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IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF ALAMEDA

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 COMMUNITY DIVISION OF THE SERVICE EMPLOYEES INTERNATIONAL UNION-UNITED HEALTHCARE WORKERS WEST; ST. JOHN'S WELL CHILD & FAMILY CENTER; and NATIONAL DAY LABORER ORGANIZING NETWORK,

Plaintiffs,

v.

MICHAEL WILKENING, as Secretary, California Health and Human Services Agency, JENNIFER KENT, as Director, California Department of Health Care Services, CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY, CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, and DOES ONE through TWENTY inclusive,

Defendants.

Case No. RG17867262

ASSIGNED FOR ALL PURPOSES TO
JUDGE Winifred Y. Smith
DEPARTMENT 21

THIRD AMENDED VERIFIED PETITION FOR WRIT OF MANDATE AND COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

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I. EXPLANATION OF AMENDMENTS: THIRD AMENDED COMPLAINT[1]

1. The Court having granted Plaintiffs leave to amend based on Defendants' discriminatory disinvestment from Medi-Cal and violations of substantive due process, Plaintiffs file this Third Amended Verified Petition for Writ of Mandate and Complaint for Declaratory and Injunctive Relief ("Third Amended Complaint").

2. This Third Amended Complaint challenges Defendants' systematic disinvestment from Medi-Cal as the program has become increasingly Latino, which, coupled with their chronic failures of administration and oversight, has resulted in Medi-Cal's disproportionately Latino participants having exceedingly poor access to care, as demonstrated by frequent denials of care, extreme wait times to obtain care, and long distances traveled to obtain care, with grave consequences for their health.

3. Plaintiffs have sued the Department of Health Care Services ("DHCS"); DHCS's Director, Jennifer Kent; the California Health & Human Services Agency ("HHSA"), the parent entity of DHCS; and the Secretary of HHSA, Michael Wilkening (collectively, "Defendants"). As set forth more completely below, Section IV.C, Defendants bear individual and collective responsibility for the methods of administration—policies, practices, actions, and inactions—challenged herein, which result in discrimination against Medi-Cal's disproportionately Latino population.

4. The challenged methods of administration, as described throughout this complaint and summarized in Section VIII, include (1) Defendants' disinvestment from the Medi-Cal program as it has become more Latino, through inactions and actions that have cumulatively resulted in a steep decline in Medi-Cal reimbursement rates compared to the market for physician

[1] The previous explanation of amendments for the Second Amended Complaint has been deleted here. The additional factual allegations in the Second Amended Complaint ("SAC") are preserved here, including: (1) further statistical and historical data showing Defendants' disinvestment trend since 1979, Section VII.C; (2) market factors affecting physician pricing, Section VII.D; (3) a comparison of Medi-Cal physician and clinician services to Medi-Cal long term care services showing that, while Defendants were disinvesting from a portion of the program that disproportionately served Latinos, they were increasing investment in a disproportionately white portion of the program, Section VII.E; and (4) further allegations as to intentional discrimination on the part of Medi-Cal's decision-makers, Section VII.F.

services since 1979; (2) failure to monitor and enforce network adequacy requirements; and (3) imposing other administrative barriers that limit access to care, which have cumulative resulted in worsening access to care for Medi-Cal's disproportionately Latino participants.

5. This Third Amended Complaint also adds allegations to clarify responsibility for Medi-Cal administration in setting rates, and updates the relevant causes of actions, Section IX, and Prayer for Relief, Section X.

II. INTRODUCTION

6. This complaint challenges ongoing civil rights violations in Medi-Cal, California's Medicaid health insurance program. Defendants have disinvested from Medi-Cal physician and clinician services[2] as its participants have become more Latino, with the end result being arbitrarily low reimbursement rates that do not reflect the costs of providing health care. These low reimbursement rates, combined with other barriers to access that Defendants have established, are denying meaningful, legally compliant health care to the over thirteen million people covered by Medi-Cal, the overwhelming majority of whom are now Latino.[3]

7. Medi-Cal covers low-income families, seniors, persons with disabilities, children in foster care, and pregnant women, as well as childless adults with incomes below 138 percent of the federal poverty level—e.g., in 2018, $16,753 for a single person or $34,638 for a family of four.

8. From 1979 to 2018, the number of Latinos with Medi-Cal grew over seven-fold, from approximately 1 million in 1979 to 7.6 million in 2018—resulting in the percentage of Latino enrollment in Medi-Cal growing from 25 percent to 58 percent over the same time period.

9. Defendants' disinvestment and other methods of administration contrary to the

[2] For ease of reference, Plaintiffs refer to both physician and clinician services interchangeably as "physician services."

[3] The Court previously dismissed without leave to amend Plaintiffs' claims that Defendants are unlawfully discriminating by denying equal access to healthcare for disproportionately Medi-Cal recipients as compared to people with Medicare and the privately insured. Plaintiffs have preserved those claims for appeal. (See First, Second, Fifth and Sixth Causes of Action, *infra*.) Plaintiffs' allegations that Defendants deny "meaningful health care" and/or fail to comply with all legal access requirements would also relate to Plaintiffs' equal access claims, if revived.

objectives and purposes of the Medi-Cal program result in a disproportionate, adverse impact on Latinos. Medi-Cal participants are disproportionately Latino compared to the general population, which is 39 percent Latino as of 2018. Current Latino enrollment in Medi-Cal stands in stark contrast to Medicare and private insurance, which are disproportionately white.

10. Defendants have failed to provide sufficient access to health care, with grave consequences for Plaintiffs and other Medi-Cal participants, who suffer lengthy delays before they receive care for urgent medical issues, must travel long distances to see specialists, and are denied needed care entirely.

11. Defendants are flouting the law's requirements that physicians must be paid at rates sufficient to ensure that Medi-Cal participants receive meaningful access to medical care, and access that is at least equivalent to the access people with other insurance coverage have, including employer-sponsored insurance and Medicare. Instead, Defendants pay reimbursement rates that are so low that they rank 48th or 49th lowest out of 50 Medicaid programs and are often mere fractions of the providers' costs of care.

12. Defendants have discriminated against Medi-Cal participants by disinvesting from the program as it has become more Latino. In earlier periods when Medi-Cal rates were higher, Latinos were a much smaller proportion of the Medi-Cal population. While Defendants have allowed Medi-Cal physician reimbursements to stagnate, per capita medical expenditures and the Consumer Price Index for physician services have soared. Defendants have also repeatedly cut reimbursement rate. Other insurers, reflecting the increasing costs of providing medical care, have improved their payments to providers.

13. Unlike for physician services, Defendants have steadily increased reimbursement rates for Medi-Cal's long-term care services, which disproportionately serve white Medi-Cal participants. For example, from 2005 to 2017, stand alone skilled nursing facilities' per diem reimbursement rates grew by approximately 50 percent.

14. Market factors affecting physician pricing, such as supply of and demand for physician services, show that rather than remain flat or decrease, physician reimbursement rates

should have increased significantly during this time, as they did for long-term care services. For example, the number of practicing physicians per 100,000 Californians has decreased, physician costs have steadily increased, competing payors have increased their payment rates, and the physician market has consolidated significantly, all of which indicate that rates should have risen. Additionally, federal funding for Medi-Cal has risen rapidly. Variations in the state budget, moreover, do not explain Medi-Cal rate cuts and stagnation, as rate cuts have been maintained even in the face of booming state economies and soaring budgets. In the face of growing Latino enrollment, Defendants have kept the rates inadequately low even when the State could afford to raise them.

15. Medi-Cal's reimbursement rates for all services have dropped from 125 percent of the national average for Medicaid to 76 percent since 1979, a drop of around 40 percent. Compared to Medicare rates, which provide a well-established and conservative benchmark of the market and for the adequacy of health care prices, Medi-Cal rates have also fallen dramatically, from 69 percent of what Medicare paid for primary care in 1979 to just 41 percent now, a drop of around 40 percent. As Medi-Cal reimbursement rates have fallen, already strained access to care under Medi-Cal has worsened.

16. Over the history of the program, decision-makers have repeatedly revealed their anti-Latino animus via their words and actions, from openly referring to Latino participants as "wetbacks," to condemning their accessing services, to actively targeting them for fraud investigations.

17. Defendants have further discriminated against Medi-Cal's overwhelmingly Latino participants by maintaining methods of administration that (1) fail to comply with their legal mandates to periodically review and revise rates and notify other actors in the Medi-Cal program of access failures; (2) fail to monitor and ensure access to health care and enforce network adequacy requirements; and (3) impose unnecessary and unjustified administrative burdens on Medi-Cal participants and providers, which further impede access to care. (See Section VIII, *infra*.)

18. Defendants' low reimbursement rates and other burdens Defendants impose on providing care to Medi-Cal patients have the purpose and effect of defeating and substantially impairing the objectives and purposes of the Medi-Cal program, including the objectives of providing meaningful, timely access to health care and of providing access to care that is equivalent to the access other insured populations enjoy.

19. Defendants' methods of administration, including their acts and omissions, have an unjustified discriminatory effect on the disproportionately Latino Medi-Cal population, and constitute purposeful discrimination. The resulting separate and unequal system of health care violates the protections of Government Code section 11135, its implementing regulations, and the California Constitution.

III. JURISDICTION AND VENUE

20. This Court has jurisdiction over the Government Code section 11135 and California Code of Regulations, title 2, section 11154(i)(2) claims pursuant to Government Code section 11139; over the request for a Writ of Mandate under Code of Civil Procedure section 1085; and to grant injunctive and declaratory relief under Government Code section 11135, Article VI, Section 10 of the California Constitution, and Code of Civil Procedure sections 410.10, 525, 526, 526a, and 1060.

21. Venue in Alameda County is appropriate under Code of Civil Procedure sections 395(a) and 401(a) in that the Defendants reside in Sacramento County and the Attorney General has an office in Alameda County.

IV. PARTIES

A. Individual Plaintiffs/Petitioners.

1. Saul Jimenez Perea and Mother, Analilia Jimenez Perea

22. Saul Jimenez Perea is a Latino Medi-Cal participant. He is 35 years old and resides in Lake County. Since his birth, Mr. Jimenez Perea has had cerebral palsy and has been semi-paraplegic. His mother, Analilia Jimenez Perea, who is 57 years old, coordinates Mr. Jimenez Perea's care.

23. Mr. Jimenez Perea has a number of complex medical conditions that require regular access to specialists. He has a history of severe seizures that have required frequent hospitalizations. Until he turned 21 in 2005, he received comprehensive and regular coverage for his condition through the California Children's Services ("CCS") program, as well as assistance and support from Shriner's Hospital. When he turned 21, Mr. Jimenez Perea lost CCS coverage and support from Shriner's. After some struggles to find coverage, his social worker helped him enroll in regular, full-scope Medi-Cal. Later, as part of the mandatory enrollment in Medi-Cal managed care, he enrolled in the Partnership HealthPlan of California ("PHP").

24. Around the time he enrolled in PHP, Mr. Jimenez Perea was having grand mal seizures every month. These seizures were so severe that they regularly sent him to the emergency room. Mr. Jimenez Perea was supposed to see a neurologist every 6 to 12 months, but neurologists to whom he was referred declined to see him due to his Medi-Cal coverage, and his mother could not find anyone willing to see him. Mr. Jimenez Perea's primary care physician tried repeatedly to assist with the neurology referrals and eventually secured a referral to a doctor at the University of California, San Francisco (UCSF). The UCSF neurologist did not have any available Medi-Cal appointments, however, and the office told his mother to call back every two to three weeks to see where she was on the waiting list. Eventually, the family secured another referral from the primary care doctor, but then Mr. Jimenez Perea had to wait another three months for his appointment. He finally saw the neurologist on October 30, 2015. Thus, it was more than a year and a half before Mr. Jimenez Perea was able to get an appointment with a neurologist, during which time he continued to have serious seizures.

25. Mr. Jimenez Perea also needs to see an ophthalmologist because hypertension linked to his cerebral palsy puts him at high risk for glaucoma and thus for blindness. He is supposed to see the ophthalmologist every three to six months. For a while, Mr. Jimenez Perea saw an ophthalmologist in an eye specialist practice. The doctor eventually refused to treat him, saying he could no longer afford to take Medi-Cal patients. The nurse at the practice told his mother that Medi-Cal paid "too little and too late." Ms. Jimenez Perea tried to find her son

another ophthalmologist, but had to try three different providers before she finally found one that would accept Medi-Cal. Then, Mr. Jimenez Perea had to wait another three months for his evaluation. All told, he waited a year for his needed ophthalmologist visit. Now, he has his eyes checked at Costco and his mother pays out of pocket for visits to an ophthalmologist in Mexico because otherwise the delays are too long between appointments.

26. Mr. Jimenez Perea also has hepatitis C, as a result of blood transfusions he has received. Prior to his enrollment in PHP, he was able to see a doctor at a liver specialist's office. But after several years, he and his mother were told that the clinic would no longer accept Medi-Cal. Mr. Jimenez Perea then had to wait many months to see a different specialist for the hepatitis treatment, again experiencing long delays because of his Medi-Cal status.

27. Ms. Jimenez Perea has sought help from her son's social workers. Even with the help of trained social workers who have endeavored to assist, including by calling Medi-Cal on her son's behalf, the Pereas were not able to get Mr. Jimenez Perea the care he needed on a timely basis.

28. In April 2018, Mr. Jimenez Perea's primary care doctor informed them he would not renew his contract with Medi-Cal, citing late and insufficient payments. The prospect of losing a treating provider who has advocated for Mr. Jimenez Perea to receive appropriate care over the years and having to find a new primary care doctor caused severe distress for him and his mother, who helps coordinate his care.

29. If Medi-Cal were administered in a non-discriminatory manner, Mr. Jimenez Perea would have received medical care with fewer delays and denials, less distance traveled, and better quality of care than he received on Medi-Cal.

2. Esther Castañeda

30. Esther Castañeda is a 57-year-old Latina covered by Medi-Cal who lives in Sacramento, California. She enrolled in Medi-Cal in 2014 and joined the Anthem Blue Cross Medi-Cal managed care plan.

31. Ms. Castañeda suffered for more than a year with intense abdominal pain because

she could not get surgery scheduled to remove her gallbladder. The problem first began in February 2015, when she experienced such severe pain that she had to go to the emergency room. She could not sit or lie down, and was vomiting. The emergency room doctors diagnosed Ms. Castañeda with cholestasis, or gallstones. They prescribed her strong pain medication and told her to seek an immediate appointment with her primary care physician, within 1 to 2 days, to get a referral to surgery. Ms. Castañeda was not able to get an appointment with her primary care clinic until more than a week later, on March 6, 2015. At her appointment, the clinic told Ms. Castañeda to make an appointment with a general surgery specialist and entered the referral.

