No. A165963

COURT OF APPEAL OF THE STATE OF CALIFORNIA
FIRST APPELLATE DISTRICT, DIVISION ONE

ANALILIA JIMENEZ PEREA, SAUL JIMENEZ PEREA, ESTHER CASTAÑEDA, REBECCA BINSFELD, OFELIA JARDON, *on behalf of themselves and a proposed class of others similarly situated*; the HEALTHCARE JUSTICE DIVISION OF THE SERVICE EMPLOYEES INTERNATIONAL UNION-UNITED HEALTHCARE WORKERS WEST; ST. JOHN'S WELL CHILD & FAMILY CENTER; and NATIONAL DAY LABORER ORGANIZING NETWORK,
Appellants,
v.
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES; CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY; MARK GHALY, in his official capacity as Secretary, California Health and Human Services Agency; MICHELLE BAASS, in her official capacity as Director, California Department of Health Care Services; and DOES ONE through TWENTY inclusive,
Appellees.

APPLICATION FOR LEAVE TO FILE AMICUS CURIAE BRIEF AND [PROPOSED] AMICUS CURIAE BRIEF OF NATIONAL HEALTH LAW PROGRAM IN SUPPORT OF APPELLANTS

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APPLICATION FOR LEAVE TO FILE AMICUS CURIAE BRIEF IN SUPPORT OF APPELLANTS

TO THE PRESIDING JUSTICE:

Pursuant to Rule of Court 8.200(c), National Health Law Program, Justice in Aging, and Legal Aid Society of San Mateo County ("NHeLP et al.") respectfully request leave to file the accompanying brief as *amicus curiae* in this proceeding in support of appellants Analilia Jimenez Perea, Esther Castañeda, Rebecca Binsfeld, Ofelia Jardon, and the proposed class. A copy of this brief accompanies the application.

The proposed *amici* are public interest legal and advocacy organizations that work with low-income Californians enrolled in Medi-Cal. Collectively, *amici* submit the proposed brief to provide the Court with additional context on the structure of Medi-Cal and the Medicaid program, including information about how Medi-Cal is different from other welfare programs and the responsibilities of the Single State Agency charged with administering Medi-Cal under federal Medicaid law. Further, the proposed brief will provide the Court with supplemental background and legislative history about relevant federal provisions that require state Medicaid programs to set rates of payment for covered services in a fee-for-service and managed care context. The additional information contained in our proposed brief will help the Court to better understand California's responsibilities under federal Medicaid law and will assist the Court in answering the question of whether Long Term Care (LTC) Medi-Cal can be a comparator for non-LTC Medi-Cal.

No party or counsel for a party in the pending case authored the proposed amicus brief in whole or in part or made any monetary contribution intended to fund its preparation or submission. *See* Cal. Ct. R. 8.200(c)(3).

Document received by the CA 1st District Court of Appeal.

STATEMENTS OF INTEREST OF THE PROPOSED AMICI

Founded in 1969, the **National Health Law Program (NHeLP)** is a charitable nonprofit corporation dedicated to protecting and advancing the health rights of low-income and underserved individuals and families. For over fifty years, NHeLP has worked to ensure that low-income individuals and families can obtain the quality health care to which they are entitled, through policy advocacy, education, and litigation that holds federal and state Medicaid agencies accountable for their programs. Collaborating with national and state-based advocacy organizations, NHeLP also provides technical expertise on health care and legal issues to policymakers, the media, and legal services programs. Based on this work, NHeLP has significant understanding of policy impacts on low-income Medicaid beneficiaries. NHeLP also possesses deep knowledge about the intricacies of federal Medicaid law—an area of law the Supreme Court has called "Byzantine" and "almost unintelligible to the uninitiated." *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981) (quoting *Friedman v. Berger*, 547 F. 2d 724, 727 n. 7 (2d Cir. 1976), *cert. denied*, 430 U. S. 984 (1977)).

