

No. 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

**EMERGENCY MOTION UNDER 9TH CIR. R.
27-3 FOR STAY OF INJUNCTION PENDING
APPEAL; REQUEST FOR ORDER
EXPEDITING APPEAL**

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CIRCUIT RULE 27-3 CERTIFICATE

I, Susan Carson, counsel for Petitioners, certify as follows:

1. I am a Supervising Deputy Attorney General for the State of California, and counsel of record for Defendants-Appellants in this matter. I submit this certification in support of Appellants' Emergency Motion to Stay Under Circuit Rule 27-3. I have personal knowledge of the matters set forth in this certification, and if called upon to testify, would and could competently testify to the matters set forth below.

2. Counsel for the Plaintiffs-Appellees may be reached as follows:

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3. The facts regarding the existence and nature of the emergency at issue are as follows:

a. On June 26, 2009, the Honorable Claudia Wilkin, District Judge for the Northern District of California, issued an order enjoining defendants from implementing California Welfare and Institutions Code

§ 12306.1(d)(6), which was to have taken effect on July 1, 2009. That statute reduced the cap of state's contribution to the wages and benefits paid to In-Home Supportive Services providers from \$12.10/hour to \$10.10/hour. Attached here to as Exhibit A is the district court's Injunction and Order.

b. Appellants made an oral request for a stay of the district court's order pending appeal during the June 25, 2009 hearing on the plaintiff's motion for preliminary injunction. On June 26, 2009, after the court issued its written order, defendants submitted a letter brief requesting that the court rule on its request for a stay pending appeal. On June 29, 2009, the district court denied the request for a stay.

c. Appellants now file this emergency motion for a stay of the injunction pending appeal of the injunction.

d. Absent an immediate stay by this Court, Appellants will be irreparably harmed and such harm will not be correctable upon appeal from the final judgment in this case. Because the reduction in the state's share has been enjoined, the state will collect less money from the counties that pay over \$10.10/hour which could result in the state losing more than \$67.4 million for Fiscal Year 2009/2010. In addition, in order to comply with the injunction, the State must arrange for changes to be made to the computer system that calculates payments to providers (the California Management,

Information, and Payrolling System or CMIPS) to reflect the injunction enjoining the change in the cap from \$10.10/hour to \$12.10/hour. Supp. Carroll Decl. ¶ 6. State will also suffer immediate injury in terms of its ability to address the State's growing fiscal crisis. If the injunction remains in place, the State will have to find savings elsewhere which may involve cutting or reducing other Medi-Cal services. Douglas Decl. ¶ 14. Further, the injunction calls into question the State's ability, in the short term, to make *any* cuts that, like the statute at issue here, might, in some Palsgrafian sense, ultimately be tied to reductions in provider reimbursements or services to beneficiaries. And, as set forth below, the very ability of the State to handle the fiscal crisis by reducing provider reimbursement rates is impacted by this injunction. Attached hereto as Exhibit B is the Supplemental Declaration of Eileen Carroll, and Exhibit C is declaration of Toby Douglas.

4. Counsel for Appellees were notified by telephone and in writing on June 26, 2009 that Appellants intended to seek this emergency motion for stay assuming the district court did not grant their stay request before Tuesday, June 30, 2009.

I declare under penalty of perjury that the foregoing is true and correct.

Executed in San Francisco, California, on June 30, 2009.

/s/ Susan M. Carson

Susan M. Carson
Attorney for Appellants

INTRODUCTION

State Defendants (Appellants)¹ request that this Court immediately enter a stay of a June 26, 2009 district court order preliminarily enjoining a statute, California Welfare and Institutions Code § 12306.1(d)(6), which was to have taken effect on July 1, 2009. If the stay does not issue, the State will suffer immediate irreparable injury far beyond the monetary cost of complying with the injunction. Most seriously, the district court's order incorrectly interprets this Court's precedents in a way that calls into question *any* effort by the State to address its current fiscal emergency by reducing funding of California's Medicaid program, known as Medi-Cal, regardless of how indirectly the reduction may impact Medicaid providers or beneficiaries. Because Medi-Cal is the second largest program cost in the State's budget (amounting to \$12.9 billion dollars, or 14% of the overall budget), and because the State currently is projected to run out of cash by July 28, 2009, the consequences of taking this program off the table for budget reductions would be severe indeed.

