jurisdiction over the appeal of each of those orders pursuant to 28 U.S.C. § 1292(a)(1).²

² While the district court had general jurisdiction over this action and this Court has general jurisdiction over this appeal, Appellants expressly reserve their right to immunity under the Eleventh Amendment of the United States Constitution.

The district court's order granting Appellees' motion for a preliminary injunction was entered on June 26, 2009, Appellants' Excerpts of Record (ER) at 374-87, and Appellants filed a notice of appeal on June 29, 2009. Appellants' Supplemental Excerpts of Record (SER) at 29-32. Appellants' notice of appeal is timely pursuant to Fed. R. App. Proc. 4(a)(1)(A).

The district court's Order Clarifying Injunction and Denying Plaintiffs' Motion for Civil Contempt Sanctions was entered on July 13, 2009, ER at 193-200, and Appellants filed an Amended Notice of Appeal to include this order in the appeal on July 23, 2009. SER at 1-28. The district court's Order Further Clarifying Injunction was entered on July 24, 2009, ER at 38-45, and Appellants filed a Second Amended Notice of Appeal to include this order in the appeal on July 28, 2009. ER at 1-37. Appellants' Amended Notice of Appeal and Second Amended Notice of Appeal are timely pursuant to Fed. R. App. Proc. 4(a)(1)(A).

ISSUES PRESENTED FOR REVIEW

1. Whether the district court committed legal error in holding that *Orthopaedic*, 103 F.3d at 1491, which held that states must analyze provider costs in setting hospital outpatient reimbursement rates under Medicaid, applies to the State's enactment of § 12306.1(d)(6), which does not set any

reimbursement rates and which concerns services for which providers do not incur any costs.

2. Whether the district court abused its discretion by entirely ignoring the evidence in the record that Appellants, although not required to do so, in fact complied with all of the requirements of *Orthopaedic*.

3. Whether the Supremacy Clause can create a valid private right of action to enforce a statute where (1) no private right of action is permitted under 42 U.S.C. § 1983; (2) no implied private right of action exists; and (3) Congress did not intend to create any private right of action.³

4. Whether *Orthopaedic* is still good law in light of *Gonzaga University v. Doe*, 536 U.S. 273 (2002), and *Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005).

5. Whether *Orthopaedic*'s analysis of § 1396a(a)(30)(A) in the context of a claim under 42 U.S.C. § 1983 can apply to a claim for federal preemption under the Supremacy Clause in light of the strong presumption against federal preemption of state regulations concerning health and safety.

³ Appellants recognize that *Independent Living Center of Southern California, Inc. v. Shewry (Independent Living I)*, 543 F.3d 1050 (9th Cir. 2008), and *Independent Living Center of Southern California, Inc. v. Maxwell-Jolly (Independent Living II)*, 572 F.3d 644 (9th Cir. 2009), are arguably controlling on issues 3, 4, and 5, and therefore raise these issues to preserve them for later appellate proceedings.

6. Whether the district court erred in finding that the balance of hardships favored Appellees and that Appellees would suffer irreparable harm if the preliminary injunction were not granted.

STATEMENT OF THE CASE

Appellees are Medicaid beneficiaries who receive IHSS services, providers of those services, and unions that represent providers of IHSS services. On May 26, 2009, Appellees filed this lawsuit in an effort to enjoin California Welfare and Institutions Code § 12306.1(d)(6), which was to take effect on July 1, 2009. Appellees argued that § 12306.1(d)(6) violates the federal Medicaid Act, 42 U.S.C. § 1396a(a)(30)(A), because the California Legislature allegedly failed to analyze the effect the statute would have on quality of care and access to IHSS services. Appellees also alleged violations of the Americans with Disabilities Act, 42 U.S.C. § 12132, and the Rehabilitation Act, 29 U.S.C. § 794(a). ER at 657-81.

On June 26, 2009, the district court issued a preliminary injunction barring § 12306.1(d)(6) from taking effect. The district court interpreted *Orthopaedic*, 103 F.3d at 1491, to require the Legislature to analyze provider costs before enacting § 12306.1(d)(6), and the district court held that the Legislature failed to do so. The district court further found that Appellees would suffer irreparable harm if the preliminary injunction were

not granted. ER at 374-87. On June 29, 2009, Appellants filed a timely notice of appeal. SER at 29-32.

The district court filed an Order Clarifying Injunction and Denying Plaintiffs' Motion for Civil Contempt Sanctions on July 13, 2009, ER at 193-200, and Appellants filed a timely Amended Notice of Appeal to include this order in the appeal on July 23, 2009. SER at 1-28. The district court filed an Order Further Clarifying Injunction on July 24, 2009, ER at 38-45, and Appellants filed a timely Second Amended Notice of Appeal to include this order in the appeal on July 28, 2009. ER at 1-37.

STATEMENT OF FACTS

A. The IHSS Program

In 1973, The IHSS program was enacted in California and funded with state/county and federal Title IV-A funds. ER at 489. In 1994, in order to be able to draw down additional federal funds, California added the personal care services program (PCSP), which is an optional service under Medicaid, to the State Plan. ER at 484-85. In 2004, the State applied to the federal Centers for Medicare and Medicaid Services (CMS) for a waiver to the State Plan in order to provide two additional compensable services as well as to add spouses and parents to the list of allowable IHSS providers. ER at 485. CMS approved this IHSS Plus Waiver, and now approximately 70,000 IHSS

recipients receive their services from either a spouse or parent. ER at 492; SER at 35. The PCSP, IHSS Plus Waiver, and Residual IHSS⁴ programs together provide services to over 440,000 individuals and include over 360,000 IHSS providers. ER at 491. Approximately 60% of IHSS recipients are served by a relative. ER at 494. In this brief, these programs are collectively referred to as IHSS.

The IHSS program is administered by the State's counties. Senate Bill 1780 (Ch. 206, Stats. Of 1996) enabled county boards of supervisors to establish a public authority (PA) or non-profit consortium (NPC) to provide the delivery of In-Home Supportive Services; 56 of California's 58 counties use either a PA or NPC for this purpose. Each of these 56 counties also has created and continues to maintain a registry from which service providers can be drawn. As of June 30, 2007, there were in excess of 14,500 persons in the registry statewide. ER at 491; SER at 65. The individual IHSS recipient is the employer and, as such, maintains the power to hire, fire, and direct the provision of services that he/she receives. ER at 491. The average recipient receives 85.5 hours a month of IHSS services. ER at 491.