Justice in Aging is a national nonprofit legal advocacy organization that fights senior poverty through law by securing access to affordable health care and economic security for older adults with limited resources. We were founded in 1972 in California and have decades of experience with Medicaid and Medi-Cal with a focus on addressing disparities in access to health and long-term care for low-income enrollees who have been marginalized and excluded from justice such as women, people of color, people with disabilities, LGBTQ+ individuals, and persons with limited English proficiency.

The **Legal Aid Society of San Mateo County (LASSMC)** has been the primary provider of civil legal services for low-income and disadvantaged residents of San Mateo County for over 60 years. Our clients

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have an average annual income of $24,000/year in a county where the average is about $122,000/year. Approximately 35% of San Mateo County residents are immigrants. Community members have noticed that immigrant residents do not access safety net benefits in the same proportion as other residents. In response, LASSMC established a multi-agency collaborative project to educate immigrants about the benefits for which they might qualify and about the effect of obtaining those benefits on their immigration status. We recommend further changes that would help secure access to critical benefits for eligible immigrant populations.

NHeLP et al. respectfully request permission to file the accompanying brief as amici curiae.

Dated: August 3, 2023

Respectfully submitted,

NATIONAL HEALTH LAW PROGRAM

By: Abigail K. Coursolle

Counsel for the Amici Curiae

Document received by the CA 1st District Court of Appeal.

BRIEF OF THE AMICI CURIAE

TABLE OF CONTENTS

Document received by the CA 1st District Court of Appeal.

TABLE OF AUTHORITIES

Cases

Statutes

Document received by the CA 1st District Court of Appeal.

Regulations

Document received by the CA 1st District Court of Appeal.

Federal Register

Other

Document received by the CA 1st District Court of Appeal.

INTRODUCTION

In this case, the Respondents-Appellees, the California Department of Health Care Services et al. (Department), characterize Medi-Cal as a welfare program, analogizing to other cases involving cash assistance programs such as food stamps. This characterization misunderstands Medi-Cal's important role as a health coverage program and downplays the importance of the Federal Medicaid Equal Access requirement, which informs the discrimination allegations in this case.

The parties dispute, among other things, whether payments for Long Term Care (LTC) Medi-Cal can serve as a proper comparator to payments for Medi-Cal physician services in a case alleging discrimination in the program. This brief provides additional information about how the Medi-Cal program is set-up and the role of a Single State Agency—California Department of Health Care Services—in administering the program. This additional context demonstrates that LTC Medi-Cal is not a program wholly separate from other parts of Medi-Cal, including Medi-Cal physician services. Rather, this coverage is part of one program, administered by DHCS and for which DHCS is responsible. This context supports the Plaintiffs-Appellants' use of LTC Medi-Cal as a comparator. We therefore urge this Court to reverse the decision of the Trial Court.

ARGUMENT

I. Medicaid's design makes it a critical part of the health insurance system in the United States, and covered services should be available to Medicaid enrollees at least to the extent such services are available to other privately or publicly insured people.

The objective of Medicaid is to "furnish medical assistance" on "behalf of individuals whose incomes and resources are insufficient to meet

Document received by the CA 1st District Court of Appeal.

the costs of necessary health care." 42 U.S.C. § 1396-1; *id*. at § 1396d(a) ("The term 'medical assistance' means payment of part or all of the cost of . . . care and services or the care and services themselves, or both[.]"); *see also* Cal. Welf. & Inst. Code § 14000 (stating goal of Medi-Cal is to enable individuals to secure health care in the same manner as the public generally and without discrimination or segregation based on economic disability). As discussed below, Medicaid is not a typical "welfare" program. It is a publicly funded health insurance program intended to operate uniformly for all enrollees and to ensure all enrollees have access to covered services on par with, and in the same sites as, the general population insured by other public or private insurers.

