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IN THE UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

WESTERN DIVISION

MANAGED PHARMACY CARE, a California corporation;[1] INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC., a California corporation; GERALD SHAPIRO, Pharm.D., doing business as Uptown Pharmacy & Gift Shoppe; SHARON STEEN, doing business as Central Pharmacy; and Tran Pharmacy, Inc., a California corporation,

Plaintiffs,

-vs.-

DAVID MAXWELL-JOLLY, Director of Department of Health Care Services of the State of California,

Defendant.

_____/

CV09-0382 CAS (MANx)

Date: February 23, 2009
Time: 10 a.m.
Courtroom: 5
Judge: Honorable Christine A. Snyder

[1] This plaintiff, Managed Pharmacy Care "MPC") was dismissed as a plaintiff on January 26, 2009 by virtue of filing a voluntary dismissal of MPC's causes of action in this case.

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The Opposition of the defendant Director is without merit.

The Director **does not contest** that the Legislature **failed to consider** the factors of quality of services, and equal access, (as required by the Medicaid rate-setting statute, 42 U.S.C. § 1396a(a)(30)(A), -- Sec. 30A), in enacting the 5% pharmacy rate cut of AB 1183.[2]

And the Director **does not contest** that the Director has **failed to meet the burden of producing a record** which shows what factors were considered by the Legislature in enacting the 5% rate reduction, (other than the budgetary considerations which were expressly stated in the statute itself).[3]

Note: These budgetary considerations, given by the Legislature as its sole reason for enacting the 5% rate cut, are as follows:

> "SECTION 45. . . .
>
> "14105.191. (a) Notwithstanding any other provision of law, **in order to implement the changes in the level of funding for health care services**, the director shall reduce provider payments as specified in this section.
>
> (b) . . . (3) . . . [F]or dates of service on and after March 1, 2009, Medi-Cal

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[2] The Director also does not contest the Legislative History set forth by Plaintiffs in Plaintiffs' Request for Judicial Notice of Legislative History of AB 1183 and AB 1781. That History is that AB 1183 was a hazardous waste material bill until Sept. 15, 2008, when it was amended in the Senate to be the health trailer bill for the 2008-09 Budget Bill. It was then passed by the Senate at 12:37 a.m. the morning of Sept. 16, 2008, and then passed by the Assembly an hour-and-a-half later, at 2:08 a.m. the morning of Sept. 16, 2008. Therein, there were no public hearings on AB 1183 and obviously neither the Senate nor the Assembly could possibly have read or understood the provisions of this multi-subject AB 1183, other than its purpose to cut health care funding to meet the appropriations enacted therefore, in the Budget Bill which was enacted at 2:08 a.m. of Sept. 16, 2008, at the exact same minute that AB 1183 was enacted.

[3] *Beno v. Shalala*, 30 F.3d 1057, 1073-1074 (9th Cir.1994):
"[W]e cannot infer an agency's reasoning from mere silence. . . . Rather, an agency's action must be upheld, if at all, on the basis articulated by the agency itself. Thus . . . the record must be sufficient to support the agency action, show that the agency has considered the relevant factors, and enable the court to review the agency's decision."

> fee-for-service payments to pharmacies shall be reduced by 5%."
>
> . . .
>
> SECTION 76. . . . **In order to make the necessary statutory changes to implement the Budget Act of 2008** at the earliest possible time, it is necessary for this act to take effect immediately." (Boldface emphasis supplied.)[4]

Hence, from the above, the Opposition brief has conceded all the facts and law which are perquisite for the District Court to conclude, *a fortiori,* that the 5% AB 1183 rate cut was enacted contrary to, and is hence preempted under the Supremacy Clause, by Sec. 30A; so that its implementation by the Director is also, *a priori*, contrary to and hence preempted, under the Supremacy Clause, by Sec. 30A.

The Director also fails to show that there is no irreparable injury.