¹State Defendants/Appellants are: 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; and John Chiang, California State Controller (who has taken no position in this litigation.)

Effective July 1, 2009, § 12306.1(d)(6) would reduce the State's share of payments to some providers of In-Home Support Services (IHSS) through the State's Medicaid program. Significantly, § 12306.1(d)(6) does not mandate that counties -- which negotiate wages and benefits paid to IHSS providers with health care worker's unions through collective bargaining -- reduce the actual payments themselves. Rather, it merely reduces the State's share toward those payments in certain counties that had negotiated the highest IHSS provider wages and benefits in the State.

For context, under current law, California pays a fixed percentage (approximately 65% of the nonfederal share) of the payments to IHSS providers, up to a statutory cap of \$12.10 per hour, with the remainder paid by the counties and the federal government. Effective July 1, 2009, under §12306.1(d)(6), the statutory cap for the State share was to change to \$10.10. This new maximum is actually the *same or higher* than the wages and benefits that were paid to IHSS providers in 36 counties before the Legislature enacted § 12306.1(d)(6), including Los Angeles, where 42% of IHSS providers are employed. Since the statute was enacted, six of the 22 counties that previously had reimbursement rates over \$10.10 have taken no

action to reduce their rates and two counties actually *increased* their wages and benefits.²

In entering the injunction, the district court incorrectly believed that its order was compelled by *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491 (9th Cir. 1997). *Orthopaedic Hospital* held, *inter alia*, that the State must rely on cost studies when setting Medicaid reimbursement rates for hospital outpatient services under 42 U.S.C. § 1396a(a)(30)(A) of the Medicaid Act, to ensure that the rates bear a reasonable relationship to the hospitals' costs of providing quality services to Medicaid beneficiaries. The district court here reasoned that, because the Legislature did not study the impact of §12306.1(d)(6) on Medicaid beneficiaries' access to quality care before it enacted the statute, the statute was preempted under 1396a(a)(30)(A) and the Medicaid Act. But *Orthopaedic* is plainly inapposite because §12306.1(d)(6) does not reduce (let alone set) Medicaid reimbursement rates for any IHSS provider.

This Court should stay the district court's injunction and expedite the Appellants' pending appeal, because, *inter alia*,

² The injunction will have no effect on the 12 counties that have reduced their wages and benefits, as the injunction restrains the State's implementation of § 12306.1(d)(6), rather than the counties' implementation of their collective bargaining agreements.

- Appellees have *no* likelihood of success on the merits. Because §12306.1(d)(6) does not reduce, let alone set, IHSS provider wages and benefits, *Orthopaedic* is inapposite, and § 1396a(a)(30)(A) is not implicated. Any impact on providers' wages and benefits will be indirect at best, as demonstrated by the six counties that have taken *no* action to reduce their reimbursement rates in the almost five months since § 12306.1(d)(6) was enacted (and the two that have *increased* their rates).
- Even were the district court correct that § 1396a(a)(30)(A) was implicated, no study was required here where the new statutory cap, from which the State's proportionate contribution would be determined, is equal or higher to the hourly rate already in effect in most parts of the State, including Los Angeles in which 42% of the State's IHSS providers work.
- Absent a stay, the State will suffer immediate severe and irreparable injury. In addition to having to pay a higher share of Medicaid costs than otherwise would be required, the injunction will call into question the State's ability, in the short term, to make any program cuts to Medi-Cal that could have an impact, no matter how indirect, on the rates paid to Medicaid providers or services available to beneficiaries. It also will necessarily drive programmatic cuts to other programs that otherwise would have been avoided.
- A stay would not result in *any* irreparable injury to IHSS providers or beneficiaries during the pendency of an expedited appeal; indeed, it would have *no effect*. IHSS providers will continue to be paid wages and benefits as governed by their collective bargaining agreements. While it is possible that some of the eight counties that still pay in excess of \$10.10 per hour could choose in the coming months to negotiate with the unions to reduce wages and benefits, that could not occur during the short time required to decide an expedited appeal.