To begin with, Medicaid's role in the health insurance landscape—both providing health coverage and paying providers for necessary care—distinguishes it from typical welfare programs such as Temporary Assistance for Needy Families (TANF), its predecessor Aid to Families with Dependent Children (AFDC), the Supplemental Nutrition Assistance Program (SNAP), and its predecessor Food Stamps. These programs put cash or coupons directly into the recipient's hands. Medicaid does not. Rather, Medicaid is a vendor payment program, meaning that the state or its contractors (*e.g.*, managed care organizations) make payments directly to health care providers who agree to provide necessary health care to enrollees and accept Medicaid payment as payment in full. The federally

Document received by the CA 1st District Court of Appeal.

required payment structure calls for Medicaid payments to be "sufficient to enlist enough providers so that care and services are available . . . [to Medicaid enrollees] . . . at least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. § 1396a(a)(30)(A); *see* H. R. Rep. No. 247, 101st Cong., 1st Sess. 390, *reprinted in* 1989 U.S. Code Cong. & Ad. News at 1906, 2116 (noting the test for evaluating access is to compare the access of Medicaid recipients living in a specific geographic area with the access of individuals in the same area who have private or public insurance coverage); 42 C.F.R. § 447.204;[1] *see also* Cal. Welf. & Inst. Code § 14079 ("The director shall periodically review the reimbursement levels . . . to comply with applicable federal Medicaid program requirements, including provisions on reasonable access to physician and dental services for Medi-Cal beneficiaries.").

The vendor payment feature of Medicaid and its sibling, Medicare, have allowed them to be key players in the struggle to end racial segregation in health care. For example, prior to the passage of Medicare and Medicaid in 1965, Jim Crow laws in the South and a separate-but-equal-vision, i.e. de facto segregation, among whites elsewhere resulted in

[1] The regulation was adopted in 1966 and has been in its present form since 1978, *see* Medicaid Regulations, 43 Fed. Reg. 45253 (Sept. 29, 1978). Congress codified the regulation in 1989, adding the phrase "in the geographic area" at the end. 42 U.S.C. § 1396a(a)(30)(A). *See Clark v. Kizer*, 758 F. Supp. 572, 575-76 (E.D. Cal. 1990), *aff'd in part & vacated in part on other grounds*, 967 F.2d 585 (9th Cir. 1992).

Document received by the CA 1st District Court of Appeal.

hospitals excluding African-Americans or providing separate accommodations for them. *See* David Barton Smith, *Power to Heal: Medicaid, Civil Rights and the Struggle to Transform America's Health Care System* 9-14 (2016). Title VI of the Civil Rights Act of 1964 was enacted to prohibit federal fund recipients from discriminating on the basis of race, color, or national origin. Citing Title VI, the federal government used federal Medicare/Medicaid payments as the primary tool to attack hospital segregation. *Id*. at 108. In 1966, the government informed every hospital in the country that to be eligible to receive any Medicare and Medicaid funding, they needed to fully, genuinely desegregate immediately (no "all deliberate speed" allowed). *Id*. at 116. "The vast majority of hospitals chose to comply in order to get the Medicare payments, and it was remarkable how fast and dramatic the changes were." *Id.* at 124.

Medicaid's design and structure have also made it a critical part of the health insurance system in the United States. Within 10 years of its enactment, Medicaid began to show up in the CDC National Center for Health Statistics' National Health Interview Survey as a form of health insurance coverage. Thereafter, Medicaid and Medicare came to be recognized as key components of the broader set of health insurance benefits available to Americans. By 1976, the National Center for Health Statistics was listing Medicaid coverage together with Medicare and private health insurance in its reports on health insurance coverage in the United

Document received by the CA 1st District Court of Appeal.

States. *See* Nat'l Center for Health Stat., *Current Estimates from the Health Interview Survey, United States-1976*, at 70, 80 (1977), https://www.cdc.gov/nchs/data/series/sr_10/ sr10_119.pdf. And several years later, a Commerce Department report referred to "Medicaid health insurance." U.S. Dep't of Com., *Characteristics of Households and Persons Receiving Selected Noncash Benefits 1980*, at 1 (1982), available at https://tinyurl.com/commercereport1982. Medicaid's role in this regard was solidified when the program was expanded with the passage of the Affordable Care Act in 2010. As Chief Justice John Roberts has noted, "[Medicaid] is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage." *Nat'l Fed'n of Indep. Bus.s v. Sebelius*, 567 U.S. 519, 583 (2012).