⁴ The IHSS Residual program provides services to undocumented individuals who are precluded from receiving services under the federal Medicaid Act. Approximately 2 percent of those served are in this program. ER at 491.

B. Rate-Setting for IHSS Services

Each county establishes the providers' wages and benefits, which vary from county to county. The costs of the IHSS program are shared among the federal government, the county, and the State; in fiscal year 2006-2007, the federal share for wages and benefits was 50%, the county share was 17.5%, and the State share was 32.5% up to the statutory maximum (currently \$12.10/hour, *see* Cal. Welf. & Inst. Code § 12306.1(d)(5)). Most counties' rates are determined through a collective bargaining process between the county's PA/NPC and a union, such as Appellee Service Employees International Union (SEIU). ER at 493. The State does not participate in setting wages and benefits in any county.

Once wages and benefits are determined via the collective bargaining process, and the PA/NPC receives approval from the county Board of Supervisors for any increase in the PA rate, which includes wages and benefits among other things, the rate package must be submitted to the California Department of Social Services (DSS) and then to the California Department of Health Care Services (DHCS) to ensure that it complies with all applicable state and federal laws. ER at 493. Prior to submission for approval by the county Board of Supervisors, the State will not have seen a Memorandum of Understanding (MOU) or approved any PA rate that

includes negotiated wages and benefits. Although the PA or NPC may set the provider wage at any amount (at or above state minimum wage), by statute the State's contribution to that amount is subject to the availability of funds through Legislative appropriation. *See* Cal. Welf. & Inst. Code § 12306.1(a).

C. Enactment of § 12306.1(d)(6)

On February 20, 2009, the Governor signed Senate Bill 6 into law, which enacted § 12306.1(d)(6). Section 12306.1(d)(6) reduces the statutory maximum for which the State will contribute a proportionate share for IHSS wages and benefits from \$12.10/hour to \$10.10/hour. Specifically:

[T]he state shall participate as provided in subdivision (c) in a total cost of wages up to nine dollars and fifty cents (\$9.50) per hour and in individual health benefits up to sixty cents (\$0.60) per hour. This paragraph shall become operative on July 1, 2009.

Cal. Welf. & Inst. Code § 12306.1(d)(6).

Significantly, the statute does not require counties to reduce wages and benefits paid to IHSS providers. In fact, the law is entirely silent as to the amount of wages and benefits a county may set. Rather, the counties are permitted to make up the difference between the State's contribution and any higher wages and benefits that the county and the union have negotiated.

ER at 493. Further, less than half of the counties (only 22 of the 56 PAs or

NPCs) pay more than \$9.50 in wages, meaning that § 12306.1(d)(6) will have *no* effect in a majority of the counties, including Los Angeles County, where 42% of the State's IHSS caseload is found. ER at 493-94.

According to DSS, 12 of the 22 counties that pay more than \$10.10/hour in wages and benefits submitted Rate Change Requests to decrease wages and benefits to some amount at or above \$10.10/hour as of July 1, 2009, in amounts ranging from 25 cents to \$2.00 per hour. Eight of these 22 counties did not submit Rate Change Requests, so their wages and benefits remained the same. And, two counties submitted Rate Change Requests to increase wages and benefits. ER at 494. All of these Rate Change Requests were approved by DSS and DHCS.

D. Proceedings Below

More than three months after § 12306.1(d)(6) was enacted, on May 26, 2009, Appellees filed this lawsuit against various state officials (Appellants), the County of Fresno, and the Fresno County In-Home Support Services Public Authority. ER at 657-81.

On June 4, 2009, Appellees filed an *ex parte* application in the district court for an order shortening time to file a motion for preliminary injunction to enjoin implementation of § 12306.1(d)(6), requesting that the motion be heard on June 26, 2009 on an abbreviated hearing schedule despite the fact

that Appellees had delayed for more than three months before bringing the motion. SER at 212-18. The district court granted the motion to shorten time before Appellants could file an opposition, and originally limited Appellants to four court days to prepare their opposition. SER at 210-11. Appellants filed an *ex parte* application seeking two additional court days to prepare their opposition (and retain an expert), which the court granted. SER at 200-09. This gave Appellants just six court days to oppose a motion that Appellees had had over three months to prepare.

On June 26, 2009, the district court entered a preliminary injunction stating:

IT IS HEREBY ORDERED that Defendants ARNOLD SCHWARZENEGGER, Governor of the State of California; JOHN A. WAGNER, Director of the California Department of Social Services; DAVID MAXWELL-JOLLY, Director of the California Department of Health Care Services; JOHN CHIANG, California State Controller; and their officers, agents, servants, employees, and attorneys, and those persons in active concert or participation with them, are HEREBY ENJOINED AND RESTRAINED from implementing California Welfare and Institutions Code § 12306.1(d)(6) without first conducting the analysis required by 42 U.S.C. § 1396a(a)(30)(A), as described in *Orthopaedic Hospital v. Belshe*, 103 F.3d [1491], 1493 (9th Cir. 1997).

ER at 386.

In an order issued later that day, the court explained its reasoning. Relying principally on *Orthopaedic*, the court explained that § 12306.1(d)(6) conflicted with § 1396a(a)(30)(A) because it violated a “procedural” requirement that the State analyze the impact on Medicaid beneficiaries’ access to care and quality of care before enacting rate reductions. ER at 382.⁵ The district court found that the balance of hardships favored Appellees because “[t]he wage reductions will cause many IHSS providers to leave employment, which in turn will leave consumers without IHSS assistance,” and potentially lead to their institutionalization (e.g., placement in nursing homes). ER at 383-84.

Appellants filed a timely notice of appeal with the district court on June 29, 2009. SER at 29-32.