Finally, Appellants note that the urgency of this request is a *direct* result of Appellees' delay in bringing suit, and that any doubt should be resolved in favor of a stay. Although the statute at issue was signed into law on February 20, 2009 (and confirmed by the State Treasurer on March 27, 2009), Appellees waited over two months, until May 26, 2009, to file their lawsuit, and until June 4, 2009 to file their motion for preliminary injunction. Appellees' failure to prosecute their case promptly severely prejudiced the State's ability to defend the lawsuit (for example, the State received only six court days to prepare its opposition) and placed a tremendous burden on the district court and now this Court. In light of these facts and the strength of the State's legal position, if there is *any doubt* with respect to the propriety of a short-term stay, it should be resolved in Appellants' favor and the stay should issue.

BACKGROUND

A. 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, plaintiffs filed this lawsuit in an effort to enjoin California Welfare and Institutions Code § 12306.1(d)(6), which takes effect on July 1, 2009. Plaintiffs contend that § 12306.1(d)(6) violates the federal

Medicaid Act, 42 U.S.C § 1396a(a)(30)(A), because the Legislature failed to conduct a study of the effect the statute would have on quality of care and access to IHSS services prior to its enactment. Plaintiffs also allege violations of the Americans with Disabilities Act, 42 U.S.C. §12132, and the Rehabilitation Act, 29 U.S.C. §794(a).

B. The IHSS program

The IHSS program in California began as a purely state-funded program in 1973. Declaration of Eileen Carroll (Carroll Decl.) ¶ 3. In 1994, in order to be able to draw down federal funds, California added the personal care services program (PCSP), which is an optional service under Medicaid, to the State Plan. Declaration of Toby Douglas (Douglas Decl.) ¶ 10. 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 services, one of which allows spouses and parents to become IHSS providers. Douglas Decl. ¶ 12. CMS approved this IHSS Plus Waiver, and now approximately 70,000 IHSS recipients receive their services from either a spouse or parent. Carroll Decl. ¶ 12, Exh. D. These three programs provide services to over 440,000 individuals and include over 360,000 IHSS providers. Over 62% of IHSS recipients are served by a relative. Carroll Decl. ¶ 10. 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.

C. 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 was 50%, county share approximately 18%, and State's share approximately 32% up to the statutory maximum (currently \$12.10/hour, *see* Welf. & Inst. Code § 12306.1(d)(5)). Most counties' rates are determined through the collective bargaining process between the county's PA/NPC and a union, such as plaintiff SEIU. Carroll Decl. ¶ 10.

Once wages and benefits are determined via the collective bargaining process, and the PA/NPC receives approval from the 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 (CDSS) and then to the Department of Health Care Services (DHCS) to ensure that it complies with all applicable state and

federal laws. 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. Welf. & Inst. Code § 12306.1(a).

D. 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's will contribute a proportionate share for IHSS wages and benefits from \$12.10 to a rate of \$10.10. 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.

Welf. & Inst. Code § 12306.1(d)(6).

Significantly, the statute does not require counties to reduce wages and benefits paid to IHSS providers. Rather, they 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. Further, less than half (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 fully 42% of the IHSS caseload is found. Carroll Decl. ¶ 13.

According to DSS, 12 counties submitted Rate Change Requests to decrease wages and benefits to some amount at or above \$10.10/hour as of July 1, in amounts ranging from 25 cents to \$2.00 per hour. Eight counties did not submit Rate Change Requests, so their wages and benefits will remain the same. And, two counties submitted Rate Change Requests to increase wages and benefits. All these Rate Change Requests have been approved by CDSS and the DHCS. Supp. Carroll Decl. 10.