Finally, as has been true since its inception in 1965, Medicaid is intended to operate uniformly for all enrollees. Federal funding covers a significant amount (at least 50 percent) of a state's spending on Medicaid coverage. 42 U.S.C. § 1396b. To receive this funding, states must offer coverage pursuant to a federally approved state Medicaid plan, which describes the population groups and services that are eligible for Medicaid payments and includes assurances that the coverage will be operated in conformity with minimum federal requirements. *Id*. § 1396a(a). These include the requirements to designate a single state agency with

Document received by the CA 1st District Court of Appeal.

responsibility for administering coverage consistent with federal and state requirements, 42 U.S.C. 1396a(a)(5); extend coverage to all individuals who meet the eligibility requirements, *id*. § 1396a(a)(10); provide medical assistance with reasonable promptness to all eligible individuals, *id*. § 1396a(a)(8); avoid unaffordable cost sharing, *id*. §§1396o, 1396o-1; offer the opportunity for a fair hearing to each individual whose claim for medical assistance is denied or not acted on promptly, *id.* § 1396a(a)(3); and make provider payments that will be sufficient to ensure access to covered services, *id*. §1396a(a)(30)(A). With only a few exceptions not relevant here, these requirements apply uniformly across covered populations and services.[2]

To sum up, Medicaid is part of the country's comprehensive health insurance system, not a typical welfare program. Its federally designated provider payment and uniform design features are intended to ensure that health care services are available to Medicaid enrollees on par with the general population and free from segregation and discrimination. California's implementation of these principles enshrines desegregation as a key goal of the program. *See* Cal. Welf. & Inst. Code § 14000(a) (stating

[2] States primarily rely on two types of delivery systems to furnish medical assistance: fee for service and managed care. Regardless of the delivery system, the state must comply with the state plan requirements of the Medicaid Act unless the requirement has been explicitly and lawfully waived by the federal government.

Document received by the CA 1st District Court of Appeal.

a goal of Medi-Cal is to enable individuals to secure health care without segregation).

II. Congress intended to make a single state agency responsible for administering Medicaid to ensure there is accountability for the program.

The Medicaid program is jointly funded by the federal government and states. Federal Medicaid law sets broad requirements, while affording participating States discretion to implement the program within the parameters set by federal law. States implement the program through a State Medicaid Plan approved by the Federal Medicaid Agency. *See* 42 U.S.C. § 1396a(a)(4).

Federal Medicaid law requires each state to designate a "single state agency" to administer its State Medicaid Plan. 42 U.S.C. § 1396a(a)(5); 42 C.F.R. § 431.10. Although the single state agency need not carry out all program functions itself, it cannot delegate its authority for exercising discretion in the administration or supervision of the program or for the issuance of policies, rules and regulations on program matters. 42 C.F.R. § 431.10(e)(1); *see also Dominguez v. Schwarzenegger*, No. C 09-02306 CW, 2010 WL 2673715 (N.D. Cal. July 2, 2010) (even though counties determine wages and benefits for In Home Support Services, single state agency is ultimately responsible for ensuring that rates paid are sufficient to ensure adequate provider participation); *Cota v. Maxwell-Jolly*, 688 F. Supp. 2d 980, 997 (N.D. Cal. 2010) ("Defendants cannot disclaim responsibility for compliance with federal law based on its decision to rely on private entities to administer ADHC services"). In enacting the single state agency provisions, Congress noted that: "This provision was included in order to provide some assurance that the States . . . will not administer the provisions for services in a way which adversely affects the availability

Document received by the CA 1st District Court of Appeal.

or the quality of the care to be provided." S. Rep. No. 404, 89th Cong., 1st Sess. (1965) (Committee on Finance Report). As one Federal Appellate Court explained, "the reason for the requirement that a state designate a 'single State agency' to administer its Medicaid program was to avoid a lack of accountability for the appropriate operation of the program." *Hillburn ex rel. Hillburn v. Maher*, 795 F.2d 252, 261 (2d Cir. 1986) (internal citations omitted).