32. Nearly every day, Ms. Castañeda called the clinic to inquire about the status of the referral, sometimes going in person to the clinic. She continued to suffer from severe pain. She could not eat and was vomiting often. Eventually, Ms. Castañeda received an appointment with a general surgery specialist for April 24, 2015—2 months after her initial visit to the emergency room—but the general surgery specialist's office later cancelled the appointment. Ms. Castañeda was told by the specialist's office that they did not take Medi-Cal after all. Ms. Castañeda's primary care physician had to re-enter the same referral multiple times to different surgeons. Ms. Castañeda felt hopeless and stopped eating to minimize the pain and avoid vomiting. She lost over 30 pounds and the pain made her anxious and fearful.

33. Finally, Ms. Castañeda received a notice that she had an appointment for October 15, 2015 with the same general surgeon in Folsom with whom her appointment had been scheduled in April. But Ms. Castañeda could not wait until October 15. Two days before the scheduled appointment, she was in the emergency room with severe abdominal pain, nausea, and vomiting. The emergency room doctor noted that she had an appointment with the surgeon on October 15. The day after she was discharged, she received a phone call telling her that the October 15 appointment with the surgeon had been canceled. She felt despair.

34. Ten months after she was initially diagnosed, in December 2015, Ms. Castañeda's clinic was still pursuing the referral for her surgery. She continued to call and visit the clinic regularly to urge that she needed to see a specialist. Finally, on January 14, 2016, she received

approval for another referral to the same doctor who had already cancelled her appointment twice for insurance reasons.

35. Meanwhile, Ms. Castañeda was in Mexico with her family in February 2016, when the pain became overwhelming. She decided to have the operation done there. Her family put together the funds to pay for the surgery out-of-pocket. The doctor in Mexico diagnosed her with chronic lithiasic choleystitis, inflammation caused by the presence of the gallstones. It was the very diagnosis the surgery she had been trying to receive is meant to prevent. The doctor said she was at risk of death if she put off the surgery any longer. He operated to remove her gallbladder and said that it would take months for her to recover. However, for more than two years, she has not been able to work full time due to the pain, weakness, and nausea she has experienced from gallstones and the subsequent surgery.

36. If Medi-Cal were administered in a non-discriminatory manner, Ms. Castañeda would have received her surgery sooner, rather than having to wait more than 10 months while suffering severe pain, nausea, and almost dying from awaiting a routine surgery.

3. Rebecca Binsfeld

37. Rebecca Binsfeld is a 36-year-old mother of four living in Sacramento with her husband and children, all covered by Medi-Cal. Ms. Binsfeld is white, and her husband and children are Latino.

38. Ms. Binsfeld has Systemic Lupus, a chronic and lifelong autoimmune disease that causes the immune system to attack the body's own tissue and organs, including the joints, kidneys, heart, lungs, brain, blood, and skin. Semiannually, Ms. Binsfeld must see a rheumatologist for her lupus and an ophthalmologist to check her eyes for blindness due to her lupus medications. She also requires prompt visits for evaluation and treatment within 24 hours when she is having a painful flare. Flares can be mild, moderate, or severe. Severe flares can cause damage to the organs, or even kidney disease or failure. Ms. Binsfeld experiences the flares as extreme fatigue to the point where she does not want to get out of bed, her whole body hurts, her joints ache, she can't grip well, and she suffers from headaches and general weakness.

39. Ms. Binsfeld was previously provided health care under Medi-Cal at the UC Davis Medical Center through the Health Net managed care plan. In or around January 2015, UC Davis stopped accepting Medi-Cal because of its low reimbursement rates. When she was first dropped from UC Davis, Ms. Binsfeld called at least fifteen providers from the book provided for Health Net participants. Each provider was either too far away, was not accepting new patients, or the first available appointment was months out. It took her four months after she started calling primary care doctors to find one that would see her, at a primary care clinic called HALO, a Federally Qualified Health Center (FQHC) that she found through word of mouth. At her very first visit, the primary care physician entered a referral for her to see a rheumatologist and ophthalmologist. UC Davis then gave her one more courtesy visit since her regular rheumatologist knew that she would have trouble accessing other specialty care. She needed to see a regular specialist, not just to receive medication that helps treat the flares, but to evaluate the cause of the flares and to adjust her treatment plan to avoid them in the future.

40. Throughout that spring and summer, the referrals were re-entered and re-extended while she went to the emergency room to deal with symptoms of lupus flares. She called the clinic as well as the specialists, who only told her to return to the clinic to request another referral. By October of 2015, she was developing myalgia and joint pain because of her disease.

41. Finally, in February 2016, she was able to schedule an appointment with a rheumatologist, 10 months after her one-time courtesy visit with her UC Davis specialist. In 2016, she saw the specialist a total of 5 times. This was not sufficient. Because she suffered from a cycle of lupus flares and since it took months to schedule an appointment, Ms. Binsfeld was not prescribed the medication when she needed it most. She continued to make several visits to the emergency room because of the lupus flares. In 2018, her rheumatologist unexpectedly closed his private practice, so Ms. Binsfeld needs to see her primary care doctor for yet another referral. She is afraid she will be left without care and medication again for months.

42. More than a year after the original referral to an ophthalmologist was entered, Ms. Binsfeld finally had an appointment in August 2016. She kept trying to get an earlier appointment

but was told that no earlier appointment was available. The last time she had seen an ophthalmologist was in January 2014. At her appointment in 2016, Ms. Binsfeld was told by the receptionist that Medi-Cal only covered one appointment every two years, which is far less than she needs for her condition.

43. Overall, the egregious delays for a rheumatologist and ophthalmologist were harmful to Ms. Binsfeld's health.

44. Ms. Binsfeld's husband, Carlos de Jesus, who is 44 years old, is also on Medi-Cal through Health Net, as is their daughter, Gloria de Jesus, who is 17 years old. Both family members have also suffered long delays in getting appointments with needed specialists because of their Medi-Cal status.

45. Mr. de Jesus suffers from chronic back pain from a previous injury. He has called doctor after doctor, and has had to go to the emergency room when unable to schedule timely appointments. Recently, Mr. de Jesus was diagnosed with Graves Disease, an immune system disorder. It took many calls and about a month and a half for him to see a specialist. The specialist with whom he could secure an appointment is in Lodi, around 40 minutes away from his home by car.

46. Like her parents, Gloria de Jesus suffers from several significant health problems: she has a heart murmur, a learning disability, and scoliosis that has necessitated two spinal surgeries. In early 2016 or late 2015, Gloria had a seizure. She went to HALO Community Clinic to get a referral to a neurologist, but it took two months for her to get an appointment. At that appointment, the neurologist didn't take any action. Over the summer, Gloria had another seizure and ended up in the emergency room. She was eventually diagnosed with epilepsy. Her family then had difficulty scheduling regular appointments with a neurologist. One of her initial appointments was cancelled and rescheduled three times, causing a delay of about two months beyond when she was supposed to see the neurologist for follow up. It was not until 2018 that her condition stabilized, and it became no longer necessary that she see a neurologist as often.

47. If Medi-Cal were administered in a non-discriminatory manner, Ms. Binsfield and

her family would be receiving medical care with fewer delays and denials, and better quality of care than they have on Medi-Cal.

4. Ofelia Jardon

48. Ofelia Jardon is a 59-year-old Latina with Medi-Cal coverage who resides in Fresno. She first enrolled in Medi-Cal several years ago and joined the CalViva managed care plan, and was then assigned to the First Choice Medical Group independent physicians association.

49. Ms. Jardon has suffered severe back pain since around 2011, when she was first diagnosed with scoliosis (a curved spine) and spondylolisthesis (a bone that slides back and forth across another bone in the back). At the end of January 2015, Ms. Jardon's back pain became so severe that she was unable to work or perform her daily activities at home. On February 4, 2015, she saw her primary care doctor at the local FQHC, Clinica Sierra Vista, who referred her to radiology and for other diagnostic testing. The testing was performed in February, but it took more than two months for the results. On May 1, 2015, Ms. Jardon was referred to neurosurgery with a diagnosis of lumbar degenerative disc disease. On July 6, 2015, Ms. Jardon saw her primary care doctor for worsening back pain. The neurosurgery referral was still pending, and the clinic tried to expedite the referral.

50. But, Ms. Jardon was unable to get a timely appointment with a neurosurgeon in Fresno. Instead, she had to wait until October 26, 2015, to be seen by a neurosurgeon in San Francisco at the University of California, San Francisco (UCSF)—almost six months after the referral had been entered, and nine months after she first came to her primary care clinic with extreme back pain. Her appointments at UCSF required travel of three hours or more each way from her home in Fresno. The surgery that was performed is a routine back surgery, and although there are neurosurgeons in Fresno equally qualified to perform the surgery Ms. Jardon needed, none would accept the referral from Medi-Cal for Ms. Jardon.

51. The UCSF doctor determined that Ms. Jardon should have the surgery "asap," based on severe lumbar degenerative disease with spondylolisthesis and severe canal and

foraminal stenosis. Her surgery was not performed until a month later, November 20, 2015.

52. Although Ms. Jardon was supposed to have physical therapy almost immediately after her surgery, and she began following up right away to try to schedule these appointments, she was not able to schedule a physical therapy appointment until January 2016.

53. Ms. Jardon continued to have back problems after her surgery, such as sharp pain, lack of mobility, and vertigo. She has had to return to see the UCSF surgeon for follow-up visits, again traveling 3 hours each way. The UCSF surgeon told her she needed a second surgery, but it took months for her to get the surgery appointment. During this time she was referred to a neurosurgeon in Fresno who had previously rejected a referral for her because he did not accept Medi-Cal, and again denied her care for the same reason. After the surgery, Ms. Jardon had to stop scheduling follow-up appointments at UCSF due to the high cost of traveling from Fresno to San Francisco.

54. If Medi-Cal were administered in a non-discriminatory manner, Ms. Jardon would have received medical care with fewer delays and denials, less distance travelled, and better quality of care than on Medi-Cal.

B. Organizational Plaintiffs/Petitioners.

1. SEIU-UHW by and Through Its Community Division

55. Headquartered in Oakland, California, Service Employees International Union—United Healthcare Workers West (SEIU-UHW) is California's largest health care worker union. It includes more than 93,000 members who are frontline caregivers, including respiratory care practitioners, as well as dietary, environmental services, and nursing staff. They work in hospitals, clinics, nursing homes, laboratories, and other health care facilities.

56. SEIU-UHW's Community Division includes approximately 6,000 leaders and supporters who are not covered by SEIU-UHW collective bargaining agreements. These leaders and supporters are Medi-Cal patients, low-wage workers, and others concerned about the adverse effect of the Medi-Cal program on their families and communities.

57. Improving Medi-Cal is a core goal for the Community Division, which grew out of

SEIU-UHW's efforts to enroll thousands of people into Medi-Cal. As a result of this enrollment effort, staff, leaders, members, and supporters became aware of Medi-Cal enrollees' inability to receive timely access to needed health care, sometimes with tragic consequences. For example:

a. Community Division supporter Rosa Gomez's 10-year old daughter, Gaby, suffered from intense vomiting and weakness for several months and was in and out of the emergency room while she waited for an appointment with a specialist; eventually she was diagnosed with advanced brain cancer, from which she died.

b. Community Division supporter Leslie Maya Daugherty bled intensely from fibroids in her uterus and was unable to find a doctor near her willing to do a standard surgery to save her uterus; she was forced to travel more than 180 miles to San Francisco for the surgery. As a carrier of the sickle cell gene, Ms. Daugherty also experienced intense pain, bleeding, and anemia while waiting for treatment for her fibroids.

c. Community Division supporter Maribel Reyes and her husband Juan España drive their teenage son, Juan España, Jr., more than 300 miles from San Jose to Los Angeles each month for a life-saving blood treatment he must receive, even though there is a facility in Northern California that could treat him. Medi-Cal reimbursement rates are so low that the doctor in Northern California says he cannot afford to provide the treatment.

d. Community Division supporter Matilde Valle suffered from pain and discharge from her belly button for many months before being diagnosed with an umbilical hernia that needed surgery, a surgery that would normally be performed right away for someone in her condition covered by private insurance.

58. These and the experiences of many, many Medi-Cal participants who belong to the Community Division have led SEIU-UHW to launch a campaign to "fix Medi-Cal," aimed at ensuring that people with Medi-Cal can receive the meaningful access to care to which they are entitled.

2. St. John's Well Child and Family Center

59. St. John's Well Child and Family Center, located in South Los Angeles, is an independent 501(c)(3) community health center that serves patients of all ages through a network of 15 Federally Qualified Health Centers (FQHCs) and school-based clinics, as well as two mobile clinics that serve the homeless. The mission of St. John's has been to eliminate health disparities and foster community well-being by providing and promoting the highest quality care in South Los Angeles.

60. St. John's does not turn anyone away for inability to pay. The services it provides include primary care, mental health, dental care, and care management for complex conditions. St. John's provides about 360,000 patient visits a year to about 100,000 unduplicated patients, the vast majority of them living below 100 percent of the Federal Poverty Level, with over half covered by Medi-Cal. Many Medi-Cal patients come to St. John's after they are unable to schedule appointments with their assigned primary care providers in other managed care organizations.

61. In 2015, St. John's patient population was approximately 83 percent Latino. This percentage has grown over time. In 2013, for example, 76 percent of the patients served by St. John's were Latino.

62. St. John's is a contracted clinic partner with Health Care LA, IPA (HCLA), an "independent physicians' association." Through HCLA, St. John's cares for patients enrolled with government-sponsored managed care programs in Medi-Cal and Medicare Advantage, as well as "dual eligibles" (i.e., patients covered by both Medicare and Medi-Cal). The Medi-Cal payments that the Health Care LA IPA receives, portions of which are passed on to St. John's, are extremely low. The IPA, which establishes its own network, has determined it must pay all its specialists above Medicare rates in order to ensure adequate access. This means that an insufficient amount remains to cover full-scope comprehensive primary care services, delivered at St. John's, along with coordination of care and administration. The low Medi-Cal rates and the State's arbitrary administrative practices jeopardize St. John's ability to fulfill its fundamental mission to provide its clients with timely access to high-quality health care.

3. National Day Laborer Organizing Network (NDLON)

63. The National Day Laborer Organizing Network (NDLON) is a non-profit organization whose headquarters is in Los Angeles County. NDLON is a nationwide network of organizations that work with day laborers.

64. The aims of NDLON include improving the lives of day laborers in the United States by fostering safer, healthier, more humane environments for day laborers to earn a living, contribute to society, and integrate into the communities where they live and work.

65. NDLON and its member organizations undertake work on day laborers' health and safety needs because day workers are injured, suffer illnesses, and die on the job at dangerously high rates.

66. NDLON, and its member organizations, work with day laborers who reside in California and are Medi-Cal participants themselves and/or have children who are Medi-Cal participants.

C. Defendants.

1. Department of Health Care Services[4]

67. Defendant Department of Health Care Services ("DHCS") is charged with administering the Medi-Cal program "in order to secure full compliance with the applicable provisions of state and federal laws." (Welf. & Inst. Code § 10740.)

68. DHCS is California's "single state agency" designated to administer or supervise the administration of the Medicaid program under Title XIX of the Social Security Act. (See 42 U.S.C. § 1396a(a)(5) [each state providing Medicaid must "provide for the establishment or designation of a single State agency to administer or to supervise the administration of the [Medicaid] plan"]; 42 C.F.R. § 431.10; Welf. & Inst. Code § 14100.1 [designating DHCS the single state agency]; State Plan Att. 1-A.)