Hence the preliminary injunction requested, to order the Director to refrain from implementing AB 1183 or the 5% pharmacy rate cut of AB 1183, for services on or after March 1, 2009, in the Medi-Cal fee-for-service program, should be granted as prayed.

PRELIMINARY

Plaintiffs seek preliminary injunction on two separate Claims for Relief.

<u>Second Claim for Relief</u> - - The Legislature failed to consider the factors of quality and equal access, in enacting the AB 1183 five percent educed rate.

In respect to the Second Claim for Relief, the Opposition **admitted**, by not contesting, that the Legislature, in enacting the 5% pharmacy rate cut of Assembly Bill (AB) 1183, failed to consider the factors of quality of services, and equal access, so that therein the Legislature's action to enact the rate cut "**to implement the changes in the level of funding for health care services,"** and "**in order to make the statutory changes to implement the Budget Act of 2008**,"[5] violated the quality and equal access clauses of the Medicaid rate-setting statute (42 U.S.C. § 1396a(a)(30)(A), -- "Sec. 30A").

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[4] A true copy of Sections 45 and 76 of AB 1183 is attached to this Reply brief as **Exhibit A.**

[5] (New) § 14105.191 Cal. Welf. & Inst. Code, enacted by Section 45 of AB 1183. *See,* **Exhibit A** attached to this Reply brief.

First Claim for Relief -- The Legislature gave inappropriate consideration of quality and access, due to use of a budget trailer bill as the vehicle for enacting the rate cut.

The Director also admitted liability in respect to the First Claim for Relief, by not contesting the fact that AB 1183 is a health budget trailer with **hundreds of different measures** all voted up or down in one vote, so that thereby it was **impossible** for the legislators to have **appropriately** considered the factors of quality, and equal access, in enacting AB 1183; all, in violation of the requirements of the quality and equal access clauses of Sec. 30A for the process of a Medicaid rate-setter to set a rate.

The Director **also admitted**, by not contesting, that the Director had the burden to produce the record of what factors, and relevant data, if any, were considered by the Legislature in enacting AB 1183; but, failed to produce any such evidence, (as required by *Clayworth v. Bonta,* 295 F.Supp.2d 1100, 1128 (E.D.Cal.2003), and *Beno v. Shalala*, *supra*, 30 F3d at 1073-1074), to show that the Legislature considered whether pharmacies, in light of their costs, could sustain the burden of the 5% reduction in rates without injury to quality or equal access for beneficiaries.[6]

Therefore, ***sans* any record** that the Legislature did consider whether the reduced rate could be sustained by pharmacies, in view of their costs, without loss of quality of services or equal access for beneficiaries, (*Clayworth ,* 295 F.Supp.2d at 1128), the Court can only find, and must conclude, that the Legislature acted without any consideration of the factors of quality and equal access, (and without consideration of costs which is relevant to quality), but, solely for budgetary reasons, to enact the 5% rate cut of AB 1183; all, in violation of the quality and equal access clauses of Sec. 30A. (*Orthopaedic Hospital v. Belshe*, 197 F.3d 1491, 1500 (9th Cir.1997).

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[6] *Clayworth* held, (295 F.Supp.2d at 1128):
"While the State certainly is entitled to conserve funds, the defendant has produced no evidence that the State legislature based the rate reduction on evidence that the reduction could be sustained by providers, in light of their costs, without loss of quality or equal access for beneficiaries."

1. All the Director's *ex post facto* studies, (the "Douglas Study" and the "Gorospe Study,") which seek to justify, *ex post facto,* the preempted rate cut, are inadmissible because *ex post facto* studies are irrelevant to the fact that the Legislature prior enacted the 5% rate cut of AB 1183 in violation of the quality and access clauses of Sec. 30A.