Thus while the single state agency can and does contract with each county to administer eligibility for Medi-Cal, that does not render Medi-Cal 58 separate programs depending on the county. Rather, the single state agency—DHCS—is responsible for keeping itself informed of the counties' adherence to the state Medicaid plan and taking corrective action if a county falls out of compliance. *See* 42 C.F.R. §§ 431.10(c)(3), 435.903; *see also, e.g., Rosen v. Tenn. Comm'r of Fin. & Admin*., 204 F. Supp.2d 1061 (M.D. Tenn. 2001) (finding the state's failure to create a written protocol for local agencies administering certain Medicaid benefits created structural deficiencies) (subsequent case history omitted). Similarly, while DHCS contracts with 24 different managed care organizations (MCOs) to deliver covered Medi-Cal services to beneficiaries, that does not mean that there are 24 different Medi-Cal programs. Rather, as the single state agency, DHCS is responsible for ensuring that its contracted MCOs deliver covered services as required under state and federal laws and regulations. *See* 42 C.F.R. §§ 431.10(b)(1), 438.1, 438.50; *see also, e.g., KC ex rel. Africa H. v. Shipman*, 716 F. 3d 107, 113 (4th Cir. 2013) (while the single state agency may contract with MCOs it may not delegate away its obligation for legal compliance to those MCOs); *McCartney ex rel. McCartney v. Cansler*, 608 F. Supp. 2d 694, 702 (E.D.N.C. 2009) (state "Medicaid program [must be] administered in compliance with federal law[and the single state agency]

Document received by the CA 1st District Court of Appeal.

may not disclaim its responsibilities under federal law by simply contracting away its duties").

In other words, Medicaid is set up to have one entity that is ultimately in charge. As a federal appellate court explained, "the vesting of responsibility over a state's Medicaid program in a single agency safeguards against the possibility that a state might seek to evade federal Medicaid requirements by passing the buck to other agencies that take a less generous view of a particular obligation." *KC*, 716 F. 3d at 112. Thus, while Medi-Cal may be administered using distinct eligibility categories, and different services it is still one program with one ultimately responsible entity: DHCS.

> Medicaid is — to put it mildly — a complicated program to administer. Seen in that light, the single state agency requirement is a sensible measure aimed at eliminating the added layer of complexity that would result if primary actors and courts were required to ask in every case, "who actually speaks for the state?" . . . . One head chef in the Medicaid kitchen is enough.

Id.; *see also JK v. Dillenberg*, 836 F. Supp. 694 (D. Ariz. 1993) ("[t]he law demands that the designated single state Medicaid agency must oversee and remain accountable for" the administration of benefits in Medicaid).

III. The single state agency always remains responsible for setting and ensuring adequate payment rates.

As the entity in charge of the Medicaid program, the single state agency determines the rates it will pay providers for delivering covered services (consistent with the boundaries set in federal law). In the state plan, the agency must describe the methods it will use to establish payment rates for each type of covered service. 42 C.F.R. § 447.201. While the agency has flexibility in establishing provider payments, the agency must provide "methods and procedures" to safeguard against unnecessary

Document received by the CA 1st District Court of Appeal.

utilization of care and services and "to assure that payments are consistent with efficiency, economy, and quality of care." 42 U.S.C. § 1396a(a)(30)(A); *see also* 42 C.F.R. § 447.201. The "equal access" provision also requires the agency to ensure that its payment rates are sufficient to attract enough providers so that " care and services are available under the [state Medicaid] plan at least to the extent such care and services are available to the general population in the geographic area." 42 U.S.C. § 1396a(a)(30)(A).

The agency has limited discretion to decide not only what rates it will pay for covered services, but also what service delivery system it will use to pay providers. Medicaid services may be provided under a fee-for-service (FFS) system, through risk-based contracts with managed care plans, or both. *See* 42 U.S.C. § 1396u-2(a) (giving state Medicaid programs the option to use managed care). In a FFS system, the state Medicaid agency pays providers directly for each covered service they furnish. In a managed care system, the agency contracts with MCOs to provide a package of benefits to enrollees in exchange for a fixed periodic payment, called a capitation payment. *See* 42 C.F.R. § 438.2 (defining capitation payment). MCOs then pay providers for the services delivered to enrollees. In a hybrid system, the agency carves out certain services from managed care contracts and pays for those services through FFS.