E. 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.

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. The district court granted the motion before Appellants could file an opposition, and originally limited Appellants to four court days to prepare their opposition.

(The district court set the hearing date for June 25th.) Appellants filed an *ex parte* application seeking two additional court days to prepare their opposition (and retain an expert), which the court granted.

On June 25, 2009, following oral argument on the motion, the court expressed its intention to issue an order granting the motion. Appellants orally requested that the court stay its order pending appeal. 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 1941, 1493 (9th Cir. 1997).

In an order issued later the next day, the court explained its reasoning. Relying principally on *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491, 1493 (9th Cir. 1997), 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. *See* Order at 9:23-25 (“No analysis in the legislative history mentions the impact of the provision on access to care or the quality of care.”).³ 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). Order at 10:26-28.

Appellants filed a letter brief the day the injunction and order issued, requesting that the court rule on its request for a stay pending appeal, and advising the court and counsel for Appellees of its intention to file the present motion on June 30, 2009 if no stay issued. The district court denied that request on June 29, 2009. Also on June 29, 2009, Appellees filed an *ex parte* motion seeking to expand the injunction beyond its current parameters, which the trial court denied the same day.

Appellants filed their notice of appeal with the district court on June 29, 2009.

³ 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.” Order at 10:21-23.

JURISDICTION

The district court had jurisdiction over the action pursuant to 28 U.S.C. § 1331. This Court has jurisdiction over the appeal pursuant to 28 U.S.C. § 1292(a).

ARGUMENT

The Court should grant the stay and order the appeal to be briefed and argued on an expedited basis. The district court erred when it determined that appellees were likely to prevail on the merits. Section 12306.1(d)(6) did not change, let alone implicate, the methods and procedures utilized to ensure that the wages and benefits paid to providers are adequate to ensure beneficiaries' access to quality care under the Medicaid program. Further, as a matter of law, the State was not required to study the effect of §12306.1(d)(6) – which merely reduced the statutory maximum upon which the State calculates its share of the hourly rate that remains higher than wages and benefits paid throughout most of the State – before the statute took effect. Finally, the balance of the equities strongly favors the State, because beneficiaries and providers will suffer *no* irreparable injury during the pendency of an expedited appeal, whereas the State will suffer immediate and far-reaching injury if the injunction remains in effect.

I. THIS COURT SHOULD STAY THE DISTRICT COURT’S ORDER AND INJUNCTION PENDING APPEAL

In determining whether Appellants’ stay request should be granted, the Court must engage in a balancing of the equities between the parties.

Relevant factors are: 1) appellant’s likelihood of success on the merits; 2) whether appellant will be irreparably injured absent a stay; 3) whether a stay will substantially injure appellees; and 4) the public interest. *See e.g., Hilton v. Braunskill*, 481 U.S. 770, 776 (1987); *Los Angeles Mem. Coliseum Comm’n v. Nat’l Football League*, 634 F.2d 1197, 1200 (9th Cir. 1980). If appellees “show[] no chance of success on the merits,” the inquiry ends, and “the injunction should not issue.” *Arcasmuzi v. Continental Airlines, Inc.*, 819 F.2d 935, 937 (9th Cir. 1987); *see also Republic of the Philippines v. Marcos*, 818 F.2d 1473, 1490 (9th Cir. 1987).

A. Appellants Have a Strong Likelihood of Succeeding on the Merits Because §12306.1(d)(6) Does Not Violate the Supremacy Clause of the U.S. Constitution or §1396a(a)(30)(A)

Appellees contend that Welfare and Institutions Code §12306.1(d)(6) violates the Supremacy Clause because it creates conflict between state and

federal law.⁴ Appellees bear a heavy burden to prove that Congress intended to preempt state law, especially in the area of public health which is a subject traditionally regulated by the states. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995); *Medical Society 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, Appellees cannot meet their burden as a matter of law.