Also, even were this *ex post facto* evidence relevant, nevertheless, the *ex post facto* Douglas Study and Gorospe Study are bogus and ersatz, of the "showcase" type, due to complete lack of authority of the Director or Department under California law to do anything other than to implement, willy nilly, the new 5% rate cut.[7]

Such *ex post facto* costs studies, done after the horse has left the barn, are barred by specific rulings to that effect by *Orthopaedic Hosp.,* 197 F.3d at 1500; and by *Clayworth*, 295 F.Supp.2d at 1129, fn. 22.[8]

Discussion

The Director, -- realizing there is no way to counter the conclusion that the Legislature procedurally violated Sec. 30A by enacting the AB 1183 rate cut without considering quality and equal access in the rate-enacting process, -- has attempted to throw a red herring across the path of the trial court, to the effect of, "Forget the Legislature and concentrate on me, the Director. I contend that if the Plaintiffs cannot show that I did not consider quality and equal access, or providers costs, they must be denied relief."

This gambit is just that, -- a red herring, -- because by the specific direction of AB

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[7] The Douglas Study was filed by defendant as Pages 25-43 of the Declaration of Toby Douglas ("Douglas Declaration"). The Gorospe Study was filed by defendant as Pages 239-248 of the Douglas Declaration.

NOTE: The Gorospe Study is simply an echo of the Douglas Study. Hence, all statements of the Plaintiffs in respect to the Douglas Study, also apply *inter alia* to the Gorospe Study.

[8] *Clayworth* held, (295 F.Supp.l2ds at 1129, fn. 22):
"The defendant has produced some evidence to show that pharmacies' costs will continue to be met after the 5% rate reduction. [Citation to record.] If so, the record suggests that this outcome is by luck, not design. Nonetheless, there is no evidence that the State considered the possible effect on beneficiaries' access to pharmacist services."

1183 and by California Constitution article 3.5, the Director is a mere administrative officer who must, by AB 1183 and article 3.5, pass through the AB 1183 rate cut, willy nilly, pro forma, (whether he concludes the new rate violates Sec. 30A, or not).

> **2. As a matter of truth and fact, -- as disclosed and admitted by the Director's own Opposition papers, -- the Department did conduct a study in 2004 of the effects of a proposed rate reduction to AWP minus 20%, plus an $8 dispensing fee, (i.e., .80 AWP + $8), -- which is less a rate cut than the reduced rates under AB 1183, -- but found and concluded, in good faith, that such a rate cut would reduce equal access to below the level required by Sec. 30A; and abandoned the proposed rate reduction as a result.**

This prior rate cut study should thereby be dispositive against the Director on the Department's later, *ex post facto*, not-in-good-faith study which is now sought to be thrust upon the Court, and which, to boot, was neither principled, reasonable, nor in accordance with the requirements of Sec. 30A.

What was this prior Department study that puts the Director out of court in the case at bar, all by itself?

This was a study conducted in 2004 by Stanley Rosenstein, then-Deputy Director of the Department. He reported, in his August 2004 Analysis[9] of the current rate statute for Medi-Cal FFS pharmacies, (which provides for payment of .83 of AWP, plus $7.25 dispensing fee, per prescription),[10] that the Department did, in 2004, consider a steeper cut, to only .**80 of AWP, plus $8.30 dispensing fee**, (which is a much higher rate than the

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[9] Analysis of Impact of Changes in Medi-Cal Reimbursement to Pharmacies for Drugs Pursuant to Welfare and Institutions Code Sections 14105.19, 14105.336, 14105.337, and 14105.45, Amended by SB 1103, of the (then) California Department of health Services, August 2004.

This report of Deputy Director Rosenstein is at Page 255 of the Declaration of Douglas in Support of Defendant's Opposition to Plaintiffs' Motion for Preliminary Injunction, (herein, "Douglas Declaration").

Plaintiffs have **highlighted** this portion of the report of Deputy Director Rosenstein.

[10] (Former) § 14105.19, Cal. Welf. & Inst. Code, enacted 2004.

reduced AB 1183 rate in case at bar of only **.7885 of AWP, plus $6.88 dispensing fee**).