States, including California, increasingly rely on MCOs to deliver Medicaid covered services. State agencies that adopt a managed care system must pay the MCO a capitation rate that is "actuarially sound," meaning the rate covers the reasonable, appropriate, and attainable costs associated with providing the services under the contract. 42 U.S.C. § 1396b(m)(2)(A)(iii); 42 C.F.R. § 438.4(a).

Capitation rates for MCOs have historically been, and continue to be, developed in connection with FFS rates. Between 1981 and 2002,

Document received by the CA 1st District Court of Appeal.

federal Medicaid regulations imposed a ceiling on capitation rates equal to the cost of providing the same services on a FFS basis to an actuarially equivalent population. 42 C.F.R. § 447.361, *repealed by* Medicaid Program; Medicaid Managed Care, 66 Fed. Reg. 6228 (Jan. 19, 2001). While the regulations no longer set a ceiling for capitation rates based on FFS rates, current regulations instruct states to consider historical factors, including the FFS experiences of the populations served by the MCO, as a benchmark when developing capitation rates. 42 C.F.R. § 438.5(c)(1); *cf. id.* § 447.203(b)(3) (directing state agencies, as part of their plans, to conduct comparative reviews of payment rates that compare FFS to Medicaid managed care rates). State agencies, including DHCS, utilize rate methodologies that consider FFS data when developing managed care capitation rates. Cal. Welf. & Inst. Code § 14301.1(3). And notably, over the years, MCOs have often paid their contracted providers using FFS payments, not capitation payments. As a result, rates of payment for both delivery systems tend to be in alignment with one another: when agencies set low Medicaid FFS rates, the rates set for Medicaid managed care are comparably low. This trend has played out in California. *See, e.g.*, Margaret Tatar *et al.*, Kaiser Family Found., *Medi-Cal Managed Care: An Overview and Key Issues* 2 (2016), https://files.kff.org/attachment/issue-brief-medi-cal-managed-care-an-overview-and-key-issues ("Problem with access to care in Medi-Cal FFS carry over into managed care, challenging Medi-Cal health plans to establish adequate provider networks and improve care").

Irrespective of the service delivery system a state agency adopts, the agency must set provider reimbursement rates within Medicaid payment rules, which dictate specific payment standards and methods for certain covered services. Among other requirements, federal payment law mandates that agencies use a public process when setting reimbursement rates for hospital services, nursing facility services, and services of

Document received by the CA 1st District Court of Appeal.

intermediate care facilities for people with cognitive disabilities (ICFs). 42 U.S.C. § 1396a(a)(13)(A). Medicaid regulations also place an upper payment limit (UPL) on the supplemental payments state programs can pay hospitals and long-term care facilities. 42 C.F.R. §§ 447.272, 447.321. By contrast, federal law sets no upper limit for Medicaid physician services.

The Medicaid reimbursement scheme is a single policy even though it may utilize different rate setting methods for different components of the program. The state plan serves as the basis for federal funding of a state's Medicaid program. Through the state plan, the agency specifies the methods and scope of its Medicaid reimbursement policy. The details documented in the plan evidence a single Medicaid reimbursement policy where each covered service is part of the same program, *id.* § 447.201, has the same funding source, *id.* § 430.10, and will be reimbursed at a rate set by the same single state agency, *id*. § 447.201. Under this one policy, the agency's payment methods and rates for each type of covered service, whether institutional or non-institutional, are paid for under the same Medicaid payment structure. As a result, an agency can apply different rate setting requirements for specific covered services without those services being carved out of the Medicaid program.