1. Appellees cannot demonstrate preemption based on § 1396a(a)(30)(a) because that statute does not apply to the reductions in state payments at issue here

There is no conflict between § 12306.1(d)(6) and § 1396a(a)(30)(A) because the latter does not apply to this state law provision. Under § 1396a(a)(30)(A), a state that accepts federal Medicaid funds must adopt a State Plan containing methods and procedures to “safeguard against

⁴ A federal statute may preempt state law in three situations, commonly referred to as (1) express preemption, (2) field preemption, and (3) conflict preemption. The only situation arguably present here is conflict preemption. *English v. General Electric Co.*, 496 U.S. 72, 79 (1990). “Under the preemption doctrine, state laws that ‘interfere with, or are contrary to the laws of congress, made in pursuance of the constitution’ are preempted.” *Lankford v. Sherman*, 451 F.3d 496, 509-10 (8th Cir. 2006).

unnecessary utilization of . . . [Medicaid] services and . . . assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available . . . at least to the extent that such care and services are available to the general population.”

On its face, §1396a(a)(30)(A) is plainly inapplicable to the situation here. 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. The methods and procedures depend on, *inter alia*, the self-interest of providers who, through their unions, negotiate their wages and benefits. Appellees have not challenged CMS’s approval of the State Plan, so the adequacy of those methods and procedures is not at issue in this lawsuit.

Appellees nonetheless contend, and the district court held, that §12306.1(d)(6) violates §1396a(a)(30)(A) because the Legislature enacted the statute without first conducting a study regarding the impact that the

statute might have on “efficiency, economy, and quality of care” and beneficiaries’ access to IHSS providers. Of course, nothing in the text of §1396a(a)(30)(A) itself requires such a study. Appellees and the district court therefore rely on this Court’s decision in *Orthopaedic* which held that the State must rely on cost studies when setting Medicaid reimbursement rates for hospital outpatient services under 42 U.S.C. § 1396a(a)(30)(A) of the Medicaid Act to ensure that the rates bear a reasonable relationship to the hospitals’ costs of providing quality services to Medicaid beneficiaries. But the legal reasoning in *Orthopaedic* does not apply here, because §12306.1(d)(6) does not purport to determine the level of wages and benefits paid to providers, let alone reduce them. Indeed, those counties that previously paid in excess of \$10.10 per hour may continue to do so, and in fact, many are. All that §12306.1(d)(2) mandates is a reduction in the State’s proportionate share of any rate in counties that choose to continue to pay in excess of \$10.10 per hour.

It is true that some counties have sought to reduce their rates in the time since §12306.1(d)(6) was enacted, and more may do so in the future. The State approved those reductions pursuant to the State Plan. As noted above, however, Appellees have not challenged the procedures set forth in the State Plan on the ground that *they* violate § 1396a(a)(30)(A), and so that issue is

not before the court. Nor could they reasonably do so, given (1) the heavy burden they would face in light of the federal government's decision to approve that State Plan for the last 14 years, see *Pharmaceutical Research and Manufacturers of America (PhRMA) v. Walsh*, 538 U.S. 644, 661 (2003) (Secretary of HHS's determinations with respect proposed state plan amendments under the Medicaid Act are "presumptively valid");⁵ and (2) the heavy participation played by the providers themselves in the rate-setting process under those procedures – a role that sets this case far apart from the provider challenges under § 1396a(a)(30)(A) that this Court considered in *Orthopaedic, California Pharmacists Ass'n v. Maxwell-Jolly*, 563 F.3d 847 (9th Cir. 2009), and *Independent Living Center of Southern California, Inc. v. Shewry*, 543 F.3d 1050 (9th Cir. 2008), *cert. denied*, --- S.Ct. ----, 2009 WL 899446 (U.S. Jun 22, 2009).