[4] It is the general and long-established rule that in actions for declaratory and injunctive relief challenging the legality of state statutes, regulations, policies, and practices, state officers with statewide administrative functions under the challenged statute are the proper parties defendant. (See, e.g., *Serrano v. Priest* (1976) 18 Cal.3d 728, 752, *supplemented* (1977) 20 Cal.3d 25.)

69. DHCS is responsible for promulgating fee-for-service rates (see Section VII.A.1, below) and managed care capitation rates (see Section VII.A.1.b, below); and for enforcing all Medi-Cal-related statutes and regulations.[5]

70. DHCS is granted "full power to supervise every phase of the administration of health care services and medical assistance . . . in order to secure full compliance with the applicable provisions of state and federal law." (Welf. & Inst. Code § 10740.)

71. DHCS must "advise public officers regarding the administration of health care services and medical assistance throughout the state, and shall supervise the administration of such services and assistance to all persons receiving or eligible to receive such services and assistance." (Welf. & Inst. Code § 10742.)

72. As the single state agency responsible for Medi-Cal administration, DHCS may not delegate, other than to its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on administration of the Medi-Cal program, including the duty to set rates and enforce network adequacy requirements. (42 C.F.R. § 431.10.)

2. Jennifer Kent

73. Jennifer Kent, Director of DHCS, is responsible for setting Medi-Cal's fee-for-service reimbursement rates and managed care capitation rates that this complaint challenges and is responsible for administering the Medi-Cal program and ensuring that Medi-Cal patients in managed care plans have proper access to services. (Welf. & Inst. Code § 10721.)

3. California Health and Human Services Agency

74. California Health and Human Services Agency ("HHSA") is the parent entity of the Department of Health Care Services.

4. Michael Wilkening

75. Michael Wilkening is the Secretary of HHSA. He oversees the Medi-Cal program, including setting of the fee-for-service and capitated managed care Medi-Cal reimbursement rates

[5] Fee-for-service and managed care are the two primary payment modalities for Medi-Cal, as explained further below in section VII.A.1.

that this complaint challenges. (Gov. Code §§ 12803, 12850, 12850.4.)

76. As the Secretary of HHSA, Mr. Wilkening has the power of general supervision over, and is directly responsible to the Governor for, the operations of HHSA and DHCS. (Gov. Code § 15554.)

V. CLASS ALLEGATIONS

77. Pursuant to Code of Civil Procedure section 382, the Individual Plaintiffs bring this action for injunctive and declaratory relief on their own behalf and on behalf of a class of all other Medi-Cal participants, excluding persons with dual eligibility for Medicare. The claims asserted in this complaint are solely for injunctive and declaratory relief for the class to provide equal access to health care for people with Medi-Cal. This complaint does not seek damages.

78. The persons in the class are so numerous that joinder of all such persons is impracticable, and the disposition of their claims in a class action is a benefit to the parties and to the Court. Over 13 million people are enrolled in Medi-Cal, 89 percent of whom are not dual-eligible for Medicare.

79. There is a well-defined community of interest in the questions of law and fact affecting the class in that they are all subject to the same acts and omissions by Defendants that cause the discrimination at issue, including Defendants' disinvestment from Medi-Cal as the program has become more Latino; inadequate reimbursement rates; Defendants' failures to ensure that provider payments are adequate to enlist sufficient providers to provide care; Defendants' failures to monitor and ensure access and network adequacy; and Defendants' imposition of administrative burdens impeding access to care.

80. Common questions of law and fact predominate over questions affecting individual members. Such predominant, common questions include, but are not limited to, the following:

a. Whether Defendants discriminated against Latinos by disinvesting from Medi-Cal as the program has become more Latino;

b. Whether Defendants have utilized methods of administration that have the purpose

or effect of discriminating against Latinos;

c. Whether Defendants have set fee-for-service reimbursement and managed-care capitation rates adequate to assure equal and adequate access;

d. Whether Defendants have failed to ensure payments to providers in managed care adequate to assure equal and adequate access;

e. Whether Defendants have set rates based on arbitrary financial constraints, rather than to ensure the objectives of the program are fulfilled;

f. Whether Defendants have failed to provide or ensure meaningful access to specialists and primary care physicians for Medi-Cal participants;

g. Whether Defendants have imposed unnecessary administrative burdens on Medi-Cal participants and providers;

h. Whether Defendants' acts and omissions have resulted in a significant disparate impact on Latinos, including unavailability of sufficient specialty and primary care providers willing and available to treat Medi-Cal participants;

i. Whether Defendants' acts and omissions constitute unlawful discrimination because they have defeated or substantially impaired the objectives of the Medi-Cal program;

j. Whether Defendants can rebut Plaintiffs' showing of disparate impact with a legally sufficient necessity;

k. Whether Defendants' actions constitute unlawful disparate treatment of Medi-Cal participants on the basis of their race and ethnic group membership;

l. Whether Plaintiffs are entitled to declaratory relief that Defendants have violated Government Code section 11135; California Code of Regulations, title 2, section 11154(i)(2); and the California Constitution;

m. Whether Defendants have violated the substantive due process rights of Medi-Cal participants; and

n. Whether this Court should issue an injunction that Defendants cease and desist

their discriminatory practices, and order that Defendants take steps to ensure equal and adequate access to care for Medi-Cal participants.

81. The claims of the Individual Plaintiffs are typical of the claims of the class as a whole because the Individual Plaintiffs are similarly affected by Defendants' acts and omissions.

82. The Individual Plaintiffs are adequate class representatives because they are directly affected by Defendants' acts and omissions. The interests of the Individual Plaintiffs are neither antagonistic to nor in conflict with the interests of the class as a whole. The attorneys representing the class are experienced in representing clients in class actions involving civil rights claims.

83. Defendants have acted and/or failed to act on grounds generally applicable to the class as a whole, making appropriate final declaratory and injunctive relief with respect to the class as a whole.

84. References to Plaintiffs shall be deemed to include each Individual Plaintiff and each member of the class, unless otherwise indicated.

VI. LEGAL FRAMEWORK

85. State and federal laws require that Defendants fulfill their legal duty to provide Medi-Cal participants with meaningful, equal access to medical services. This duty includes paying providers rates sufficient to provide equivalent access to that available to the general public covered by Medicare and private insurance, which, unlike Medi-Cal, pay reimbursement rates that reflect current costs and other market conditions for providers.[6]

86. Civil rights laws prohibit denial of "the equal protection of the laws," and prohibit Defendants from using "criteria or methods of administration that . . . have the purpose or effect of subjecting a person to discrimination on the basis of ethnic group identification," and that "have the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of . . . [a] program with respect to a person of a particular ethnic group identification." (Cal. Const., art. I, § 7(a); *ibid.* art. IV, § 16(a); Cal. Code Regs., tit. 2, § 11154(i)(2).)

[6] The allocation of responsibilities for Defendants is described above in Section IV.C.

87. California law provides that the objective and purpose of Medi-Cal is to allow "eligible persons to secure health care in the same manner employed by the public generally, and without discrimination or segregation based purely on their economic disability." (Welf. & Inst. Code § 14000(a).)

88. Welfare and Institutions Code section 14079 provides that reimbursement rates in Medi-Cal must be reviewed on an annual basis and periodically revised "to ensure the reasonable access of Medi-Cal beneficiaries to physician and dental services," looking at, among other factors, "[a]nnual cost increases for physicians as reflected by the Consumer Price Index," "[p]hysician reimbursement levels of [M]edicare, Blue Shield, and other third-party payors," and "[p]revailing customary physician charges within the state and in various geographical areas."

89. The federal Medicaid Act provides that Medi-Cal reimbursement rates must be "adequate to enlist providers for the level of care and services . . . available to the general population . . . .," 42 U.S.C. § 1396a(a)(30)(A) ("Section 30(A)"), and that medical care must "be provided with reasonable promptness to all eligible individuals," 42 U.S.C. § 1396a(a)(8) ("Section (a)(8)").

90. State law incorporates Sections 30(A) and (a)(8) in the Medi-Cal State Plan, which Defendants are required to follow as a matter of state law. (Cal. Code Regs., tit. 22, § 50004(b).)

91. State law provides that "it is the intent of the Legislature that health care services" available under Medi-Cal "be at least equivalent to the level provided in 1970-71." (Welf. & Inst. Code § 14000.1.)

92. Defendants are also charged with the enforcement of managed care plans' state-law requirements under the Knox-Keene Act, the Welfare and Institutions Code, and contracts with DHCS to: (1) include a minimum number of primary care providers per participant in their networks, (2) ensure appointment availability within a maximum number of days, and (3) provide for physicians within a maximum distance or travel time from where participants live. (See, e.g., Welf. & Inst. Code § 14197; Health & Safety Code §§ 1340-1399.864; Cal. Code Regs., tit. 28, §§ 1000-1300.826.)

93. Defendants utilize methods of administration that violate their duties under these and other laws to provide access to health care on a non-discriminatory basis.

94. Defendants comprehensively regulate the provision of health care for all Californians, effectively creating a single system of care for all residents in which the access to health care that Defendants provide for Medi-Cal participants must match the access to care of the remainder of the general insured population. This oversight includes licensing and certifying all physicians and other licensed health care professionals, as well as health care facilities, all of which serve patients with Medicare, Medi-Cal, and every other major type of health insurance. Within this single system, Defendants discriminate against Medi-Cal participants.

VII. STATEMENT OF FACTS

A. Defendants' Low Reimbursement Rates, Inadequate Monitoring of Medi-Cal Participants' Access to Health Care, and Administrative Practices Result in Inadequate Provider Participation.

1. Defendants Set Inadequate Rates.

95. Medi-Cal pays physicians and clinicians via two methods: fee-for-service and managed care.

96. Defendant DHCS, under the direction of Defendant Kent, who is overseen by Defendant Wilkening and Defendant HHSA, is the single state entity responsible for determining and implementing the rates that Medi-Cal pays under both methods.

97. Notably, the statutory scheme does not assign these mandatory duties to any other parties: they rest squarely in the purview of Defendants Kent and DHCS, and they are non-delegable. (See, e.g., Welf. & Inst. Code § 14105; 42 C.F.R. § 431.10.)

98. DHCS's role as the single state entity charges it with the responsibility not only to evaluate whether the rates meet applicable legal requirements, including whether they provide meaningful access, but also to notify other government actors in the Medi-Cal system if the rates do not meet these standards. (See, e.g., Welf. & Inst. Code § 10742.)

99. As a matter of law and practice (as factual and expert evidence will show), other executive branch officials, the Legislature, and the federal government rely on DHCS to fulfill its

duties in the rate-setting process and in the administration of Medi-Cal. Yet DHCS has repeatedly failed to fulfill these duties, including, as described herein, failing to conduct regularly required rate reviews that appropriately consider whether all legal access requirements are being met, and failing to inform the Legislature and other officials that such access requirements are not being met.

100. In fact, DHCS certifies in the State Plan that Medi-Cal's payments are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population. (State Plan § 4.19(i) [citing 42 CFR §§ 447.201, .204].) However, DHCS knows or should know that this certification is false.

a. Fee-for-Service

101. Medi-Cal's reimbursement rates for services it covers under the more traditional fee-for-service (FFS) model are abysmally low. Under FFS, Medi-Cal reimburses providers directly a fixed amount for a particular service, and DHCS pays according to a fixed fee schedule.

102. A number of Medi-Cal participants currently receive services paid for directly by Defendants through FFS. In addition, Defendants use the FFS fee schedule as a benchmark to set the managed-care capitation rate and as a benchmark for the fees paid by managed care plans to physicians in their networks, as described below.

103. Under state law, the Director of DHCS had initial responsibility for setting FFS rates. (Welf. & Inst. Code § 14077.)

104. Since initially setting FFS rates, the Director of DHCS has also been required to annually review and periodically revise physician rates to ensure access, including considering whether the rates afford "reasonable access," including evaluating the rates based on specified factors. (Welf. & Inst. Code § 14079.) Yet, current DHCS Director Kent and her predecessors have repeatedly failed to complete this mandatory duty.

105. Defendants' actions and failures to act have resulted in rates stagnating for years while medical inflation eviscerates their real value.

106. The Legislative Analyst's Office has stated that there is "no rational basis" for

Defendants' rate-setting system.

b. Capitation Rates for Medi-Cal Managed Care

107. Since the 1980s, California has sought to move Medi-Cal participants into managed care. Medi-Cal managed care requires participants to enroll with local managed-care organizations ("MCOs") established by their county of residence, private insurers, or regional bodies. Presently, the vast majority of Medi-Cal participants are enrolled in managed care.

108. Under Medi-Cal managed care, the State pays MCOs a fixed, "capitated" rate per Medi-Cal participant, which Defendants are supposed to determine based on actuarial assumptions about the cost of care and utilization. (42 C.F.R. § 438.4.)[7]

109. Defendant DHCS sets Medi-Cal managed-care capitation rates under the direction of Defendant Kent, who is overseen by Defendant Wilkening and Defendant HHSA. (See Welf. & Inst. Code § 14087.5(c)(1) ["the department shall have *exclusive* authority to negotiate the rates . . . of county organized health systems contracts and contract amendments"] [emphasis added]; *id.* § 14087.98 [same for rural health plans]; *id.* § 14089(h) [same for geographic managed care]; *id.* § 14087.3(d)(1) ["the department shall determine preliminary per capita rates of payment for services provided to Medi-Cal beneficiaries enrolled in a managed care program . . . ."].)

110. From the managed-care capitation rates that Defendants set, MCOs then contract with providers—such as individual doctors, physician groups, and hospitals—to provide medical services to their participants, paying those providers either a negotiated amount per service or a monthly per-member per-month amount (a practice called "sub-capitation").

111. It is widely recognized that Defendants have set the managed-care capitation rates paid to MCOs arbitrarily low due to, among other reasons to be established at trial: (1) Defendants' use of the low Medicaid fee-for-service fee schedule as a component of the capitation rate-setting process; (2) Defendants' use of so-called "efficiency factors" to further lower capitation rates; (3) problems in the data supplied by the Defendants, which actuaries rely

[7] By way of general background, these managed-care capitation rates vary by MCO based on assumptions about the MCO's particular insurance pool, i.e., the population of people receiving insurance from that MCO, which may include people whose cost of care varies widely.

upon to calculate capitation rates; (4) Defendants' categorical selection of the lower of the range of capitation rates recommended by actuaries; and (5) Defendants' manipulation of rates to fit within perceived budget constraints, or to fulfill political motivations.

112. Once Defendants set managed-care capitation rates, they update them annually, using the previous year's experience as the baseline for each group. Defendants fail to evaluate access to care or to consider contract compliance in the managed-care capitation rate-setting process, despite well-documented network inadequacy and other access violations by the MCOs.

113. In the past, Defendants explicitly incorporated budgetary factors in the managed-care capitation rate-setting process, first coming up with managed-care capitation rates and then applying an arbitrary budget factor to reduce the rates. Defendants' method of setting managed-care capitation rates based on the previous year's rates embeds those past budget-based rate decisions into the current capitation rates.