On July 13, 2009, in response to further motions from Appellees, the district court issued an Order Clarifying Injunction and Denying Plaintiffs’ Motion for Civil Contempt Sanctions. ER at 193-200. The district court ordered the State to “rescind the State’s approval of all county rate reduction requests which were submitted after February 20, 2009, to be effective July

⁵ The district court declined to rule on the other grounds cited by Appellants, such as whether § 12306.1(d)(6) violated “the substantive requirements of Section 30(A) or their claim that Defendants violated the Americans with Disabilities Act and the Rehabilitation Act.” ER at 383.

1, 2009, and reinstate the State’s approval of the pre-July 1 rates.” ER at 200. On July 23, 2009, Appellants filed an Amended Notice of Appeal to include this order in the appeal. SER at 1-28.

On July 24, 2009, in response to further motions from Appellees, the district court issued an Order Further Clarifying Injunction in which the court ordered Appellants, rather than the counties as required by regulations, to immediately pay all IHSS providers the “correct amount owed for the pay period ending July 15, 2009” under the terms of the court’s July 13, 2009 order. ER at 45. On July 28, 2009, Appellants filed a timely Second Amended Notice of Appeal to include this order in the appeal. ER at 1-37.

SUMMARY OF ARGUMENT

The district court committed reversible legal error in granting a preliminary injunction barring Appellants from implementing § 12306.1(d)(6), which reduces the level of the State’s contribution to IHSS provider wages and benefits that are established by the counties. The district court erroneously held that § 1396a(a)(30)(A), as interpreted by *Orthopaedic*, 103 F.3d at 1491, required the State to conduct an “analysis” of the statute’s impact on quality of care and access to care prior to enacting § 12306.1(d)(6). The district court is incorrect, as *Orthopaedic* applies only to the setting of Medicaid reimbursement rates, and § 12306.1(d)(6) does not

set any rates. Accordingly, the requirements of § 1396a(a)(30)(A) and *Orthopaedic* are inapplicable to § 12306.1(d)(6).

The district court committed further error by ignoring the fact that Appellants, though not required to do, in fact complied with everything that § 1396a(a)(30)(A) and *Orthopaedic* could possibly require. The State has established a system under which IHSS provider wages and benefits are set through a collective bargaining process between the counties and provider unions. This collective bargaining process provides a far greater assurance that payments will be consistent with quality of care and access to care than any “analysis” under *Orthopaedic* could provide. Moreover, Appellants in fact conducted precisely the type of analysis that the district court held was required here, as the California Department of Social Services submits an annual Report to the Legislature that analyzes quality, access, and other aspects of the IHSS program in great detail.

The district court compounded its error by finding that Appellees would suffer irreparable harm if § 12306.1(d)(6) were not enjoined. There is no credible evidence in the record to support the district court’s findings, as the district court relied on a series of improbable assumptions and a declaration from Appellees’ expert that the expert herself essentially conceded was fatally flawed.

ARGUMENT

I. STANDARD OF REVIEW

“The district court's grant of a preliminary injunction is reviewed for ‘abuse of discretion’ and should be reversed if the district court based ‘its decision on an erroneous legal standard or on clearly erroneous findings of fact.’” *Stormans, Inc. v. Salecky*, 571 F.3d 960, 969 (9th Cir. 2009) (quoting *FTC v. Enforma Natural Prods., Inc.*, 362 F.3d 1204, 1211-12 (9th Cir. 2004)). This Court “consider[s] a finding of fact to be clearly erroneous if it is implausible in light of the record, viewed in its entirety, or if the record contains no evidence to support it.” *Id.* (quoting *Nat’l Wildlife Fed’n v. Nat’l Marine Fisheries Serv.*, 422 F.3d 782, 794 (9th Cir. 2005)). “The district court's interpretation of the underlying legal principles, however, is subject to de novo review.” *Id.*

To warrant injunctive relief, a plaintiff “must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest.” *Winter v. Natural Resources Defense Council, Inc.*, ___ U.S. ___, 129 S. Ct. 365, 374 (2008). A plaintiff seeking a preliminary injunction has the burden “to demonstrate that irreparable injury is *likely* in the absence of an injunction.” *Id.* at 375.

“Issuing a preliminary injunction based only on a possibility of irreparable harm is inconsistent with our characterization of injunctive relief as an extraordinary remedy that may only be awarded upon a clear showing that the plaintiff is entitled to such relief.” *Id.* at 375-76. “In each case, courts ‘must balance the competing claims of injury and must consider the effect on each party of the granting or withholding of the requested relief.’” *Id.* at 376 (quoting *Amoco Prod. Co. v. Village of Gambell*, 480 U.S. 531, 542 (1987)).

II. THE DISTRICT COURT ERRED AS A MATTER OF LAW IN HOLDING THAT PLAINTIFFS ARE LIKELY TO SUCCEED ON THE MERITS

In entering the injunction, the district court erred as a matter of law in holding that *Orthopaedic*, 103 F.3d at 1491, required the State to conduct an analysis of provider costs prior to enacting § 12306.1(d)(6). Moreover, even if such an analysis were required (which it is not), the district court committed clear error in granting the injunction because the State in fact conducted precisely the analysis that the district court’s opinion purports to require.

A. Neither § 1396a(a)(30)(A) Nor *Orthopaedic* Requires an Analysis of § 12306.1(d)(6)’s Impact on Access to Care or Quality of Care

1. Neither § 1396a(a)(30)(A) nor *Orthopaedic* applies in this case

The district court erred as a matter of law in holding that the Legislature was required to conduct an “analysis” of the “impact of the provision on access to care or the quality of care” prior to enacting § 12306.1(d)(6). ER at 382. In reaching this holding, the district court relied on *Orthopaedic*, which held that under § 1396a(a)(30)(A),

the Director must set hospital outpatient reimbursement rates that bear a reasonable relationship to efficient and economical hospitals’ costs of providing quality services, unless the Department shows some justification for rates that substantially deviate from such costs. To do this, the Department must rely on responsible cost studies, its own or others’, that provide reliable data as a basis for its rate setting.