As discussed, states have considerable flexibility to set reimbursement rates within Medicaid payment rules. These rules have evolved over time. However, the core requirements have remained the same for decades. Since 1989, the "equal access" provision has provided the overarching framework for Medicaid rate setting. The comments preceding recently proposed rules interpreting the "equal access" provision explain the influential role reimbursement rates play in deciding the amount, type and quality of care Medicaid enrollees receive:

> [H]igher rates of acceptance by some providers of new patients with payers other than Medicaid (specifically,

Document received by the CA 1st District Court of Appeal.

> Medicare and private coverage), and indications by some providers that low Medicaid payments are a primary reason for not accepting new Medicaid patients, may suggest that some beneficiaries could have a more difficult time accessing covered services than other individuals in the same geographic area.

U.S. Dept. of Health & Human Servs., Medicaid Program; Ensuring Access to Medicaid Services, Commentary, 88 Fed. Reg. 27960, 28028 (May 3, 2023). The comments noting the correlation between access to care and low provider payment rates are relevant in California, where Medi-Cal rates have not increased in more than two decades despite an expanding Medi-Cal population. *See*, *e.g.*, Cal. Welf. & Inst. Code § 14007.8 (expanding Medi-Cal eligibility to lower-income residents regardless of documentation status); Cal. Med. Ass'n, *Medi-Cal Rate Timeline*, https://www.cmadocs.org/mco/history (last accessed Aug. 2, 2023). As the agency in charge of the largest public health insurer in California, DHCS is responsible and accountable for ensuring that Medi-Cal payment rates are set at a level that will ensure Medicaid enrollees access to care and services on par with the other health insurance programs available to Californians.

Here, LTC Medi-Cal and Medi-Cal physician services are two of a wide array of services that DHCS has incorporated into the state plan and made a part of the Medi-Cal health insurance benefits available to low-income Californians. As components of the same benefits package, LTC Medi-Cal and Medi-Cal physician services are both eligible for Medi-Cal payments. Payments for both services are funded by the same source and subject to the same equal access requirements, which govern the adequacy of provider payment rates. See 42 U.S.C. § 1396a(a)(30)(A); Cal. Welf. & Inst. Code § 14000(a). Yet DHCS has chosen to adjust LTC rates for inflation, without making comparable adjustments to physician rates, despite legislative direction to do so. *See* Cal. Welf. & Inst. Code

Document received by the CA 1st District Court of Appeal.

§ 14079(b); Medi-Cal State Plan Attachment 4.19-D (using California Consumer Price Index in rate calculations for long-term care and nursing facilities). Their shared characteristics make LTC Medi-Cal a proper comparator for Medi-Cal physician services in Plaintiffs-Appellants' case alleging disparities in access for Medi-Cal's disproportionately Latine enrollees.

CONCLUSION

To protect the interests of Medi-Cal beneficiaries to be free from discrimination, and to ensure compliance with federal Medicaid requirements, Amicus Curiae respectfully urges this Court to reverse the decision of the trial court.

Dated: August 3, 2023

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE WITH WORD COUNT REQUIREMENT

Pursuant to Rule of Court 8.204(c)(1), the undersigned certifies that the computer program used to generate this brief indicates that it does not exceed 14,000 words.

Dated: August 3, 2023

Respectfully submitted,

NATIONAL HEALTH LAW PROGRAM

By: Abigail K. Coursolle

Counsel for the Amicus Curiae

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PROOF OF SERVICE

Perea v. California Department of Health Care Services
Amicus of NHeLP, et al.
Court of Appeal, First Appellate District, Division 1
Case No. A165963

I, Abigail Coursolle, am over the age of 18 years and not a party to this action. My business address is 3701 Wilshire Boulevard, Suite 315, Los Angeles, California 90010.

On August 3, 2023, I served the **APPLICATION FOR LEAVE TO FILE AMICUS CURIAE BRIEF AND PROPOSED AMICUS CURIAE BRIEF OF NATIONAL HEALTH LAW PROGRAM *ET AL.* IN SUPPORT OF APPELLANTS** on all counsel of record via the Court's electronic filing system, TrueFiling, https://tf3.truefiling.com.

I declare that under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on August 3, 2023, at Los Angeles, California.

Abigail K. Coursolle

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