2. Even if § 1396a(a)(30)(A) were implicated, no study would be required here before §12306.1(d)(6) could take effect

Even were the State required to conduct a study before reducing its *share* of wages and benefits paid to providers, there would be no legal or

⁵ In 1994, the agency was called the Health Care Financing Administration (HCFA). Today it is called the Centers for Medicare and Medicaid Services (CMS).

rational basis for requiring a State to do so here. This is because the statute at issue merely reduced the statutory cap toward which the State will contribute to an amount *that is still greater than the level of IHSS wages and benefits paid in most parts of the State*, including the entire county of Los Angeles (which, by itself, employs 42% of providers). Experience statewide already has shown that \$10.10 is sufficient to ensure adequate providers in Los Angeles County and the other 35 counties in which rates are less than or equal to the new statutory cap. Requiring the State to conduct a formal “study” regarding the plain adequacy of a rate that is already in effect throughout the state makes no sense at all and is not legally required. Put another way, the fact that some counties, historically, were outliers does not create rights in providers in those counties that are enforceable under 42 U.S.C. §1396a(a)(30)(A) or the Supremacy Clause.

3. The district court’s injunction is improper because it does not further Congress’s intent.

Even were there a substantive conflict between the state and federal statutes (which there is not), the district court’s entry of an injunction is improper because it does not further congressional intent but rather subverts it. Congressional intent is touchstone of any preemption case. *See Wyeth v. Levine*, ___ U.S. ___, 129 S. Ct. 1187, 1194 (2009) (congressional intent is the

“ultimate touchstone in every pre-emption case”). As this Court has previously held, there is no evidence that Congress intended to allow private enforcement of section 1396a(a)(30)(A) by either beneficiaries or providers. *Sanchez v. Johnson*, 416 F.3d 1051, 1062 (2005). Indeed, to the contrary, Congress’ intent to preclude private challenges to reimbursement rates is evidenced by the repeal of the Boren Amendment, as discussed extensively in *Sanchez*. See also *Pennsylvania Pharmacists Association v. Houstoun*, 283 F.3d 531, 540 & n. 15 (3d. Cir. 2002) (noting that “[o]ne of Congress’s main objectives – perhaps its dominant objective – in repealing the Boren Amendment was to take away the right to sue under § 1983”); 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 of action for hospitals and nursing facilities relative to the adequacy of the rates they receive.”). The courts should not utilize the Supremacy Clause to resurrect cases that Congress acted expressly to preclude, given the role that Congressional intent plays in any Supremacy Clause action.⁶

⁶ This argument is not foreclosed by this Court’s decision in *Independent Living* 543 F.3d 1050 (9th Cir. 2008), which held that a private party could state a preemption claim under the Supremacy Clause based on a
(continued...)

4. Appellees have no chance of success because they cannot state a claim under the Supremacy Clause

Finally, Appellees plaintiffs have no likelihood of success because §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); *Edelman v. Jordan*, 415 U.S. 651, 674 (1974). Nor does §1396a(a)(30)(A) confer rights that are privately enforceable under 42 U.S.C. § 1983. *Sanchez v. Johnson*, 416 F.3d at 1062. Appellants recognize that, in *Independent Living*, this Court held that plaintiffs may sue for injunctive relief directly under the Supremacy Clause. Appellants believe *Independent Living* was wrongly decided because it conflicts with numerous Supreme Court precedents, including *Gonzaga*, 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 that *Independent Living* is arguably controlling on this

(...continued)

purported conflict between a state statute and 42 U.S.C. § 1396a(a)(30)(A). The present argument is raised in connection with to the merits of Appellees' preemption claim, a question that this Court expressly declined to reach in *Independent Living*. See 543 F.3d at 1066.

point here, and therefore raise these arguments to preserve them for later proceedings.

B. The Balance of the Hardships Tilts Strongly in the State's Favor

The balance of the hardships tilts strongly in the State's favor. If the injunction is not stayed, the State will suffer irreparable injury beginning immediately. By contrast, if the injunction *is* stayed, Appellees will suffer absolutely *no* immediate injury (whether irreparable or otherwise) in the time required to decide an expedited appeal.

1. The State will suffer immediate injury if the injunction is not stayed

Unless the injunction is stayed, the State will suffer immediate irreparable injury in several forms, both financial and in terms of its ability to address the growing fiscal crisis in the state.