114. On information and belief, Defendants inappropriately continue to take budgetary considerations into account in the rate-setting process.

115. Unsurprisingly, Defendants' low managed-care capitation rates lead to low payments to the providers who contract with Medi-Cal MCOs to provide medical services to Medi-Cal participants.

116. Further, Defendants' method of setting managed-care capitation rates results in Medi-Cal managed-care capitation rates that are lower than the cost of providing care and far below the actuarially equivalent rates for individuals on Medicare and employer-sponsored insurance.

117. Although the Legislature, the federal government, and other executive branch officials rely on Defendants to inform them that the capitation rates and payments to physicians are too low to afford meaningful, legally required access, Defendants have failed to provide such notification, thereby defaulting in their legal duties.

118. Defendants' setting of managed-care capitation rates in this manner perpetuates and reinforces past discrimination and amounts to a method of administration that defeats or

impairs the objectives of the Medi-Cal program.

2. Low Payments to Providers Result in Fewer Providers Willing to Treat Medi-Cal Participants.

119. Defendants fail to set both the fee-for-service rates and managed-care capitation rates high enough to ensure equal access to quality care for Medi-Cal participants, and the insufficient reimbursements make it difficult to enlist specialty and primary care providers.

120. Physicians overwhelmingly cite low Medi-Cal payments as their reason for limiting the number of Medi-Cal patients they serve.

121. Physicians' willingness to accept Medicaid patients increases as Medicaid payment rates increase. Acceptance rates by primary care physicians of new Medicaid patients are higher in states where the ratio of Medicaid to Medicare fees is higher.

122. Despite Medi-Cal's high enrollment, substantially fewer physicians provide care to Medi-Cal patients than to Medicare and commercial insurance patients, which provide higher reimbursement rates that more accurately reflect provider costs.[8]

123. Certain types of physicians are very unlikely to accept Medi-Cal patients at all, such as general internal medicine, surgery, family medicine, medical specialties, and psychiatry. Indeed, a recent study showed that the number of California physicians serving Medi-Cal patients was about the same as the number of physicians serving the uninsured in three important specialties: surgery, emergency medicine, and psychiatry. The percentage of physicians accepting new Medi-Cal patients is even lower than the percentage of physicians with any Medi-Cal patients, presenting a particular challenge for Medi-Cal participants seeking to establish a new physician-patient relationship.

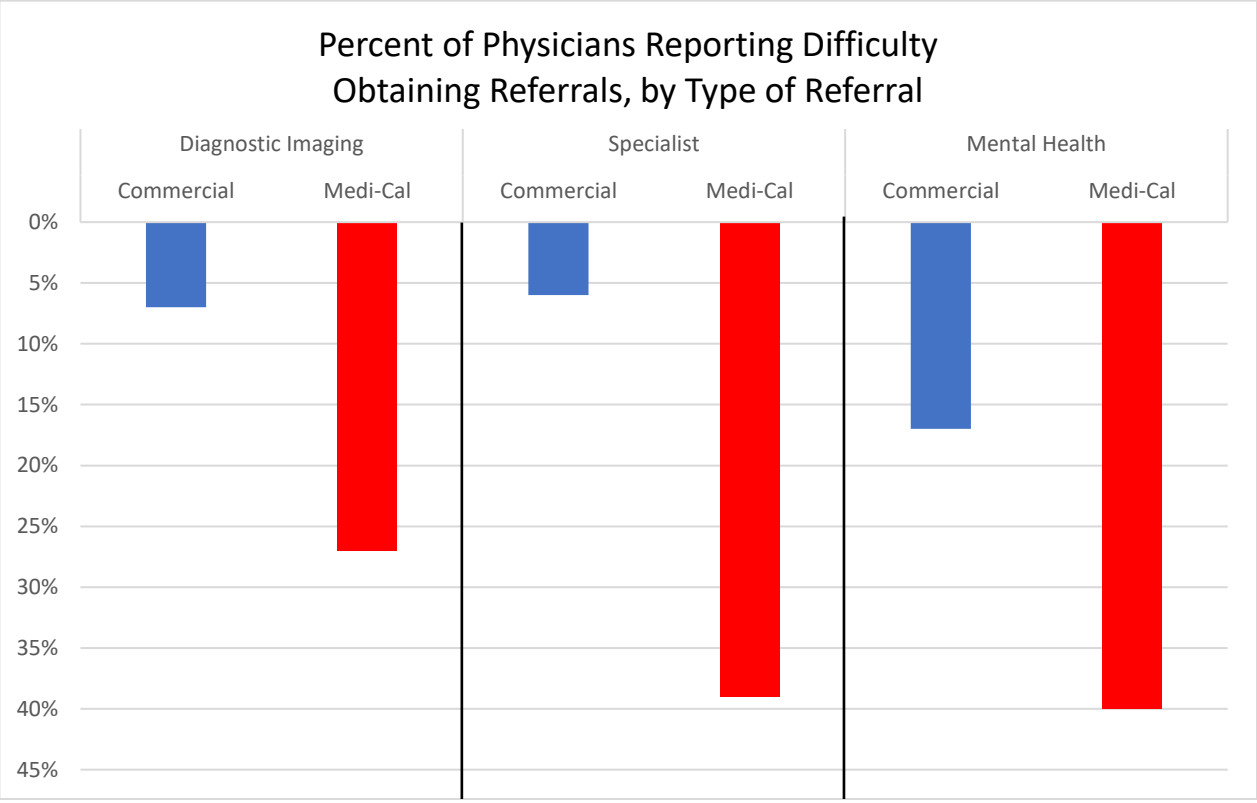
124. Provider participation in Medi-Cal is not only low as compared to other insurance, it also does not meet the network adequacy standards set by State regulation to ensure adequate access to care: the number of full-time-equivalent primary care physicians reporting that they participate in Medi-Cal is *below* the minimum of one primary care physician per 2000

[8] Commercial insurance includes both employer-sponsored insurance and other, significantly less common forms of private insurance, such as individually purchased policies.

participants provided for by regulation. Research suggests that providers over-report their willingness to accept Medi-Cal, meaning that actual acceptance rates are likely *even lower*.

125. However, Defendants have not conducted rate reviews and revisions required by Section 14079 to ensure the reasonable access of Medi-Cal participants to physician services despite overwhelming provider participation shortages.

126. Physicians report much greater difficulty obtaining referrals for their Medi-Cal patients compared to their patients with commercial insurance.



Source: Janet Coffman, MPP, PhD, et al., *Physician Participation in Medi-Cal: Is Supply Meeting Demand?* at 20 (California Health Care Foundation June 2017).

127. Consequences of difficulties obtaining referrals include delayed diagnosis or treatment, duplication of testing, reduced continuity of care, worsening complications, and untreated chronic or acute conditions.

128. Defendants' method of setting rates reduces the number of providers who will see Medi-Cal patients and causes the access problems Medi-Cal participants experience. This has the purpose and effect of violating Defendants' duty to administer Medi-Cal in a non-discriminatory

fashion.

3. Defendants Fail to Meet Their Mandatory Duties to Adequately Monitor Access and to Enforce Network Adequacy Standards.

129. Defendants administer the Medi-Cal system in a manner that fails to fulfill Defendants' mandatory legal requirements to monitor access problems and enforce network adequacy requirements.

130. There are several sources for these network adequacy requirements:

a. For years, the Knox-Keene Act and its implementing regulations have placed certain "network adequacy" standards on covered plans, which includes most Medi-Cal MCOs. These requirements include timeliness standards, under which MCOs must "ensure that [their] contracted provider network[s] ha[ve] adequate capacity and availability of licensed health care providers to offer enrollees appointments" that meet certain timeframes, including 48 hours for urgent care appointments that do not require prior authorization, 96 hours for urgent care appointments that do require prior authorization, 10 business days for non-urgent primary care appointments, 15 business days for non-urgent specialist appointments, and 15 business days for ancillary services. (Cal. Code Regs., tit. 28, § 1300.67.2.2(c).) Distance standards and provider-participant ratios require that "[a]ll enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated primary care provider in such numbers and distribution as to accord to all enrollees a ratio of at least one primary care provider (on a full-time equivalent basis) to each 2,000 enrollees." (Cal. Code Regs., tit. 28, § 1300.51(d)(H)(i).)

b. For MCOs not subject to the Knox-Keene Act, contracts between DHCS and the plans impose similar network adequacy requirements.

c. Since January 1, 2018, Welfare and Institutions Code section 14197 has imposed time and distance requirements for primary and specialty care on all Medi-Cal plans.

131. As the single state agency, DHCS is obligated to enforce all three sources of network adequacy requirements.

132. Yet, Defendants have failed to adequately monitor Medi-Cal MCOs for compliance with these requirements. For example, in 2015, the California State Auditor determined that Defendant officials failed to monitor MCOs for compliance with network adequacy criteria and, to the extent it could be determined, the MCOs failed to comply with the requirements. Three years later, Defendants have failed to fully implement several of the State Auditor's recommendations.

133. The Department of Managed Health Care (DMHC), which sits under Defendant HHSA, regularly reports that "based on the widespread inaccuracy of the timely access compliance data health plans submitted . . . the DMHC is unable to determine whether health plans met [their] responsibility" to provide "timely access to health care services." Without such timely access data, it is impossible for DHCS to assess or verify that timely access standards are being met for the plans under its purview.

134. Defendants have also failed to ensure that the clear standards in the Knox-Keene Act, its contracts, and Welfare and Institutions Code section 14197 are actually met or enforced in reality. For example, Defendants allow MCOs to participate in Medi-Cal despite the fact that they have too few providers in their networks, with network directories creating the illusion of widespread access to care, when in reality the opposite is true. This failure has the purpose or effect of defeating or substantially impairing Medi-Cal's objective of providing equal access to care by causing individual Plaintiffs and others like them to wait many months, or even years, for their needed appointments, in violation of Defendants' own timeliness standards.

135. Furthermore, Defendants allow "sub-capitation," under which MCOs provide per-member per-month fees to independent physician associations ("IPAs") and other organizations, and then those IPAs and other organizations in turn may sub-capitate even further to other physician groups and providers. The consequence for sub-capitated patients is that they may be in narrower networks than provider directories reflect, because their physician may be limited to only referring to providers in the patient's sub-capitated network. The incentives are to deny care rather than provide it, because each entity in a sub-capitated network makes more money if less

care is provided, so there is an acute need for regulation and oversight of such narrow networks. The State, however, provides no such oversight and does not determine whether the sub-capitated networks meet the network adequacy requirements established by State law.

4. Defendants Also Create Administrative Burdens for Medi-Cal Providers and Participants, Thereby Limiting Access to Care.

136. Beyond failing to enforce network adequacy standards, Defendants administer Medi-Cal in such a way as to discourage provider participation. Physicians limiting the number of Medi-Cal patients they see cite unnecessary administrative burdens and delays in payment as the most significant reasons (after low reimbursement rates) why they limit the number of Medi-Cal patients in their practices.

137. Likewise, Defendants have subjected providers to onerous and unpredictable clawbacks when Defendants determine retroactively, long after services have been provided, that patients were not eligible for Medi-Cal or that a service was not authorized or required. Providers are deterred from providing services to Medi-Cal patients as a result, or suffer financially for doing so.

138. Medi-Cal regularly delays payments to providers relative to other forms of insurance, creating an additional administrative hurdle to provider participation. For example, while Medicare and other forms of insurance implement new CPT codes by January 1 each year, DHCS regularly delays its implementation until September or October, resulting in up to an eight or nine month delay for payment of services corresponding with the new CPT codes.

139. Other administrative barriers to access for providers and participants include the difficulties of obtaining referrals; time limits on referrals that cause them to expire before patients are able to schedule appointments with the limited number of specialists willing to treat Medi-Cal patients; and the existence of sub-capitated networks that complicate and further limit the numbers of specialists willing to treat a given Medi-Cal patient.

140. These administrative burdens impede access to care and have the purpose and effect of defeating Medi-Cal's objectives and discriminating against Medi-Cal participants on the basis of ethnicity.

B. Medi-Cal Participants Have Inadequate Access to Health Care, Which Is Substantially Worse Than That of Their Counterparts Covered by Other Insurance.

141. The Individual Plaintiffs, like others with Medi-Cal, receive inadequate, unequal access to medical care by being denied needed medical care, suffering from delays in obtaining care, traveling long distances to obtain care, and receiving lower quality care than if they were covered by other forms of insurance that cover others in the general California population.

142. Defendants create difficulties in accessing primary and specialty care, which leave individual Plaintiffs' and other Medi-Cal participants' chronic and acute conditions untreated or inadequately treated. For example, Medi-Cal participants are particularly likely to be initially diagnosed at late stages with breast, colon, and rectal cancer; and they are particularly unlikely to receive breast-conserving surgery or to receive recommended radiotherapy for breast cancer.

143. The Individual Plaintiffs' stories exemplify the access problems borne out by the data. For example, Saúl Jimenez Perea was unable to see a neurologist for about a year and a half while he was experiencing grand mal seizures. The delay for Esther Castañeda was so long that she almost died while waiting for surgery. Rebecca Binsfeld has had to wait months to receive treatment for her lupus, all the while experiencing debilitating and dangerous flares. Ofelia Jardon had to travel from Fresno to the Bay Area for a common back surgery. These experiences—like those of the members of the Community Division of SEIU-UHW—are representative of the types of problems that are commonplace among Medi-Cal participants, and are significantly worse than the access problems experienced by those on other insurance.