103 F.3d at 1496.

Orthopaedic is inapplicable to § 12306.1(d)(6) for at least two separate reasons. First, unlike the regulations at issue in *Orthopedic*, § 12306.1(d)(6) does not set any reimbursement rates. ER at 493; Cal. Welf. & Inst. Code § 12306.1(d)(6). This distinction is tremendously important, because the concern in *Orthopaedic* was that rates were being set without adequate procedures to “assure” that the rates were “consistent with efficiency,

economy, and quality of care.” 103 F.3d at 1496 (citing § 1396a(a)(30)(A)). Section 12306.1(d)(6) does not set rates, nor does it change any of the extensive procedures already in place to ensure that the wages and benefits paid to IHSS providers are consistent with quality of care and access to care. ER at 493.

Those procedures include the setting of IHSS providers’ wage and benefit amounts by each individual county through a collective bargaining process in which the county (or its PA or NPC) negotiates wages and benefits with the provider union. ER at 493. The State plays no role in the setting of these wage and benefit amounts through the collective bargaining process, and the State’s only involvement is to review the counties’ total “PA rates” (which include wages, benefits, payroll taxes, and administrative costs) to ensure that the rates comply with all applicable state and federal laws. ER at 493.

Section 12306.1(d)(6) does not alter this collective bargaining process. It simply limits the amount of the State’s contribution to the wages and benefits that are negotiated and paid by the counties (or the counties’ PAs or NPCs) to IHSS providers. *See* Cal. Welf. & Inst. Code § 12306.1(d)(6). Under section 12306.1(d)(6), counties remain free to set wages and benefits at any level they can negotiate with the provider unions (as long as they

comply with the State minimum wage). Accordingly, *Orthopaedic*'s requirement that State "rate setting" bear a reasonable relationship to provider "costs," *Orthopaedic*, 103 F.3d at 1496, does not apply to § 12306.1(d)(6) because that section does not set any rates.

Second, *Orthopaedic* is inapplicable here because it dealt with the specific issue of assessing "costs" for hospitals and similar types of provider entities that incur overhead costs when they provide Medi-Cal services. *See Orthopaedic*, 103 F.3d at 1496 (requiring the State "to consider *the costs hospitals incur in delivering services* when setting specific payment rates" for hospital outpatient services) (emphasis added). Here, in contrast, the providers of IHSS services are not entities but individuals, approximately 60 percent of whom are spouses, parents, or other relatives of the beneficiaries, and approximately 50 percent of whom live with the recipients they serve. ER at 494. These providers do not incur any overhead costs because they are providing only their time and labor; nor are they paid "rates" for specific services, but rather receive hourly wages and benefits for the work they perform. ER at 493. Under such circumstances, a requirement that the State rely on "cost studies" would be nonsensical and virtually impossible to comply with, as there are simply no "costs" for the State to study. Accordingly, *Orthopaedic* does not, and cannot, apply to § 12306.1(d)(6),

and the district court's reliance on *Orthopaedic* constitutes reversible legal error.

Additionally, by its express terms § 1396a(a)(30)(A) is plainly inapplicable to the situation here. Section 1396a(a)(30)(A) applies only to State Medicaid Plans, stating that “[a] *State plan* for medical assistance” must “provide such methods and procedures” to “assure that payments are consistent with efficiency, economy, and quality of care.” 42 U.S.C. § 1396a(a)(30)(A) (emphasis added). Section 12306.1(d)(6) does not modify in any way the State Plan that governs the IHSS program, nor does it modify the methods and procedures set forth in the State Plan to ensure that Medi-Cal rates are “consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers” so that care and services are available. Those methods and procedures have remained the same since 1994, when the federal government first approved California's State Plan for IHSS services. ER at 490. The methods and procedures depend on, inter alia, the self-interest of providers who, through their unions, negotiate their wages and benefits. ER at 493. Because § 12306.1(d)(6) does not alter the State Plan, it is not preempted by § 1396a(a)(30)(A).

2. Appellees cannot show any preemption of § 12306.1(d)(6)

Because Appellees are proceeding solely under the Supremacy Clause, to prevail on the merits they will have to show that § 12306.1(d)(6) is preempted by § 1396a(a)(30)(A) under the doctrine of federal preemption. The district court failed to conduct any preemption analysis at all, ER at 380-83, and if it had it would have concluded that § 1396a(a)(30)(A) does not, and was not intended by Congress to, preempt § 12306.1(d)(6) or any similar state statutes.

In determining whether federal law preempts a state statute, courts start with “the assumption that the historic police powers of the States were not to be superseded by the [federal legislation] unless that was the *clear and manifest purpose of Congress.*” *Pacific Gas & Elec. v. State Energy Res. Conservation & Dev. Comm’n*, 461 U.S. 190, 206 (1983) (quoting *Rice v. Santa Fe Elevator Co.*, 331 U.S. 218, 230 (1947)) (emphasis added). There is also a strong “presumption that state or local regulation of matters related to health and safety is not invalidated under the Supremacy Clause.” *Hillsborough County v. Automated Med. Labs.*, 471 U.S. 707, 715 (1985). Accordingly, courts “have required ‘compelling evidence of an intention to preempt’ in traditionally state-regulated fields” such as health and safety.

Medical Soc. of the State of New York v. Cuomo, 976 F.2d 812, 816 (2d Cir. 1992). Further, the very nature of the Medicaid program, which is “based on a scheme of cooperative federalism,” also counsels against preemption. *King v. Smith*, 392 U.S. 309, 316 (1968).

Here, there is no evidence that Congress intended that all state statutory provisions concerning payments to Medicaid providers be preempted by § 1396a(a)(30)(A)⁶; in fact, there is overwhelming evidence that Congress did *not* intend for statutes such as § 12306.1(d)(6) to be preempted. *See Sanchez*, 416 F.3d at 1059 (“[T]he flexible, administrative standards embodied in [§ 1396a(a)(30)(A)] do not reflect a Congressional intent to provide a private remedy for their violation.”); *id.* at 1061 (“Because § 30(A) . . . lacks ‘rights-creating’ language and ‘any focus on individual entitlements,’ and does not anticipate a judicially enforceable remedy,” it is “unenforceable.”); H.R. Rep. No. 105-149, at 591 (1997) (“It is the Committee’s intention that, following enactment of this Act, neither this nor any other provision of [§ 1396a] will be interpreted as establishing a cause

⁶ While this Court has held that certain *rate-setting* statutes are preempted by § 1396a(a)(30)(A), *see Independent Living II*, 572 F.3d at 644, this Court has not held that § 1396a(a)(30)(A) preempts statutes such as § 12306.1(d)(6) that do not set rates, and there is no evidence that Congress intended for such statutes to be preempted.

of action for hospitals and nursing facilities relative to the adequacy of the rates they receive.”). Accordingly, Appellees cannot show that § 12306.1(d)(6) is preempted, and thus they cannot prevail on the merits in this action.