The immediate financial injury to the State will include having to pay a full proportionate share of the hourly wage in the 14 counties that, to date, have chosen not to reduce IHSS providers' wages and benefits from \$12.10/hour to \$10.10/hour. Initially, the State estimated that full implementation of § 12306.1(d)(6) would save the State \$98 million. Some portion of that savings would be lost were the injunction to remain in place, although in the time provided, the State has not been able to determine a

firm number. (The best estimate is now \$67.4. Supp. Carroll Decl. ¶ 11.)

In addition, in order to comply with the injunction, the State must arrange for changes to be made to the computer system that calculates payments to providers (the California Management, Information, and Payrolling System or CMIPS). Supp. Carroll Decl. ¶ 6.

The State will also suffer immediate injury in terms of its ability to address the State's growing fiscal crisis. If the injunction remains in place, the State will have to find savings elsewhere which may involve cutting or reducing other Medi-Cal services. Douglas Decl. ¶ 14. Further, the injunction calls into question the State's ability, in the short term, to make *any* cuts that, like the statute at issue here, might, in some Palsgrafian sense, ultimately be tied to reductions in provider reimbursements or services to beneficiaries. As demonstrated above, the causal relationship in the *present* case is fairly attenuated, depending as it does on the actions of the counties and unions, and on the terms of their preexisting contractual arrangements between those entities.

2. Appellees will suffer no injury during the pendency of an expedited appeal if the district court's injunction is stayed.

In direct contrast to the State's situation, IHSS providers and beneficiaries will not be immediately impacted *in any way* by the injunction.

Since providers' wages and benefits are set forth in collective bargaining agreements, there will only be a change in payments if and when the county and union renegotiate the level of wages and benefits. Supp. Carroll Decl.

¶8. The possibility of that occurring during the short time required to decide an expedited appeal is extremely remote.

Although there were counties that renegotiated wages and benefits as a result of the reduction in the State's contribution, there are counties that did not, and still other counties that have a separate and distinct basis for renegotiating wages and benefits.⁷ And, for the majority (over two-thirds) of providers, §12306.1(d)(6) had no impact whatsoever – past or present -- because the counties in which they work pay less than \$10.10/hour.

C. The Public Interest Weights in Favor of a Stay

It is undisputed that California is facing the most severe budget crisis in the State's modern history. In order to balance the State's budget (which is constitutionally required), the Legislature has enacted budget cuts to, among other things, education and Medi-Cal, the two largest elements of the State's budget. It took a measured approach in reducing the State's contribution to

⁷ That is the situation with defendant Fresno County which under its collective bargaining agreement has the authority to renegotiate and reduce its payments because of the decrease in realignment funds.

the wages and benefits of IHSS providers rather than eliminate the program altogether. Section 12306.1(d)(6) did not impact the majority of providers in the State, and for those providers who could be impacted, counties were permitted – and did in 14 counties – to make up some or all of the difference in the reduction of the State’s contribution. Thus, given the severity of the State’s fiscal crisis and potential cost savings to the State with the reduction and the minimal impact to IHSS providers statewide, the public interest is best served by the court staying the injunction issued by the district court.

II. THIS COURT SHOULD ISSUE AN ORDER EXPEDITING THE APPEAL

Pursuant to Federal Rule of Appellate Procedure Rule 2, Appellants request an order expediting the appeal and setting an early hearing date. Expediting the appeal will adequately protect providers and beneficiaries from any remote and indirect future effects of the enactment of § 12306.1(d)(6).

CONCLUSION

This Court should stay the district court's injunction of §12306.1(d)(6) pending Appellants' appeal, and enter an order expediting that appeal.

Dated: June 30, 2009

Respectfully submitted,

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CV 09-2306 CW
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 our knowledge, there are no related cases.

Dated: June 30, 2009

Respectfully Submitted,

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**CERTIFICATE OF COMPLIANCE
PURSUANT TO FED.R.APP.P 32(a)(7)(C) AND CIRCUIT RULE 32-1
FOR CV 09-2306 CW**

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 _____ 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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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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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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June 30, 2009.

Dated

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