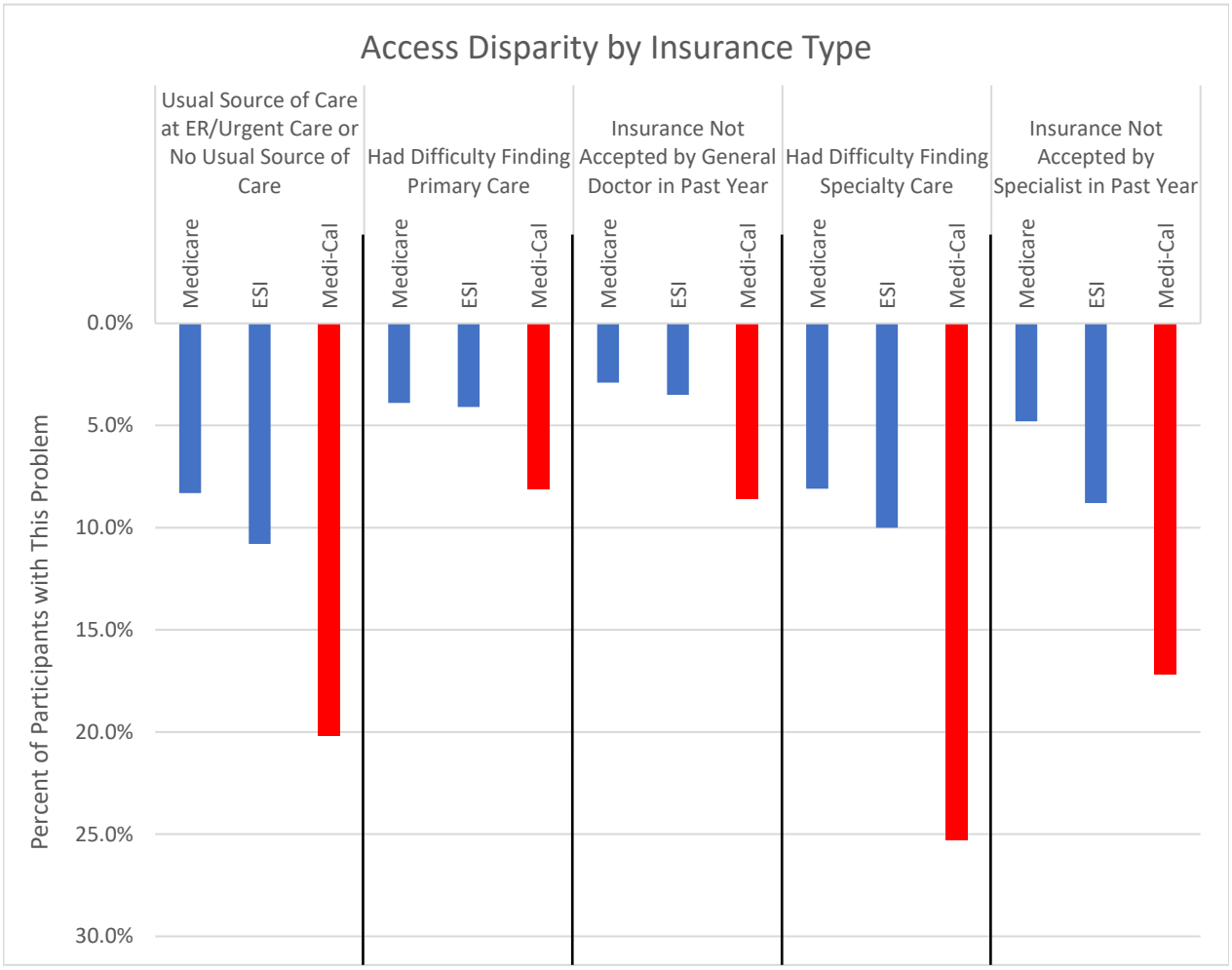
144. Plaintiffs have substantially less access to health care than Medicare participants and those with employer-sponsored insurance (ESI), by far the two other most predominant forms of health insurance the general population receives in California.

145. In 2016, when compared to those with Medicare or employer-sponsored insurance, Medi-Cal participants were significantly more likely to receive their care at an emergency room or urgent care, or to lack a usual source of care entirely.[9] With respect to primary care, Medi-Cal

[9] For purposes of this analysis, "dual eligibles"—those who are eligible for both Medicare and Medi-Cal—are considered to be on Medicare, as Medicare is the primary payor for their services.

participants were significantly more likely to report difficulty finding care and to have had their insurance coverage rejected by a provider. With respect to specialty care, Medi-Cal participants were even more likely to report difficulty finding care and to have had their insurance coverage rejected by a provider. From 2013 to 2016, 24 percent of Medi-Cal participants who tried to get an appointment within two days because they were sick or injured were *never* able to get such an appointment, compared to 9 percent of those with Medicare who tried and 9 percent of those with employer-sponsored insurance who tried, while another 25 percent of those Medi-Cal participants were only sometimes able to get such an appointment, compared to 14 percent of those with Medicare and 14 percent of those with employer-sponsored insurance.

Dual eligibles have better access to care than do those with just Medi-Cal. Moreover, as discussed below in section VII.E, the one service dual eligibles do rely on Medi-Cal to pay for—long-term care—has seen regular rate increases, unlike physician services.



Source: UCLA Center for Health Policy Research, 2016 California Health Interview Survey.

146. Access to care for Medi-Cal participants has worsened during the relevant time period. For example, from the early 2000s to 2016, Medi-Cal participants became much more likely not to have a usual source of care other than an emergency room, and to have had *no* visits with physicians in the preceding 12 months.

147. Medi-Cal health maintenance organizations (HMOs), a type of managed care plan, have received significantly worse rankings than their employer-sponsored insurance and Medicare counterparts, across the board, in such areas as patients' ability to get care quickly and easily; patients' satisfaction with the quality of care and their health plan; the proper receipt of preventative services like breast and colorectal cancer screening, flu shots, pneumonia shots, and BMI assessments; and the proper receipt of treatments for acute and chronic illnesses, such as diabetes, heart disease, and mental illness.

C. As Medi-Cal Has Become Significantly More Latino Since the Late 1970s, the State Has Disinvested from the Program, Harming All Current Medi-Cal Beneficiaries.

148. Medi-Cal's participants have become significantly more Latino since the late 1970s. While Medi-Cal participants were approximately 25 percent Latino in 1980, when Latinos were about 19 percent of the state population, Medi-Cal is now 58 percent Latino, despite Latinos only constituting about 39 percent of the state population.

149. During this same time, Defendants have, via inaction and action, significantly cut physician reimbursement rates, without performing adequate analysis of how these cuts impact legally-required health care access, and without informing the Legislature or other government actors of the effects of such cuts, despite their duties to do so:

a. First, DHCS has repeatedly failed to meet its obligations to review and periodically revise rates.

i. DHCS's obligations to review and revise rates arise not only pursuant to specific substantive legal authorities, such as Welfare and Institutions Code section 14079 and Welfare and Institutions Code sections 14087.3 et seq., but also pursuant to its role as the single state agency with responsibility for administering Medi-Cal, which includes a duty to ensure and certify that rates are sufficient to meet its access obligations.

ii. DHCS has been derelict in these duties, repeatedly allowing rates to stagnate while failing to adequately notify the executive branch, the Legislature, and the federal government of the myriad access problems caused by the low rates, adequately assess the impact of low rates on access, determine other ways to pay for higher physician rates within its budget, or seek budget increases to cover higher physician rates.

iii. Long-term rate stagnation has occurred repeatedly since 1979. The latest period of rate stagnation began around 2000, the last time there was a systemwide increase in rates.

iv. Meanwhile, national per capita medical expenditures and physician

services CPI have soared. For example, physician services CPI grew by more than 50 percent from 2000 to the present.

v. Thus, even absent any affirmative steps to cut physician rates, DHCS's inaction has effectively resulted in significant cuts to physician rates due to the past 19 years of inflation.

vi. The stagnation of rates resulting from DHCS's inaction in the face of medical inflation is the primary driver of their current inadequacy.

b. Compounding the inadequacy caused by DHCS's inaction, the Legislature, acting through DHCS, and DHCS on its own have repeatedly cut or attempted to cut Medi-Cal rates. Where the Legislature has made cuts, DHCS has failed to perform its mandatory duty to adequately advise them and others in the executive branch of the impact of such cuts on DHCS's ability to meet its obligations to ensure meaningful, legally compliant access.

i. For example, in 1982, the Legislature reduced rates for physician services by 10 percent. (Cal. Stats. 1982, ch. 328 § 53.)

ii. In 1987, the Department of Health Services (DHCS's predecessor agency), attempted to impose a 10 percent across-the-board rate cut to Medi-Cal, but that cut was blocked by the courts. (See *Cal. Medical Ass'n v. Kizer* (E.D. Cal.) No. Civ. S-87-0182 LKK.)

iii. In 1992, the Legislature cut physician rates for anesthesia, radiology, and surgery by 9.5 percent. (Welf. & Inst. Code § 14105(f); Cal. Stats. 1992, ch. 723 § 1.)

iv. In 2003, the Legislature cut rates by 5 percent, citing as its rationale "the significant state budget deficit projected for the 2003-04 fiscal year . . . ." (Cal. Stats. 2003, ch. 230 § 62.5.)

v. In 2008, the Legislature increased these cuts to 10 percent, but was blocked by the courts. (See Welf. & Inst. Code § 14105.19; Cal. Stats.

2008, 3rd Ex. Sess., ch. 3 § 14; *Independent Living Center of So. Cal. v. Shewry* (C.D. Cal. Aug. 18, 2008) 2008 WL 3891211.)

vi. From 2008 to 2012, the Legislature implemented 1 to 5 percent rate cuts in certain Medi-Cal payments to doctors, dentists, hospitals, and other providers that participate in Medi-Cal. (See Welf. & Inst. Code § 14105.191; Cal. Stats. 2008, ch. 758 § 45.)

vii. The Legislature again imposed 10 percent rate cuts in 2011 that were subject to court challenge, but ultimately implemented in 2013. (Welf. & Inst. Code § 14105.192(d)(1); Cal. Stats. 2011, ch. 3 § 93.5; *Managed Pharmacy Care v. Sebelius* (9th Cir. 2013) 716 F.3d 1235.)

viii. Currently, legislatively imposed cuts generally result in an additional 10 percent decrease in the value of physician rates compared to the fee schedule incorporated by reference into DHCS regulation. While this is ultimately a smaller driver of rate inadequacy than DHCS's failure to update the fee schedule in the face of inflation, it compounds the problems caused by that inaction, and provides a more urgent need for DHCS to act to raise rates within the scope of its authority.

150. Medi-Cal reimbursement rate cuts—via action and inaction—have impacted fee-for-service and managed care alike. Managed care physician payments generally parallel fee-for-service rates and capitation rates are derived from those payments. Further, the rate cuts have at times required actuarially equivalent managed care capitation rate cuts. (See, e.g., Welf. & Inst. Code § 14105.192(d)(2).)

151. The inaction and actions described above have cumulatively resulted in a steep decline in Medi-Cal reimbursement rates compared to the market for physician services since 1979:

a. Since 1979, Medicaid rates across the country have steadily risen compared to California's. On the Medicaid Fee Index, which compares Medicaid fee-for-

service payments across states, California has dropped from 125 percent of the national average in 1979 to 76 percent in 2016 for all services, which amounted to a drop from 15th to 48th out of 50 programs in amounts paid to physicians for services.

b. The adequacy of Medi-Cal rates is frequently measured by comparison to Medicare rates under state and federal law as well as in academic and policy studies, among other reasons because Medicare rates are determined using a common standard that recognizes the relative cost of care in different regions. Indeed, Defendant DHCS itself has elected to use Medicare rates for purposes of comparison.

i. For primary care, Defendants now reimburse providers who care for Medi-Cal patients just 41 percent of what Medicare reimburses providers for the same services, ranking Medi-Cal 49th out of 50 Medicaid programs in the United States, a significant drop from 1979, when they paid 69 percent of what Medicare paid and Medi-Cal ranked 37th out of 50 programs.

ii. Medi-Cal fee-for-service reimbursement rates for all services as a share of Medicare rates have fallen to the point where Medi-Cal now ranks 48th out of 50 programs and only pays 52 percent of what Medicare pays for the same service, significantly below the national average ratio for Medicaid programs of 72 percent.

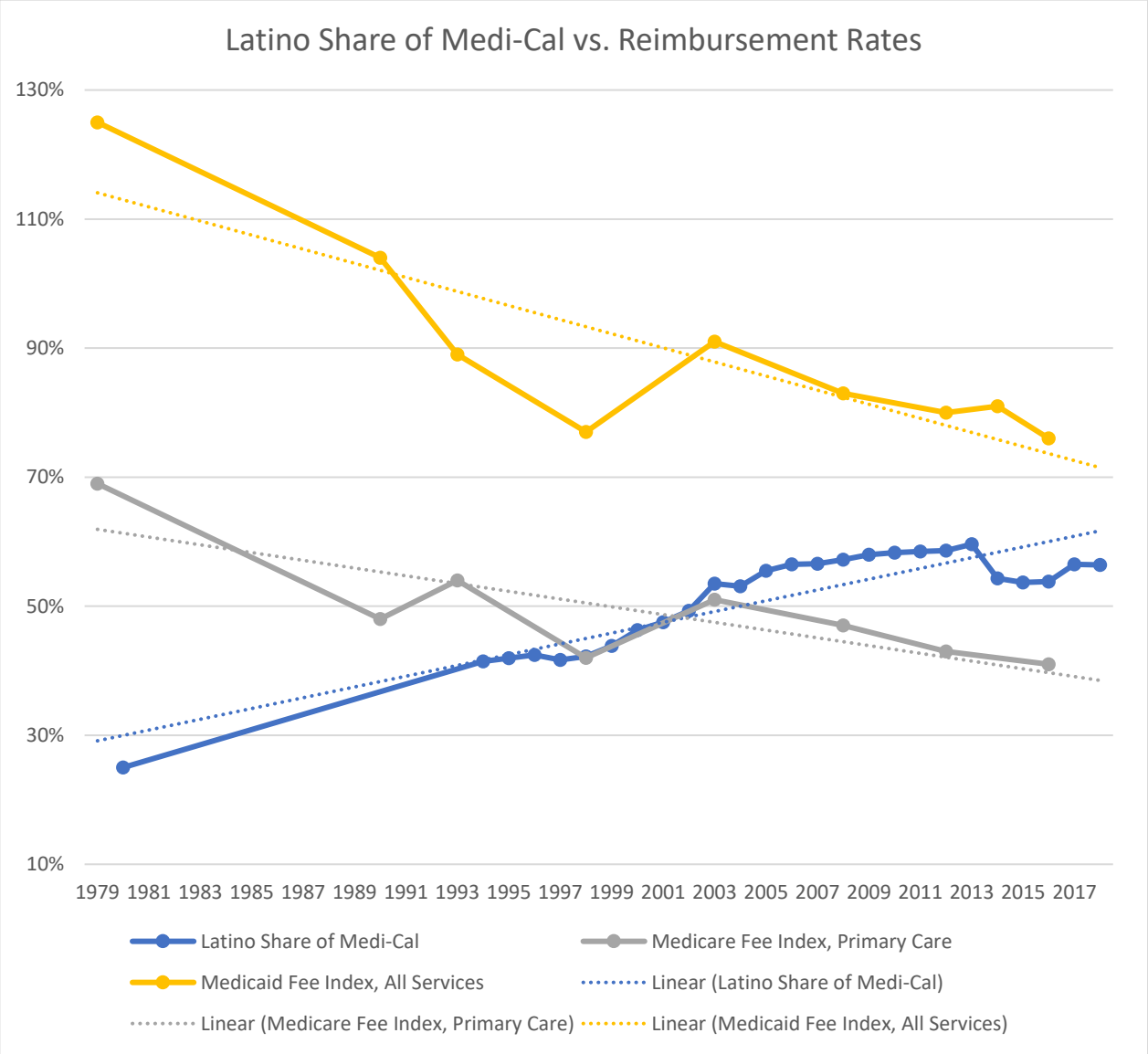
152. Constraints in the state budget do not justify Medi-Cal rate cuts. At the same time that the State has used economic constraints to justify slashing the rates and allowing them to stagnate, it has also chosen to proactively invest in Medi-Cal's long-term care services, which serve a disproportionately white population. Then, it has repeatedly failed to raise the rates in times of economic and budgetary growth, as inflation continues to eat away at their real value.