B. Although *Orthopaedic* Does Not Apply Here, the State Nonetheless Complied with *Orthopaedic*’s Requirements

Even if *Orthopaedic* applied here, which it does not, Appellants nonetheless have complied with everything that *Orthopaedic* could possibly require.

Orthopaedic held that the State, in setting Medicaid reimbursement rates, “must set hospital outpatient reimbursement rates that bear a reasonable relationship to efficient and economical hospitals’ costs of providing quality services, unless the Department shows some justification for rates that substantially deviate from such costs,” and that, “[t]o do this, the [State] must rely on responsible cost studies, its own or others’, that provide reliable data as a basis for its rate setting.” 103 F.3d at 1496. The purpose of this requirement is procedural, to ensure that the State, in accordance with § 1396a(a)(30)(A), has adequate procedures in place to “assure that payments are consistent with efficiency, economy, and quality of care.” *Id.* at 1496 (quoting 42 U.S.C. § 1396a(a)(30)(A)). *Orthopaedic*

emphasized that Congress intended the requirements of § 1396a(a)(30)(A) to be quite flexible as long as the State has reasonably adequate procedures in place. *See id.* at 1499 (“The requirements of § 1396a(a)(30)(A) are more flexible than the Boren Amendment.”); *id.* at 1498 (“The Department need not follow a rigid formula of payments equal to an efficiently and economically operated hospital’s costs regardless of other factors.”); *id.* at 1497 (“Congress wanted to simplify the administrative burden, and allow states more flexibility in devising ways to make services available, while at the same time containing costs.”). Here, the State complied with everything that *Orthopaedic* could possibly require.

First, the wages and benefits paid to IHSS providers are set through the collective bargaining process, in which the providers, through their union, are directly involved in the negotiation process. ER at 493. When wages are set through collective bargaining, there is a conclusive presumption (1) that those wages are acceptable to the employees; and (2) that the employees had equal bargaining strength with their employer in the negotiations. *See Medler v. United States, Bureau of Reclamation*, 616 F.2d 450, 454 (9th Cir. 1980) (“[E]mployees who are subject to collective bargaining agreements do not require the safeguards and inducements provided [by statute for other employees]. Presumably, the bargaining union

has negotiated an agreement containing terms and conditions of employment which are acceptable to its members.”); *Waggoner v. Dallaire*, 649 F.2d 1362, 1367 (9th Cir. 1981) (“[T]he rule in this circuit [is] that parties to a collective bargaining agreement are conclusively presumed to have equal bargaining strength.”) (citation omitted). Thus, the collective bargaining process provides for precisely the type of procedures that *Orthopaedic* requires—specifically, procedures that virtually guarantee that the wages and benefits paid are consistent with “efficiency, economy, and quality of care” and sufficient to provide access to care. Indeed, given the strong presumptions that attach to collective bargaining agreements, these procedures provide a far *greater* assurance of quality and access to care than the reliance on “cost studies” discussed in *Orthopaedic*, 103 F.3d at 1496.

Second, in enacting § 12306.1(d)(6) the Legislature had before it the July 2008 Report to the Legislature on the IHSS program, which contains extensive data regarding quality and access in the IHSS system. This Report includes data on the number of providers available to work on the provider registries for each county, SER at 65; data on service shortages and the availability of emergency back-up providers, SER at 68-71; data on PA/NPC rates and IHSS provider wages and benefits by county, SER at 72-83; data from provider and consumer satisfaction surveys and PA/NPC surveys, SER

at 84-90; and a detailed analysis summarizing the report. SER at 91-92. As required by law, these Reports to the Legislature are prepared annually and must include assessments of the quality of care provided under the IHSS program. *See* Cal. Welf. & Inst. Code § 12301.6(o); Cal. Senate Bill 1780 (Ch. 206, Stats. of 1996); ER at 492. Indeed, these extensive studies are precisely the type of “responsible” studies that the court discussed in *Orthopaedic*, 103 F.3d at 1496, and there is nothing more that could possibly be required of the State to meet both the letter and spirit of *Orthopaedic*’s requirements.⁷

C. Plaintiffs Cannot Maintain a Valid Cause of Action Under the Supremacy Clause Because § 1396a(a)(30)(A) Is Not Privately Enforceable

Appellees cannot demonstrate a likelihood of success on the merits because section 1396a(a)(30)(A) cannot be enforced by private parties. No implied right of action exists directly under the Social Security Act of which the Medicaid Act is a part. *Maine v. Thiboutot*, 448 U.S. 1, 6 (1980);

⁷ The district court erroneously stated that Appellants “concede that the California legislature did not consider the Section 30(A) factors when it adopted California Welfare and Institutions Code § [12306.1(d)(6)].” ER at 382. This is incorrect, as Appellants have *not* conceded that the State failed to consider the § 1396a(a)(30)(A) factors, and the record shows that the State did in fact consider those factors, notwithstanding the fact that it was not required to do so. SER at 40-199.

Edelman v. Jordan, 415 U.S. 651, 674 (1974). Nor did Congress intend to create any privately enforceable rights under section (30)(A). *Sanchez*, 416 F.3d at 1057-62. Nonetheless, citing *Independent Living I*, 543 F.3d at 1050, the district court permitted plaintiffs to sue for injunctive relief directly under the Supremacy Clause. ER at 382. *Independent Living I* was wrongly decided because it conflicts with both Supreme Court and Ninth Circuit precedents, including *Gonzaga*, 536 U.S. at 283; *Alexander v. Sandoval*, 532 U.S. 275, 286 (2001); and *Sanchez*, 416 F.3d at 1057-62, 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. 103, 107 (1989); *Chapman v. Houston Welfare Rights Org.*, 441 U.S. 600, 615 (1979). Appellants recognize, however, that *Independent Living I* is arguably controlling here, and therefore raise these arguments to preserve them for later appellate proceedings.