153. Moreover, were Defendants to cite the budget as a basis for its cutting the rates,

this would be legally insufficient because Defendants must design the rates to meet the requirements of the program for timely, adequate access, without exception for budget constraints. (See, e.g., *Beno v. Shalala* (9th Cir. 1994) 30 F.3d 1057, 1069 n.30.)

154. The resulting Medi-Cal reimbursement rates are so low they are often far below providers' actual costs of doing business.

155. Notwithstanding the mandatory duty of Welfare and Institutions Code section 14079 to annually review and periodically revise FFS reimbursement rates, Defendants have not done so. Thus, the FFS fee schedule has not kept pace with rates paid by other forms of insurance, and, on the whole, has repeatedly either stayed the same or decreased in the face of extraordinary medical inflation.



156. Medi-Cal's disproportionately Latino composition stands in stark contrast to the disproportionately white composition of Medicare and employer-sponsored insurance pools, which, together with Medi-Cal, comprise 92 percent of the State's insured populations. While white people are approximately 37 percent of the state population, Medi-Cal is less than a quarter white. On the other hand, Medicare is well over half white, but less than a quarter Latino, while employer-sponsored insurance is over 40 percent white and under 30 percent Latino. As stated above, access is much better in employer-sponsored insurance and Medicare.

157. Moreover, the data strikingly illustrate that current Medi-Cal participants, who are

enrolled in a program associated with a Latino population, are adversely affected by current low reimbursement rates compared to past Medi-Cal participants. When Latinos were not such a large proportion of participants, reimbursement rates were higher and more reflective of the costs of providing care, and participants had much better access to health care.

158. Medi-Cal participants are disproportionately Latino, thus the lower Medi-Cal reimbursement rates today compared to the rates paid by other forms of insurance, and even to Medi-Cal rates in the past, have an adverse, disparate impact on Latinos.

D. Market Factors, Including the Supply of and Demand for Physician Services, Show That Rates Should Have Risen Significantly Over This Time Period.

159. Expert testimony and further statistical evidence will show that economic indicators related to medical pricing demonstrate that physician payment rates should have risen significantly, rather than stagnated or decreased over the period at issue:

a. First, other payors, primarily Medicare and employer-sponsored insurance, have steadily increased their payment rates to providers over the time period at issue. These higher rates are barometers of the market for physician services. Accordingly, even if the relative number of physicians were not decreasing, Medi-Cal would still need to pay commensurately higher rates in order to compete with Medicare and employer-sponsored insurance for the limited supply of physician services, which it has not done.

b. Second, the decreased supply of physicians indicates that they should command higher rates now than in the past, yet Defendants continue to set arbitrarily low rates. The number of active physicians per 100,000 Californians dropped from 181 in 2008 to 156 in 2015, after holding steady from the mid-1980s to the early 2000s.

c. Third, physician costs, such as rent, staff salaries, malpractice insurance, and required health information technology improvements, have steadily risen throughout the relevant time period. Thus, the economics of treating patients in exchange for Medi-Cal's low reimbursement rates have worsened for physicians, who stand to lose more money than they would have in earlier years.

d. Fourth, the provider market has consolidated significantly during the relevant time period, as physicians increasingly join larger provider groups. As a result of this consolidation, physicians have greater bargaining power to demand higher rates of pay. Other payors have increased rates in the face of such consolidation. Defendants have not, effectively shutting off Medi-Cal's access to broad swaths of physicians.

160. In the face of these market factors pointing to higher rates, fiscal factors for the State have not justified Defendants' continued payment of abysmally low reimbursement rates:

a. Federal funding for Medi-Cal has *increased* over time, as the federal government takes on a larger share of the expense for more recently added populations under the Children's Health Insurance Program (CHIP) and the Affordable Care Act (ACA). Thus, increased physician payments would have put *less* of an impact on the state budget than they would have in earlier periods.

b. Defendants' cuts to Medi-Cal cannot be explained by variations in the state budget. The budget's general and special funds have consistently constituted between approximately 6 and 7 percent of the state economy since 1984, i.e., the budget has grown and contracted in line with state GDP. Medi-Cal rates, however, have not followed this trajectory. When Defendants have cut Medi-Cal rates, they have failed to raise them consistent with the long-term growth of the budget and medical inflation. Even when the economy has boomed and the state budget has soared, Defendants have repeatedly failed to use such money to bring physician rates in line with the market, instead letting them stagnate. And, when deciding to cut physician rates to save money in the budget, Defendants have done so rather than look elsewhere in the budget; have made deeper cuts than necessary; and have made the cuts despite repeat warnings that such rate cuts would negatively impact access to physician services, and despite suggestions for alternative ways to achieve savings in the budget.

E. Defendants Have Prioritized Long-Term Care Spending in the Medi-Cal Program, Which Disproportionately Serves White Participants, Over Physician Services.

161. While Defendants have repeatedly cut or held flat physician and clinician reimbursement rates in Medi-Cal, at least one other service paid for by Medi-Cal and overseen by Defendants has consistently seen rate increases over the same time period: long-term care.

162. Long-term care consists of payments to facilities that receive Medi-Cal participants for extended periods of time, primarily skilled nursing facilities. Most people receiving long-term care are seniors, who were over 75 percent of the long-term care population in 2012, the last date for which claims data is publicly available.

163. Relative to the entire population of Medi-Cal participants, which is 58 percent Latino and 22 percent white, and to the entire population of California, which is 39 percent Latino and 37 percent white, the population of individuals served by long-term care is significantly whiter. In 2012, the last year for which claims data is publicly available, the population of people on long-term care was 64 percent white and 19 percent Latino. On information and belief, and subject to further discovery and expert testimony, the population of Medi-Cal recipients in long-term care in 2018 remains nearly 60 percent white and under 25 percent Latino.

164. Defendants implement automatic rate increases for long-term care that do not exist for physician services. Defendants spell this out in the state plan for Medi-Cal, which sets forth the methodology by which Defendants automatically update long-term care reimbursement rates. As a result, long-term care rates have steadily increased while physician payments have stagnated. For example, Level B nursing facilities statewide—which are the largest category of long-term care facilities, accounting for over $4 billion in annual Medi-Cal spending—were paid a weighted average rate of approximately $140 per day in 2005, but a weighted average rate of approximately $210 per day in 2017, an increase of approximately 50 percent, representing over 3 percent annualized growth. Freestanding subacute nursing facilities saw equally fast increases between 2005 and 2014, growing from approximately $140 to $190 per day, an increase of 36 percent, also over 3 percent annualized growth. From 2003 to 2007, nursing home reimbursement rates increased by 31.5 percent, faster than the national average of 23.4 percent. As stated above,

physician payments either stayed flat or decreased over the same time period.

165. Unlike physician services, which dropped from 125 percent of the national Medicaid average in 1979 to 76 percent of that average in 2016, California's long-term care rates have increased relative to national averages, steadily rising from 73 percent of that average in 1984 to 93 percent of the national Medicaid average in 2007. On information and belief, and subject to further discovery and expert analysis, California's long-term care rates have continued to grow faster than the national average since 2007, and are now around the national average.

166. Long-term care payments are a significant part of Medi-Cal spending. They represented 31% of total Medi-Cal spending in FY 2010. Thus, Defendants have made the conscious decision to prioritize long-term care, which disproportionately serves white participants, over physician services, which serve the broader, more Latino Medi-Cal population. Notably, these two populations barely overlap. Ninety percent of long-term care patients have their physician services covered by Medicare, shielding them from the effects of declining physician payment rates in Medi-Cal.

167. Market factors affecting pricing for these long-term care facilities do not indicate that their rates should have risen more than physician services. In fact, those factors show that physician services rates should have risen faster. For example, occupancy rates at long-term care facilities have held relatively constant since at least 2005. Moreover, long-term care services are subject to the same budgetary constraints as physician services, yet Defendants have raised reimbursement rates for the service that disproportionately serve white people, long-term care, and not for the service that disproportionately serves Latinos, physician services.

F. The Discriminatory Nature of Defendants' Disinvestment Is Consistent with the Historical Context of Discrimination Against Latinos in the Provision of Health Care Benefits As Well As Remarks of Decisionmakers Indicating Bias.

168. Defendants' disinvestment from Medi-Cal is motivated by group animus against Latinos, as are their continued underinvestment and failure to adequately ensure access. Defendants' conduct over the years further demonstrates this animus.

169. From practically its start, decision-makers' attitudes about Medi-Cal have been

racially charged. For example, in December 1970, just five years after the passage of Medi-Cal's implementing legislation, California's Human Relations Secretary, who oversaw Medi-Cal at that time, proclaimed that "welfare and its voracious accomplice—Medi-Cal—have dragged California to the brink of financial disaster" and bemoaned that immigrants were burdening the system because of court decisions striking down state residency requirements, stating that "Wetbacks from Mexico collect welfare and health care." These remarks were made concurrent with attempts by the executive branch to impose 10 percent rate cuts to physicians pursuant to Welfare & Institutions Code section 14120, which were blocked by a court.

170. The obsession with Latinos' use of Medi-Cal reached a fever pitch in later decades, as the Latino share of the state population—and Medi-Cal enrollees—grew significantly. For example, one former HHSA secretary and Department of Health Services (DHS) director, the predecessor agency to Defendant DHCS, claimed in August 1993 that Medi-Cal incentivized "illegal immigrants" to come to California. Similarly, a DHS deputy director stated around this time that "[w]e need to put some teeth into the residency requirements; to try to not make Medi-Cal a magnet for people solely coming here for medical care." When discussing undocumented immigrants' use of health benefits in February 1993, the chair of the State Senate's Special Committee on Border Issues stated that "[i]t seems rather strange that we go out of our way to take care of the rights of these individuals who are perhaps on the lower scale of our humanity, for one reason or another."

171. While ostensibly about immigration status, these comments were in actuality coded racial dog whistles, reflecting and resulting in bias against Latinos generally, as Plaintiffs will demonstrate via further factual evidence and expert testimony.

172. For example, beginning in 1994, Defendants singled out and sought repayment from Latinos in Medi-Cal in collaboration with the federal Immigration and Naturalization Service (INS). In these efforts, people returning to the country from Mexico were asked about their use of Medi-Cal and told to repay benefits before reentering the country even if they were properly covered by Medi-Cal insurance. The State Auditor documented DHS's wrongful threats

to imprison and attempts to influence immigration status, as well as demands for repayment higher than the actual cost of Medi-Cal benefits received. DHS officials singled out Latina women with young children to interrogate about who paid for their children's birth, regardless of their immigration status. Unsurprisingly, these programs, as well as the conduct of DHS fraud investigators and staff, intimidated Latinos and chilled their participation in Medi-Cal.

173. As recently as October 2017, Defendant Kent referred to the population on Medi-Cal as "not like us" and called them "bennies," earning a rebuke from the Little Hoover Commission, which found her "tone and tenor" to be "troubling," "when discussing the millions of Californians the department is charged to serve."

174. Plaintiffs intend to introduce additional evidence of the historical context of the State's disinvestment from Medi-Cal following discovery.

VIII. SUMMARY OF UNLAWFUL METHODS OF ADMINISTRATION

175. In sum, Defendants maintain methods of administration that have the purpose and effect of subjecting Latinos to discrimination, and that defeat and impair the purposes of the Medi-Cal program with respect to Latinos.

176. Defendants' unlawful methods of administration include policies, practices, actions, and inactions.

177. One such unlawful method of administration is Defendants' disinvestment from Medi-Cal over time as the program has become more Latino. (See, e.g., ¶¶ 148-174, *supra*.) This disinvestment is comprised of a number of closely related actions and inactions, including the following:

a. Inappropriately low/discriminatory rates: Defendants have caused the real value of fee-for-service reimbursements and managed care payments to physicians to fall significantly, by allowing them to stagnate. (See, e.g., ¶¶ 14, 15, 105, 149, 159, *supra*.)

b. Failure to conduct rate reviews: Defendants are required to conduct regular rate reviews and have failed to do so. (See, e.g., ¶¶ 17, 88, 104, 155, *supra*.)

c. Failure to consider required access factors: When they have set or cut fee-for-service reimbursement and managed care capitation rates, Defendants have failed to sufficiently consider substantive access requirements (see, e.g., ¶¶ 104, 112, *supra*) and have inappropriately relied on budgetary factors (see, e.g., ¶¶ 149.b.iv, 153).

d. Inappropriate managed care rate-setting methodology: Defendants employ a methodology for setting Medi-Cal managed care rates that results in arbitrarily low payments to providers, and fail to ensure that payments to providers are sufficient to ensure meaningful access to care. (See, e.g., ¶¶ 107-116, *supra*.)

e. Failure to warn: Defendants have failed to notify other actors also involved with Medi-Cal reimbursement rates, including other members of the executive branch, the Legislature, and the federal government, that payments to providers are too low to ensure equal and adequate access to care. (See, e.g., ¶¶ 98-100, *supra*.)

f. False certification: Moreover, Defendants have actively misled them by certifying that the rates are adequate, despite that they knew or should have known that was not the case. (¶ 100.)

g. Increasing long-term care rates: Meanwhile, Defendants have steadily increased reimbursement rates for Medi-Cal's long-term care services, which disproportionately serve white Medi-Cal participants. (See, e.g., ¶¶ 13, 161; Section VII.E, *supra*.)

178. A second unlawful method of administration is Defendants' failure to monitor and enforce network adequacy and other substantive Medi-Cal requirements. (¶ 92; Section VII.A.3, *supra*.).

a. Defendants are failing to implement and monitor compliance with Medi-Cal managed care network adequacy requirements. (¶ 129-135.)

b. Defendants allow managed care organizations to participate in Medi-Cal despite knowing that they have too few providers in their networks, including by allowing

participation of sub-capitated networks without adequate oversight. (¶ 133, 135.)

179. A third unlawful method of administration is Defendants' creation of administrative burdens that thwart access to healthcare for Medi-Cal participants. (See, e.g., ¶¶ 136-140, *supra*.)

a. Defendants impose unnecessary administrative burdens on payments to providers. (See, e.g., ¶ 136, *supra*.)

b. Defendants subject providers to clawbacks. (See, e.g., ¶ 137, *supra*.)

c. Defendants unduly delay payments to providers. (See, e.g., ¶ 138, *supra*.)

d. Defendants allow Medi-Cal managed care plans to delay and deny care to participants, including through setting time limits on referrals to specialists, imposing other difficult administrative barriers to referrals to specialists, and by allowing subcapitated networks that reduce plan participants' access to care. (See, e.g., ¶ 139, *supra*.)

180. All these methods of administration, collectively and individually, harm access to care for Medi-Cal's growing Latino population, who are denied the meaningful access that is the core objective of the Medi-Cal program.

181. All these methods of administration, collectively and individually, constitute prohibited discrimination and are unlawful under Government Code section 11135 and California Code of Regulations, title 2, section 11154(i)(2), as well as the Equal Protection and Substantive Due Process Clauses of the California Constitution, as set forth below.