D. Orthopaedic Is No Longer Good Law

Appellees cannot demonstrate a likelihood of success on the merits because *Orthopaedic* is no longer good law. Specifically, it conflicts with this Court's subsequent decision in *Sanchez*, 416 F.3d at 1051. There, this Court analyzed § 1396a(a)(30)(A) under the standards set forth in the Supreme Court's intervening decision in *Gonzaga*, and held that

§ 1396a(a)(30)(A)'s "broad and diffuse" language does not create any specific rights, and is "ill-suited to judicial remedy; the interpretation and balancing of the statute's indeterminate and competing goals would involve making policy decisions for which this court has little expertise and even less authority." *Sanchez*, 416 F.3d at 1060. That holding cannot be squared with *Orthopaedic*'s holding that states must rely on cost studies in setting certain types of rates—i.e., that a specific standard applies to the states' rate-making under § 1396a(a)(30)(A). Appellants recognize, however, that *Independent Living II* is arguably controlling here, and therefore raise these arguments to preserve them for later appellate proceedings.

E. *Orthopaedic*'s § 1983 Analysis Does Not Apply to a Preemption Claim

Appellees cannot demonstrate a likelihood of success on the merits because the standards set forth in *Orthopaedic*, on which they rely, do not apply to a preemption claim. *Orthopaedic* was not a preemption case, but rather a direct cause of action to enforce § 1396a(a)(30)(A) under § 1983. *Orthopaedic*, 103 F.3d at 1495. The standards for stating a valid preemption claim are quite different from, and set a much higher bar for plaintiffs than, the standards for stating a valid claim under § 1983. *See Pacific Gas & Elec.*, 461 U.S. at 206; *Rice v. Santa Fe Elevator Co.*, 331 U.S. 218, 230

(1947). The difference between these standards is particularly pronounced here, given the strong “presumption that state or local regulation of matters related to health and safety is not invalidated under the Supremacy Clause.” *Hillsborough County*, 471 U.S. at 715. Accordingly, the requirements of *Orthopaedic* are inapplicable in the preemption context, as the court must conduct a separate and independent analysis based on federal preemption law. Appellants recognize, however, that *Independent Living II* is arguably controlling here, and therefore raise these arguments to preserve them for later appellate proceedings.⁸

III. THE DISTRICT COURT’S FINDING THAT APPELLEES WOULD SUFFER IRREPARABLE HARM ABSENT AN INJUNCTION IS NOT SUPPORTED BY ANY CREDIBLE EVIDENCE AND CONSTITUTES CLEAR ERROR

The District Court’s determination based on a cascade of improbabilities that “[t]he wage reductions will cause many IHSS providers to leave employment, which in turn will leave consumers without IHSS assistance” which would lead them to be institutionalized was contrary to the evidence before it. There was no credible evidence to support this scenario.

⁸ Appellants also note that a Petition for Rehearing and Rehearing *En Banc* is currently pending in *Independent Living II* that raises the issues described in Sections II.C, II.D, and II.E of this brief.

The primary evidence upon which the district court relied, the declaration of Appellees' expert, Dr. Howes, was fatally flawed and lacking in credibility. For her conclusion that if wages and benefits were reduced—she does not say by how much—turnover of providers would increase and cause 4,000 recipients to go without services and 2,700 individuals to be admitted to skilled nursing facilities, Dr. Howes relied on a survey she conducted during the summers of 2004 and 2005 of approximately 5,000 providers (out of a statewide total of 360,000) in seven counties, which did not include Los Angeles County which represents 42% of the caseload statewide. ER at 499-504, 567. The district court also ignored the fact that Dr. Howes *admitted* on reply that Appellants' expert Dr. Brown's approach, rather than Dr. Howes' approach, "is, of course, the correct approach," but that she did not follow this correct approach because "the data requirements to do this analysis would require large scale funding and enormous lead time." ER at 443-44. Dr. Howes further conceded that "[t]he analysis that I have provided is one that could be done in the short period of time that was afforded to me. Dr. Brown's argument that a full scale study would provide

more accurate estimates is possibly correct,” and “such a full scale study is warranted.” ER at 444.⁹

Thus, despite Dr. Howes’ admission that her analysis and conclusions were flawed, and that a “full scale study [would be] warranted in order to reach such conclusions,” the district court relied entirely on Dr. Howes’ initial declaration and ignored all expert testimony (including Dr. Howes’ own reply declaration) that contradicted it. This constituted clear error.

The district court’s reliance on declarations that presumed individuals would go without services and opined about what would happen should that be the case was also clear error. Appellees never established causation—that is, a direct link connecting their cascade of improbabilities.

Specifically, Appellees never established the links showing that a reduction in the State’s contribution to IHSS provider rates would lead to a reduction in the actual provider rates negotiated between the counties and unions through collective bargaining, which would then lead to a particular IHSS

⁹ According to Dr. Howes, data from the Case Management, Information, and Payrolling System (CMIPS) from DSS, Medi-Cal claims data from CMS, the Client Master File from the Department of Developmental Services, information from the California Employment Development Department and the status of unions in counties would all be necessary to conduct a proper study. ER at 444. She did not look at any of this data.

provider ceasing to provide services, which would then lead to the IHSS recipient who had hired that provider being unable to find a replacement, which would then to that recipient then being forced to enter a skilled nursing facility. The evidence submitted by Appellees simply *assumed* the worst at each step of this cascade with no basis in fact. In other words, Appellees submitted nothing but speculative statements from physicians and a staff member at Appellee SEIU with no direct knowledge of any individual recipient's situation, and the district court erroneously relied on these unsubstantiated statements.

In direct contrast, the district court ignored the following undisputed evidence submitted by Appellants that rebutted Appellees' contention that the reduction in the state's contribution to wages and benefits would lead to individuals being admitted to skilled nursing facilities:

- Some counties that pay more than \$10.10 per hour did not reduce their rates in response to § 12306.1(d)(6). ER at 494.
- Counties maintain registries of providers available, willing and able to work (at least 14,500 statewide). ER at 491-92; SER at 65.

- Approximately 60% of recipients receive services from a relative, and approximately 50% of providers live with the recipients they serve. ER at 494.
- Approximately 70,000 providers are taking care of either a spouse or child under the IHSS Plus waiver. SER at 35.
- 36 counties, including Los Angeles and San Diego Counties, pay \$10.10 per hour or less and there is no evidence that there is any lack of quality or access in these counties. ER at 493-95; SER at 40-199.
- Quality of care and access are monitored by the counties, DSS, DHCS, and CMS. ER at 490, 492-94; SER at 40-199.

Thus, there simply was no credible evidence before the district court to support its finding that the reduction of the State's contribution to wages and benefits paid in a select, few counties would lead to thousands of individuals being institutionalized. ER at 383-85.¹⁰

¹⁰ The district court's finding that § 12306.1(d)(6) would cost the state tens of millions of additional dollars, because in-home care is less than expensive than care provided in skilled nursing facilities, was erroneously based on its conclusion that thousands of individuals would be forced into facilities because of this reduction in the State's share of wages and benefits.

In direct contrast, to show the harm that the State would suffer as a result of enjoining § 12306.1(d)(6), appellants submitted evidence of the State's dire fiscal crisis, and the measured approach it took with regard to the IHSS program.¹¹ If the injunction remains in place, the State will have to find savings elsewhere which will likely involve cutting or reducing other Medi-Cal services. ER at 484-86. But, perhaps more significantly, this injunction calls into question the State's ability to make any type of reductions to provider payments or services to beneficiaries which it must be able to do in order to balance the budget. If this injunction is upheld, it will be unclear whether the State may ever undertake any action to reduce its payments no matter what the circumstances, which will have serious and long-lasting consequences for the fiscal stability of the State.

¹¹ IHSS is an optional service under Medicaid, and therefore, could have been eliminated altogether. Moreover, appellants could have eliminated the IHSS Plus waiver which permits spouses and parents to provide these services.

CONCLUSION

For each of the foregoing reasons, this Court should reverse the district court and vacate the preliminary injunction.

Dated: August 7, 2009

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09-16359

IN THE UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

**MIKESHA MARTINEZ, by and through
her husband and next friend Carlos
Martinez, et al.,**

Plaintiffs and Appellees,

v.

**ARNOLD SCHWARZENEGGER,
Governor of the State of California, et al.,**

Defendants and Appellants.

STATEMENT OF RELATED CASES

To the best of Appellants' knowledge, there are no related cases.

Appellants acknowledge that Appellees have argued that the following cases are "related":

- *Independent Living Center of Southern California, Inc. v. Shewry*,
Nos. 08-56061, 08-56422, 08-56554, 08-57016; and
- *California Pharmacists Association v. Maxwell-Jolly*,
Nos. 09-55365, 09-55532, 09-55692.

Appellees' characterization of these cases as "related" is incorrect. The issues raised in this case are neither the same as nor "closely related" to the issues raised in *Independent Living* or *California Pharmacists*. 9th Cir. R.

28-2.6. While all three of these cases involve a claim of federal preemption of a state statute under 42 U.S.C. § 1396a(a)(30)(A), the similarity ends there. The state statutes at issue in *Independent Living* and *California Pharmacists* set Medi-Cal reimbursement rates, while the statute at issue here does not set any reimbursement rates and does not alter the State's procedures for setting such rates. Accordingly, the issues raised in this case are markedly different from those presented in either *Independent Living* or *California Pharmacists*, and are not "closely related" under 9th Cir. R. 28-2.6.

Dated: August 7, 2009

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**CERTIFICATE OF COMPLIANCE
PURSUANT TO FED.R.APP.P 32(a)(7)(C) AND CIRCUIT RULE 32-1
FOR 09-16359**

I certify that: (check (x) appropriate option(s))

1. Pursuant to Fed.R.App.P. 32(a)(7)(C) and Ninth Circuit Rule 32-1, the attached **opening/answering/reply/cross-appeal** brief is

Proportionately spaced, has a typeface of 14 points or more and contains 8,053 words (opening, answering and the second and third briefs filed in cross-appeals must not exceed 14,000 words; reply briefs must not exceed 7,000 words)

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Monospaced, has 10.5 or fewer characters per inch and contains ____ words or ____ lines of text (opening, answering, and the second and third briefs filed in cross-appeals must not exceed 14,000 words or 1,300 lines of text; reply briefs must not exceed 7,000 words or 650 lines of text).

2. The attached brief is **not** subject to the type-volume limitations of Fed.R.App.P. 32(a)(7)(B) because

This brief complies with Fed.R.App.P 32(a)(1)-(7) and is a principal brief of no more than 30 pages or a reply brief of no more than 15 pages.

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3. Briefs in **Capital Cases**.
This brief is being filed in a capital case pursuant to the type-volume limitations set forth at Circuit Rule 32-4 and is

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4. **Amicus Briefs.**

Pursuant to Fed.R.App.P 29(d) and 9th Cir.R. 32-1, the attached amicus brief is proportionally spaced, has a typeface of 14 points or more and contains 7,000 words or less,

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August 7, 2009

Dated

/s/ Gregory D. Brown

Gregory D. Brown
Deputy Attorney General

ADDENDUM

42 U.S.C. § 1396a. State plans for medical assistance

(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 (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area; and

* * *

Cal. Welf. & Inst. Code § 12306.1. Increase in provider wages or benefits; funding; approval; state participation

(a) When any increase in provider wages or benefits is negotiated or agreed to by a public authority or nonprofit consortium under Section 12301.6, then the county shall use county-only funds to fund both the county share and the state share, including employment taxes, of any increase in the cost of the program, unless otherwise provided for in the annual Budget Act or appropriated by statute. No increase in wages or benefits negotiated or agreed to pursuant to this section shall take effect unless and until, prior to its implementation, the department has obtained the approval of the State Department of Health Care Services for the increase pursuant to a determination that it is consistent with federal law and to ensure federal financial participation for the services under Title XIX of the federal Social Security Act, and unless and until all of the following conditions have been met:

(1) Each county has provided the department with documentation of the approval of the county board of supervisors of the proposed public authority or nonprofit consortium rate, including wages and related expenditures. The documentation shall be received by the department before the department and the State Department of Health Care Services may approve the increase.