IX. CAUSES OF ACTION

First Cause of Action [Preserved for Appeal]

Gov. Code § 11135 *et seq.*; 2 Cal. Code Regs. § 11154(i)(2)
Discrimination – Defeating or Substantially
Impairing the Objectives and Purposes of the Program:
Discriminatory Effects
By all Plaintiffs against all Defendants

182. Plaintiffs re-allege and incorporate by reference all preceding allegations in the complaint as though fully set forth here.

183. Government Code section 11135 and its implementing regulations prohibit

discrimination in programs or activities funded by the State. Section 11135(a) provides, in pertinent part, that "[n]o person in the State of California shall, on the basis of . . . race, national origin, ethnic group identification . . . [or] color . . . be unlawfully denied full and equal access to the benefits of, or be unlawfully subjected to discrimination under, any program or activity that is conducted, operated, or administered by the state or by any state agency, is funded directly by the state, or receives any financial assistance from the state."

184. Medi-Cal is subject to Section 11135 and the implementing regulations because Defendants conduct, operate, or administer Medi-Cal as a program or activity and Medi-Cal is a state-funded program.

185. Regulations implementing Section 11135 provide that it is an unlawful, discriminatory practice "to utilize criteria or methods of administration that . . . have the purpose or effect of [1] subjecting a person to discrimination on the basis of ethnic group identification . . . [or] [2] defeating or substantially impairing the accomplishment of the objectives of the recipient's program with respect to a person of a particular ethnic group identification . . . ." 2 Cal. Code Regs. § 11154(i)(2).

186. Key objectives and purposes of the Medi-Cal program include affording equal, adequate, and timely access to all Medi-Cal participants, including but not limited to:

a. "allow[ing] . . . eligible persons to secure health care in the same manner employed by the public generally, and without discrimination or segregation based purely on their economic disability," Welf. & Inst. Code § 14000(a);

b. ensuring "reasonable access of Medi-Cal beneficiaries to physician and dental services" by evaluating and periodically revising rates within the statewide and geographic markets for those services in relation to prevailing customary charges, the physicians' services component of the Consumer Price Index, Medicare, Blue Shield, and other third-party payors, Welf. & Inst. Code § 14079;

c. fulfilling legal duties to ensure that Medi-Cal providers meet minimum time, distance, and physician-patient ratio standards for primary and specialty care, *see*,

e.g., Welf. & Inst. Code § 14197; Health & Safety Code §§ 1340-1399.864; 28 Cal. Code Regs. §§ 1000-1300.826;

d. ensuring equal access for Medi-Cal participants comparable to the access available to other insured Californians, as well as making care available with reasonable promptness. *See* 42 U.S.C. § 1396a(a)(30)(A); 42 U.S.C. § 1396a(a)(8); *see also* California Medi-Cal State Plan; 22 Cal. Code Regs. § 50004.

187. Defendants' methods of administering Medi-Cal are defeating and impairing these objectives and purposes of the Medi-Cal program set forth in, among other law, the Welfare & Institutions Code, the Knox-Keene Act, the Medicaid Act, and the Medi-Cal state plan — all of which reflect the legislative intent that Medi-Cal patients should receive health care that is equal to that provided to people with other forms of health insurance in California.

188. Defendants' actions and inactions—including setting arbitrary, low reimbursement rates, failing to meet mandatory duties to periodically review and to revise those rates to ensure access, and failing to monitor and enforce managed care access requirements—have resulted in limiting health care access for Medi-Cal participants, by, among other things, limiting the number of physicians and other providers willing to serve Medi-Cal participants, and by encouraging physicians and other providers to give preference to disproportionately white patients with private insurance or Medicare, by reserving for their exclusive use appointments and beds which are, due to Defendants' policies and methods of administration, unavailable to Medi-Cal patients.

189. Defendants' actions and inactions discriminate against Latinos because they are the majority of Medi-Cal participants and are overrepresented in that insurance program. Because of Latinos' increased enrollment in Medi-Cal, Defendants' policies limiting the number of physicians and other providers that will accept arbitrarily low Medi-Cal reimbursement rates disproportionately harm Latinos.

190. Defendants' actions and inactions result in segregating the health care system when, by law, California's health care system is intended to be a single, integrated system in which Medi-Cal participants receive equal access to health care as the rest of the insured

population. Instead, Defendants' actions and inactions have created a two-tier system: an inferior tier for Medi-Cal recipients, who are predominantly Latino, and a superior tier for people with Medicare and private insurance, who are predominantly white. The two-tier system defeats the objectives and purposes of the Medi-Cal program.

191. Defendants' actions and inactions violate the rights of Plaintiffs and the proposed class under Section 11135 and Section 11154(i)(2); wherefore, Plaintiffs are entitled to declaratory and injunctive relief as set forth below.

Second Cause of Action [Preserved for Appeal]
Gov. Code § 11135 et seq.; 2 Cal. Code Regs. § 11154(i)(2)
Discrimination – Defeating or Substantially
Impairing the Objectives and Purposes of the Program:
Discriminatory Purpose
By all Plaintiffs against all Defendants

192. Plaintiffs re-allege and incorporate by reference all preceding allegations in the complaint as though fully set forth here.

193. Defendants' actions and inactions described above have been taken with unlawful, discriminatory intent, motivated by anti-Latino animus.

194. Evidence of such discriminatory intent includes, but is not limited to, Defendants' numerous departures from normal procedures for administration of Medi-Cal — such as their failure to conduct mandatory rate reviews and revisions, their failure to enforce mandatory network adequacy and access requirements, and their failure to conduct mandatory oversight of access within the Medi-Cal program — the stark access disparities demonstrated by statistical evidence, their history of biased remarks and conduct with respect to Medi-Cal's Latino participants, the foreseeability of harm to Latinos from Defendants' conduct, their history of disinvestment from Medi-Cal as its participants have become more Latino (set forth below as separate causes of action), and other evidence to be identified in discovery.

195. Defendants' actions and inactions violate the rights of Plaintiffs and the proposed class under Section 11135 and Section 11154(i)(2); wherefore, Plaintiffs are entitled to declaratory and injunctive relief as set forth below.

Third Cause of Action [Amended]
Gov. Code § 11135 *et seq.*; 2 Cal. Code Regs. § 11154(i)(2)
Discrimination – Disinvestment
Discriminatory Effects
By all Plaintiffs against all Defendants

196. Plaintiffs re-allege and incorporate by reference all preceding allegations in the complaint as though fully set forth here.

197. It is a discriminatory practice under Section 11135 for a state-funded program or a program conducted, operated or administered by a state agency to disinvest from or limit the provision of its benefits as that program's benefits are increasingly extended to members of a protected class.

198. It is a discriminatory practice under Section 11154(i)(2) to implement "criteria or methods of administration that . . . have the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of . . . [a] program with respect to" Latinos, i.e., persons "of a particular ethnic group identification."

199. Defendants have discriminated against the Plaintiff class of Medi-Cal participants by disinvesting from the Medi-Cal program and underfunding it as Latino enrollment in the Medi-Cal program has increased. (See, e.g., *supra* § VII.C.)

200. Defendants' disinvestment constitutes a method of administration that has the effect of defeating and/or substantially impairing the objectives of Medi-Cal with respect to Latino Medi-Cal participants. (See, e.g., *supra* § VI.) Defendants' disinvestment includes allowing the real value of rates to fall significantly, insufficient enforcement and monitoring of access, and imposing administrative barriers to care. (See ¶¶ 175-180, *supra*.)

201. By allowing reimbursement rates to stagnate and implementing rate cuts, thus increasingly failing to ensure that payments to physicians are adequate to afford meaningful access to care, and through the additional methods of administration described herein, ¶¶ 175-180, Defendants have caused an unjustified disparate impact on Latinos in the form of significantly reduced and inadequate access to health care, seriously harming the health of Plaintiffs and the members of the Plaintiff class.

202. Defendants' disinvestment disparately impacts Medi-Cal participants today, who

are overwhelmingly and disproportionately Latino, as compared to Medi-Cal participants in the past, who were significantly less Latino.

203. This disinvestment has built upon and perpetuated past discrimination, when rates were set arbitrarily low as the share of Latino participants rapidly grew.

204. The inadequate access driven by this disinvestment is compounded by DHCS's failure to monitor and enforce access requirements, as well as administrative barriers created by its administration of Medi-Cal.

205. This disinvestment has taken place despite supply- and demand-side economic factors, which show that physician payment rates should have risen. (See *supra* § VII.D.)

206. Moreover, rates have actually increased for the subpopulation of Medi-Cal participants that *is* disproportionately white—those on long-term care. (See *supra* § VII.E.) Indeed, the comparison to long-term care, while supporting the larger disinvestment theory along with the other cumulative evidence set forth herein, also supports, in the alternative, a standalone, traditional discrimination claim, whereby a protected class is treated worse than their white comparators.

207. Thus, the disinvestment claim challenges the cumulative effect, worsening over time, of a number of different actions and inactions, including: (1) that DHCS has failed to set adequate Medi-Cal fee-for-service reimbursement rates and managed care capitation rates, including by letting rates stagnate in the face of inflation and implementing rate cuts, while failing to complete their mandatory duties to review and set rates, as well as failing to recommend or request that the state Legislature fund adequate Medi-Cal fee-for-service reimbursement rates and managed care capitation rates, while knowingly misrepresenting to other parts of the executive branch, the Legislature, and the federal government that current rates are adequate to meet their obligations; (2) that DHCS has failed to adequately monitor access and enforce network adequacy standards; and (3) that DHCS has created administrative burdens that deter physician participation in Medi-Cal and otherwise limit access.

208. Defendants' disinvestment violates the rights of Plaintiffs and the proposed class

under Section 11135 and Section 11154(i)(2); wherefore, Plaintiffs are entitled to declaratory and injunctive relief as set forth below.

Fourth Cause of Action [Amended]
Gov. Code § 11135 *et seq.*; 2 Cal. Code Regs. § 11154(i)(2)
Discrimination – Disinvestment
Discriminatory Purpose
By all Plaintiffs against all Defendants

209. Plaintiffs re-allege and incorporate by reference all preceding allegations in the complaint as though fully set forth here.

210. Defendants' disinvestment actions constitute unlawful, intentional discrimination, motivated by anti-Latino animus.

211. Defendants carried out this intentional unequal treatment by purposefully disinvesting from the program over time.

212. Evidence of Defendants' discriminatory intent includes, but is not limited to, the following:

- Defendants' disinvestment from Medi-Cal as its participants have become more Latino;
- Departures from normal procedures for administration of Medi-Cal—such as Defendants' failure to conduct mandatory rate reviews and revisions, their failure to enforce mandatory network adequacy and access requirements, and their failure to conduct mandatory oversight of access within the Medi-Cal program;
- Stark access disparities demonstrated by statistical evidence;
- Defendants' history of biased remarks and conduct with respect to Medi-Cal's Latino participants;
- The foreseeability of harm to Latinos from Defendants' actions and inactions;
- Defendants' relatively higher funding for long-term care that disproportionately serves white Medi-Cal participants; and
- Other factual and expert evidence to be identified and produced in discovery, and offered at trial.

213. Defendants' disinvestment has defeated and substantially impaired the objectives and purposes of Medi-Cal.

214. Defendants' disinvestment perpetuates and builds upon past discrimination, when rates were set arbitrarily low as a result of the growing Latino enrollment in the program, which officials responsible for administering Medi-Cal referred to in alarmist, racially coded and explicitly racist language.

215. Defendants' purposeful disinvestment violates the rights of Plaintiffs and the proposed class under Section 11135 and Section 11154(i)(2); wherefore, Plaintiffs are entitled to declaratory and injunctive relief as set forth below.

Fifth Cause of Action [Preserved for Appeal]
Cal. Const. Art. I, § 7(a) & Art. IV, § 16(a)
California Constitution – Equal Protection
Discriminatory Effects Based on Comparison to the General Insured Population
By all Plaintiffs against all Defendants

216. Plaintiffs re-allege and incorporate by reference all preceding allegations in the complaint as though fully set forth herein.

217. As set forth above, Defendants fail to ensure equal access to health care.

218. Latinos are a protected class under the California Constitution.

219. Access to health care is a fundamental right under the California Constitution.

220. Medi-Cal beneficiaries are similarly situated to the remainder of the general insured population with regard to their health care access under the California Constitution because (a) access to health care is a fundamental right; (b) the California Legislature has declared that the Medi-Cal program is intended to provide Medi-Cal participants with access that is equal to the access that exists for people with Medicare and private insurance, a requirement also reflected in the federal Medicaid Act and Section 14079; and (c) Defendants license and certify all health care providers and facilities in the State of California, and those providers and facilities serve Medi-Cal, Medicare, and private pay patients alike.

221. Defendants' challenged conduct has an unjustified discriminatory effect on Medi-Cal participants who are disproportionately Latino, as compared to the remainder of the general

insured population, which is disproportionately white.

222. Defendants have violated the rights of Plaintiffs and the proposed class to receive equal protection of the laws, pursuant to Article I, section 7(a) and Article IV, section 16(a) of the California Constitution, by failing to provide them with access to care comparable to the remainder of the general insured population.

Sixth Cause of Action [Preserved for Appeal]
Cal. Const. Art. I, § 7(a) & Art. IV, § 16(a)
California Constitution – Equal Protection
Discriminatory Purpose Based on Comparison to the General Insured Population
By all Plaintiffs against all Defendants

223. Plaintiffs re-allege and incorporate by reference all preceding allegations in the complaint as though fully set forth herein.

224. Defendants' unlawful conduct is intentional.

225. Plaintiffs have given notice of their claims to the State but Defendants have provided no relief. Defendants are aware of the harm that their underfunding of the Medi-Cal program is causing to Medi-Cal participants, that the population is predominantly Latino, and that the Latino share of participants has been growing, and have failed to remedy the grave access disparities and ongoing harm to Medi-Cal participants' health despite their knowledge.

226. Defendants' disinvestment from Medi-Cal, continued egregious failure to implement Medi-Cal programs to provide access to health care equal to that of the remainder of the general insured population of California, departures from standard procedures and legal requirements, history of discrimination against Latinos, and multiple remarks evidencing bias against the disproportionately Latino Medi-Cal population indicate unlawful discriminatory intent on the part of the State. Plaintiffs intend to ascertain further evidence of discriminatory intent in discovery.

227. Defendants have violated the rights of Plaintiffs and the proposed class to receive equal protection of the laws, pursuant to Article I, section 7(a) and Article IV, section 16(a) of the California Constitution, by purposely discriminating against them based on the fact that Medi-Cal

is a predominantly Latino program, contrary to the purposes of Medi-Cal to ensure access to care for all Medi-Cal participants equal to the access to health care of the remainder of the general insured population.

Seventh Cause of Action [Amended]
Cal. Const. Art. I, § 7(a) & Art. IV, § 16(a)
California Constitution – Equal Protection
Discriminatory Effects Based on Disinvestment
By all Plaintiffs against all Defendants

228. Plaintiffs re-allege and incorporate by reference all preceding allegations in the complaint as though fully set forth herein.

229. Defendants have discriminated against the Plaintiff class of Medi-Cal participants by disinvesting from the Medi-Cal program and underfunding it as Latino enrollment in the Medi-Cal program has increased.

230. Present Medi-Cal participants are similarly situated to past Medi-Cal participants in all relevant respects, including but not limited to with regard to supply- and demand-side factors indicating that Medi-Cal payments to physicians should be rising to keep pace with the market, such as shrinking physician supply, rising costs of doing business for physicians, industry-wide physician consolidation, and increasing payments from other payors competing for the same limited supply of physician services.

231. Defendants' challenged conduct has an unjustified discriminatory effect on Latinos, who are currently disproportionately represented in the Medi-Cal program and now comprise a majority of Medi-Cal participants, as compared to past Medi-Cal participants, who were significantly less Latino.

232. Defendants have also created an unlawful classification within the Medi-Cal program as between long-term care participants, who are disproportionately whiter and receive the benefits of regular rate increase as compared to recipients of physician services, who are disproportionately Latino and subjected to the State's discriminatory, inadequately low rates that result in denials of the benefits that Medi-Cal is supposed to provide.

233. This disinvestment has built upon and perpetuated past discrimination, when rates

were set arbitrarily low as the share of Latino participants rapidly grew.

234. Defendants have thus violated the rights of Plaintiffs and the proposed class to receive equal protection of the laws, pursuant to Article I, section 7(a) and Article IV, section 16(a) of the California Constitution, disinvesting from the Medi-Cal program as it has become more disproportionately Latino.

Eighth Cause of Action [Amended]
Cal. Const. Art. I, § 7(a) & Art. IV, § 16(a)
California Constitution – Equal Protection
Discriminatory Purpose in Disinvestment
By all Plaintiffs against all Defendants

235. Plaintiffs re-allege and incorporate by reference all preceding allegations in the complaint as though fully set forth herein.

236. Defendants intentionally discriminated against Latinos by increasingly flouting the law's equal access requirements and purposefully disinvesting from the program over time as it became predominantly Latino.

237. Defendants' discriminatory intent is further demonstrated by the context for this disinvestment, including a history of remarks by decisionmakers indicative of bias, administration of the program in a way that deters Latino access to benefits, contemporaneous failures to follow regulatory and statutory requirements governing the administration of Medi-Cal, the foreseeability of harm to Latinos from their actions and inactions, significantly higher reimbursement for long-term care catering to disproportionately white Medi-Cal participants, and other evidence to be identified in discovery.

238. Defendants' disinvestment perpetuates and builds upon past discrimination, when rates were set arbitrarily low as a result of the growing Latino enrollment in the program, which officials responsible for administering Medi-Cal referred to in alarmist, racially coded language.

239. Defendants have thus violated the rights of Plaintiffs to receive equal protection of the laws, pursuant to Article I, section 7(a) and Article IV, section 16(a) of the California Constitution by failing to provide them with access to health care provided to Medi-Cal

participants when there were fewer Latinos enrolled.

Ninth Cause of Action [Amended]
Cal. Const. Art. 1, §7(a)
California Constitution – Substantive Due Process
By all Plaintiffs against all Defendants

240. Plaintiffs re-allege and incorporate by reference all preceding allegations in the complaint as though fully set forth herein.

241. Article 1, section 7(a) of the California Constitution guarantees Plaintiffs the right of substantive due process, which prohibits Defendants from infringing on Plaintiffs' constitutionally protected property and liberty interests, or fundamental rights, in a manner that shocks the conscience.

242. As government agencies charged with the duty of implementing the Medi-Cal program, Defendants have had ample time and opportunity to consider how their challenged conduct would likely harm Plaintiffs' and the class's health, and acted with knowledge and deliberate indifference in failing to ensure adequate access to health care as required by law.

243. Defendants substantially infringed state law because of their anti-Latino animus. Defendants intentionally discriminated against Latinos by treating the predominately Latino Medi-Cal program worse than it treated the program when it was not predominately Latino and by favoring disproportionately white populations within Medi-Cal. Defendants carried out this intentional unequal treatment by disinvesting from the program, failing to conduct mandatory rate reviews and revisions, and by violating their own minimum access standards and monitoring requirements.

244. Defendants' anti-Latino animus is further demonstrated by, for example, the history of singling out Latinos for denial of access to health care, discriminatory remarks by Medi-Cal decisionmakers, and other conduct to be identified in discovery.

245. Defendants intentionally discriminated against Latinos by violating the constitutional protections and the state civil rights law's prohibitions on disinvesting from a state-funded benefits program because the program became predominately Latino. Defendants'

intentional disinvestment was motivated by their anti-Latino animus and carried out in violation of Article I, section 7(a) and Article IV, section 16(a) of the California Constitution; Government Code section 11135; and California Code of Regulations, title 2, section 11154.

246. Defendants intentionally discriminated against Latinos by failing to enforce time, distance, and provider-patient ratio standards, which require, *inter alia*, that primary care physicians are no more than thirty minutes or fifteen miles from the residence of Medi-Cal enrollees; and that Medi-Cal enrollees do not have to wait more than fifteen days for an appointment with a specialist. They also intentionally discriminate against Latinos through other methods of administration that constitute unlawful discrimination. (¶¶ 175-180.) Defendants blatantly violated their own standards because the Medi-Cal program became predominately Latino.

247. Defendants undertook the duty to provide Plaintiffs with sufficient access to medical care by establishing the Medi-Cal program, holding it out as a sufficient source of health care for indigent Californians who cannot afford alternative health care programs, and providing a justification for employers of indigent workers not to provide employer-sponsored insurance.

248. Defendants have acted and continue to act with deliberate indifference, which is beyond negligent. Defendants engage in conscience-shocking behavior by having actual knowledge that they have created an objectively, sufficiently serious risk to Plaintiffs' known medical needs by deciding to undertake the duty of providing the sole means of adequate access to medical care for indigent Californians, and then deliberately violating their own minimum access standards and deliberately disinvesting from the Medi-Cal program because it became predominately Latino.

249. Defendants violated Plaintiffs' due process rights by creating an excessive health risk to Plaintiffs' known medical needs and then disregarding it despite their legal duty to provide Plaintiffs adequate access to medical care. Defendants intentionally denied and delayed Plaintiffs' access to needed medical care knowing that their administration of the Medi-Cal program created conditions posing a risk of objectively, sufficiently serious harm to Plaintiffs' health if they did

not receive needed medical treatment.

250. Defendants' administration of the Medi-Cal program deliberately flouted their own minimum access laws as well as anti-discrimination laws and constitutional protections. Defendants undertook the duty of providing Plaintiffs with their sole means of accessing medical care, and then deprived Plaintiffs adequate access to needed care despite the known risk and actual outcome of harming Plaintiffs' health.

251. Defendants knew about Plaintiffs' medical needs and intentionally denied and delayed Plaintiffs' access to needed treatment, which harms Plaintiffs' health and deprives them of their constitutionally protected property interests, liberty interests, and fundamental rights.

Tenth Cause of Action
Code Civ. Proc. § 526a
Taxpayer's Action for Injunctive Relief
By all Plaintiffs against all Defendants

252. Plaintiffs re-allege and incorporate by reference all preceding allegations in the complaint as though fully set forth herein.

253. Plaintiffs are citizens and residents of the United States and of the State of California who were assessed and have paid taxes to the State of California within one year of the commencement of this action.

254. Defendants, by illegally discriminating against Plaintiffs and the class as alleged herein, have expended and wasted tax monies of the State of California in an illegal manner. Defendants will continue to expend and waste tax monies as alleged herein in violation of California law to the irreparable injury of Plaintiffs, requiring a multiplicity of suits, unless restrained by the issuance of an injunction under California Code of Civil Procedure § 526a.

Eleventh Cause of Action
Code of Civil Procedure § 1085
Writ of Ordinary Mandate
By All Petitioners Against All Respondents

255. Plaintiffs re-allege and incorporate by reference all preceding allegations in the complaint as though fully set forth herein.

256. Petitioners are beneficially interested parties entitled to a peremptory writ to "compel the performance of an act which the law specifically enjoins." (Code of Civ. Proc. § 1085.)

257. Under the Constitution, the California Government Code and the Medicaid and Medi-Cal statutes, all Respondents have a legal duty to administer the Medi-Cal program on a non-discriminatory basis, including the duty to refrain from imposing criteria or methods of administration that have the purpose or effect of defeating or substantially impairing the objectives of the Medicaid and Medi-Cal programs on the basis of protected characteristics, including race, color, and ethnic group identification.

258. Respondents are failing, as set forth herein, to comply with their ministerial legal duties:

a. under the equal protection clause of the California Constitution, to ensure equivalent access to health care.

b. under the substantive due process clause of the California Constitution, to not infringe upon Plaintiffs' constitutionally protected liberty and property interests, as well as their fundamental rights, in a manner that shocks the conscience;

c. under Government Code section 11135, to ensure that Medi-Cal beneficiaries are not unlawfully denied full and equal access to the benefits of the Medi-Cal Program, or unlawfully subjected to discrimination; and

d. under title 2, section 11154(i)(2) of the California Code of Regulations, to refrain from implementing "criteria or methods of administration that . . . have the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of . . . [a] program with respect to" Latinos, i.e., persons "of a particular ethnic group identification."

259. Respondents do not have the legal discretion to administer the Medi-Cal program in a way that violates these ministerial duties.

260. Petitioners lack a plain, speedy, and adequate remedy at law except by way of

peremptory writ of mandate pursuant to California Code of Civil Procedure section 1085.

X. PRAYER FOR RELIEF [AMENDED]

WHEREFORE Plaintiffs pray for judgment and the following specific relief:

a) A declaration that Defendants' actions have violated the rights of Plaintiffs to be free from discrimination under Government Code section 11135 and its implementing regulations, and to equal protection and substantive due process under the California Constitution;

b) An order and judgment enjoining Defendants from violating Government Code section 11135 and its implementing regulations, as well as the substantive due process and equal protection clauses of the California Constitution, including but not necessarily limited to an order enjoining Defendants to:

i. Take all steps necessary and under Defendants' control to design, enact into law, and place into operation a plan for paying reimbursement rates to doctors and clinicians for treating Medi-Cal beneficiaries that complies with all existing laws, affords meaningful access consistent with the objectives of the program, and that ensures non-discrimination;

ii. Take all steps necessary and under Defendants' control to design, enact into law, and place into operation a plan for ensuring payments to providers in Medi-Cal managed care networks that complies with all existing laws, ensures meaningful access consistent with the objectives of the program, and ensures non-discrimination;;

iii. Seek funding sufficient to set Medi-Cal reimbursement rates that are consistent with the objectives of the Medi-Cal program, including the objectives of providing meaningful access to health care for Medi-Cal beneficiaries that complies with all existing laws, and operating the Medi-Cal program without any discriminatory impact or purpose;

iv. Cease all methods of administration that are causing unlawful discrimination;

v. Adequately monitor and enforce existing network adequacy and timely access requirements for all Medi-Cal beneficiaries; and

vi. Remove excessive barriers to access to care for Medi-Cal beneficiaries, including by ensuring timely payment to physicians and other clinicians, and by facilitating referrals to specialists.

(*See Serrano v. Priest* (1976) 18 Cal.3d 728, 751-752.)

c) A Writ of Mandate pursuant to California Code of Civil Procedure section 1085 requiring Defendants to comply with Government Code section 11135 and its implementing regulations, as well as with the substantive due process and equal protection clauses of the California Constitution.

d) Reasonable attorney fees and costs of suit;

e) Continued exercise of jurisdiction to oversee compliance; and

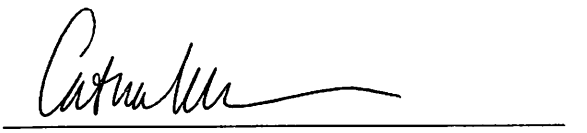
e) Such other and further equitable relief as this Court may deem appropriate and just.

Respectfully submitted,

MEXICAN AMERICAN LEGAL DEFENSE AND EDUCATIONAL FUND
Thomas A. Saenz

CIVIL RIGHTS EDUCATION AND ENFORCEMENT CENTER
Bill Lann Lee
Tim Fox

FEINBERG, JACKSON, WORTHMAN & WASOW LLP
Catha Worthman
Darin Ranahan
Andrea Obando

Dated: March 8, 2019 By: 

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ATTORNEYS FOR PETITIONERS/PLAINTIFFS

VERIFICATION

I, Esther Castañeda, state that:

1. I am a petitioner in the above-entitled action.

2. I am aware of the nature of the Third Amended Verified Petition for Writ of Mandate and Complaint for Declaratory and Injunctive Relief being filed on my behalf, the legal bases for the Petition, and the relief being sought.

3. To the extent that the Petition is based upon facts known to me, including the facts stated under my name in the section entitled "Parties," I verify them to be true, and otherwise I am informed and believe that all facts herein are true.

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

Executed on March 6, 2019 at Sacramento, California.

Petitioner and Plaintiff

I, Lisbeth Espinoza, hereby declare under penalty of perjury that I am proficient in both Spanish and English, and have read the declarant's portion of the Third Amended Verified Petition for Writ of Mandate and Complaint for Declaratory and Injunctive Relief to the declarant in Spanish. I have also read the foregoing Verification to the declarant in Spanish who has affirmed to me that its contents are both true and correct.

Executed on March 6, 2019 at Sacramento, California

Lisbeth Espinoza

VERIFICATION

I, Rebecca Binsfeld state that:

1. I am a petitioner in the above-entitled action.

2. I have read my portion of the Third Amended Petition for Writ of Mandate and Complaint for Declaratory and Injunctive Relief and know the contents thereof.

3. To the extent that the Petition is based upon facts known to me, including the facts stated under my name in the section entitled "Parties," I verify them to be true, and otherwise I am informed and believe that all facts herein are true.

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

Executed on March 7, 2019 at Sacramento, California.

Petitioner and Plaintiff

VERIFICATION

I, Helen Jordan state that:

1. I am a petitioner in the above-entitled action.

2. I have read my portion of the Third Amended Petition for Writ of Mandate and Complaint for Declaratory and Injunctive Relief and know the contents thereof.

3. To the extent that the Petition is based upon facts known to me, including the facts stated under my name in the section entitled "Parties," I verify them to be true, and otherwise I am informed and believe that all facts herein are true.

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

Executed on March 7, 2019 at 9:00 p.m., California.

Helen Jordan

Petitioner and Plaintiff

PROOF OF SERVICE

I, Olivia Ruiz, declare:

My business address is 2030 Addison Street, Suite 500, Berkeley, CA 94704. I am over the age of 18 and not a party to the above-entitled action.

On March 8, 2019 I served the following document:

THIRD AMENDED VERIFIED PETITION FOR WRIT OF MANDATE AND COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

via email.

The name and address of each person to whom I emailed the document are:

XAVIER BECERRA
Attorney General of California
SUSAN M. CARSON
Supervising Deputy Attorney General
GREGORY D. BROWN
Deputy Attorney General
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102

Gregory.Brown@doj.ca.gov
Susan.Carson@doj.ca.gov

Attorneys for Defendants

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

Executed on March 8, 2019 at Berkeley, California.

Olivia Ruiz
olivia@feinbergjackson.com