(2) Each county has met department guidelines and regulatory requirements as a condition of receiving state participation in the rate.

(b) Any rate approved pursuant to subdivision (a) shall take effect commencing on the first day of the month subsequent to the month in which final approval is received from the department. The department may grant approval on a conditional basis, subject to the availability of funding.

(c) The state shall pay 65 percent, and each county shall pay 35 percent, of the nonfederal share of wage and benefit increases negotiated by a public authority or nonprofit consortium pursuant to Section 12301.6 and associated employment taxes, only in accordance with subdivisions (d) to (f), inclusive.

(d)(1) The state shall participate as provided in subdivision (c) in wages up to seven dollars and fifty cents (\$7.50) per hour and individual health benefits up to sixty cents (\$0.60) per hour for all public authority or nonprofit consortium providers. This paragraph shall be operative for the 2000-01 fiscal year and each

year thereafter unless otherwise provided in paragraphs (2), (3), (4), and (5), and without regard to when the wage and benefit increase becomes effective.

(2) The state shall participate as provided in subdivision (c) in a total of wages and individual health benefits up to nine dollars and ten cents (\$9.10) per hour, if wages have reached at least seven dollars and fifty cents (\$7.50) per hour. Counties shall determine, pursuant to the collective bargaining process provided for in subdivision (c) of Section 12301.6, what portion of the nine dollars and ten cents (\$9.10) per hour shall be used to fund wage increases above seven dollars and fifty cents (\$7.50) per hour or individual health benefit increases, or both. This paragraph shall be operative for the 2001-02 fiscal year and each fiscal year thereafter, unless otherwise provided in paragraphs (3), (4), and (5).

(3) The state shall participate as provided in subdivision (c) in a total of wages and individual health benefits up to ten dollars and ten cents (\$10.10) per hour, if wages have reached at least seven dollars and fifty cents (\$7.50) per hour. Counties shall determine, pursuant to the collective bargaining process provided for in subdivision (c) of Section 12301.6, what portion of the ten dollars and ten cents (\$10.10) per hour shall be used to fund wage increases above seven dollars and fifty cents (\$7.50) per hour or individual health benefit increases, or both. This paragraph shall be operative commencing with the next state fiscal year for which the May Revision forecast of General Fund revenue, excluding transfers, exceeds by at least 5 percent, the most current estimate of revenue, excluding transfers, for the year in which paragraph (2) became operative.

(4) The state shall participate as provided in subdivision (c) in a total of wages and individual health benefits up to eleven dollars and ten cents (\$11.10) per hour, if wages have reached at least seven dollars and fifty cents (\$7.50) per hour. Counties shall determine, pursuant to the collective bargaining process provided for in subdivision (c) of Section 12301.6, what portion of the eleven dollars and ten cents (\$11.10) per hour shall be used to fund wage increases or individual health benefits, or both. This paragraph shall be operative commencing with the next state fiscal year for which the May Revision forecast of General Fund revenue, excluding transfers, exceeds by at least 5 percent, the most current estimate of revenues, excluding transfers, for the year in which paragraph (3) became operative.

(5) The state shall participate as provided in subdivision (c) in a total cost of wages and individual health benefits up to twelve dollars and ten cents (\$12.10) per hour, if wages have reached at least seven dollars and fifty cents (\$7.50) per hour.

Counties shall determine, pursuant to the collective bargaining process provided for in subdivision (c) of Section 12301.6, what portion of the twelve dollars and ten cents (\$12.10) per hour shall be used to fund wage increases above seven dollars and fifty cents (\$7.50) per hour or individual health benefit increases, or both. This paragraph shall be operative commencing with the next state fiscal year for which the May Revision forecast of General Fund revenue, excluding transfers, exceeds by at least 5 percent, the most current estimate of revenues, excluding transfers, for the year in which paragraph (4) became operative.

(6) Notwithstanding paragraphs (2) to (5), inclusive, the state shall participate as provided in subdivision (c) in a total cost of wages up to nine dollars and fifty cents (\$9.50) per hour and in individual health benefits up to sixty cents (\$0.60) per hour. This paragraph shall become operative on July 1, 2009.

(e)(1) On or before May 14 immediately prior to the fiscal year for which state participation is provided under paragraphs (2) to (5), inclusive, of subdivision (d), the Director of Finance shall certify to the Governor, the appropriate committees of the Legislature, and the department that the condition for each subdivision to become operative has been met.

(2) For purposes of certifications under paragraph (1), the General Fund revenue forecast, excluding transfers, that is used for the relevant fiscal year shall be calculated in a manner that is consistent with the definition of General Fund revenues, excluding transfers, that was used by the Department of Finance in the 2000-01 Governor's Budget revenue forecast as reflected on Schedule 8 of the Governor's Budget.

(f) Any increase in overall state participation in wage and benefit increases under paragraphs (2) to (5), inclusive, of subdivision (d), shall be limited to a wage and benefit increase of one dollar (\$1) per hour with respect to any fiscal year. With respect to actual changes in specific wages and health benefits negotiated through the collective bargaining process, the state shall participate in the costs, as approved in subdivision (c), up to the maximum levels as provided under paragraphs (2) to (6), inclusive, of subdivision (d).

CERTIFICATE OF SERVICE

Case Name: **Mikeshia Martinez, et al. v.** No. **09-16359**
Schwarzenegger, et al.

I hereby certify that on August 7, 2009, I electronically filed the following documents with the Clerk of the Court by using the CM/ECF system:

APPELLANTS' OPENING BRIEF

Participants in the case who are registered CM/ECF users will be served by the CM/ECF system.

I further certify that some of the participants in the case are not registered CM/ECF users. On August 7, 2009, I have mailed the foregoing document(s) by First-Class Mail, postage prepaid, or have dispatched it to a third party commercial carrier for delivery within three (3) calendar days to the following non-CM/ECF participants:

Clerk to Honorable Claudia Wilken
United States District Court-
Northern District
1301 Clay Street, Suite 400 S
Oakland, CA 94612

I declare under penalty of perjury under the laws of the State of California the foregoing is true and correct and that this declaration was executed on August 7, 2009, at San Francisco, California.

Nancy Quach
Declarant

/s/ Nancy Quach
Signature