But this lesser rate cut was rejected by the Department **for the reason** that the Department concluded that this would **impair access** by Medi-Cal beneficiaries to pharmacy services. Thus, Deputy Director Rosenstein reported that in August 2004:

> "Based on DHS recommendations, the May revisions of the Governor's proposed budget for the 2004/2005 Budget year initially contained a proposal to modify the current reimbursement policy to pay a **dispensing fee rate of $8.30 but a much lower EAC[11] of AWP-20%**. . . . Based on data that pharmacists provided to DHS staff, **a concern developed** that AWP-20% could be **too large a reduction in reimbursement** with respect to some brand name drugs, **with a possible reduction in provider participation** that might have **negatively impacted beneficiary access**." (Boldface emphasis supplied.). (Note: This report is set forth at Page 255 of the Douglas Declaration.)

NOTE: A true copy of this portion of Deputy Director Rosenstein's August 2004 report is attached to this Reply brief as **Exhibit B**, (marked so as to be easily readable).

I.e., in 2004 the Department, in good faith and in accordance with the requirements of the equal access clause of Sec. 30A, **abandoned and did not adopt any such rate cut to only 80% of AWP, plus $8.30 dispensing fee**, due to the fact that the Department recognized this would not be consistent with equal access, as required by Sec. 30A.

Therefore it is revolting, as being arbitrary and capricious, in violation of law, for Deputy Director Douglas to now have undertaken an *ex post facto* and *faux* "analysis" of the AB 1183 rate cut, -- which rate is a much greater rate cut than even the proposed rate of 80% of AWP, plus $8.30 dispensing fee, (which was analyzed and rejected by the Department in 2004 for being violative of Sec. 30A), -- and seek to now "pass it off" to the District Court as a genuine, bona fide, good faith study, **when, (if this *ex post facto* "study" had been in good faith), the Deputy Director would have concluded as did former Deputy Director Rosenstein,** that a rate cut so great will negatively impact beneficiary access; will pay pharmacies less than what it costs them to acquire-and-

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[11] I.e., "Estimated Acquisition Cost."

dispense brands; and so truthfully inform the Court, (as did Rosenstein in 2004) that, (in the words of Rosenstein), that the 5% rate cut **is** "too large a reduction in reimbursement" with respect to brand drugs, which will cruelly and inevitably negatively impact beneficiary access.

Conclusion on this subpoint:

(1) The Douglas Study and the Gorospe Study should be stricken, as a bad-faith attempt to hoodwink the District Court by a *faux* study of the impact of the rate reduction of AB 1183, which deliberately omitted the data and the findings of the prior Rosenstein study, so as to arrive at a deliberately pre-set, false, result.

(2) In any event, the Douglas Study and the Gorospe Study are, under *Orthopaedic Hosp.*, 197 F.3d at 1500, **not admissible** to show that the new AB 1183 rate is consistent with quality and equal access as required by Sec. 30A, for the reason that all *ex poste facto* studies to support or defeat a Medicaid rate which have been prior enacted or adopted without consideration of quality and equal access, are inadmissible, under the *Orthopaedic Hosp.* holding on this subject, (197 F.3d at 1500).

* * * *

3. The Director is collaterally estopped on the following claims, by prior rulings of District Courts and the Ninth Circuit in which the Director raised these same meritless claims, and was adjudicated against, once and for all. The Court is therefore requested to find that the Director is barred, by collateral estoppel, from making or raising the following claims, again, in the within case at bar (No. 2:09-cv-0382):

1. **The Director is collaterally estopped from claiming, objecting, or raising in this case, again, the frivolous claim** that Medi-Cal beneficiaries, and Medi-Cal providers suing *jus tertii* for the benefit of their Medi-Cal patients, have no standing to sue to prevent threatened injury from the Director implementing a Medicaid rate reduction enacted by the Legislature which is preempted, under the Supremacy Clause, by the contrary provisions of Sec. 30A. *See*, *Orthopaedic Hosp.,* 197 F.3d at 1500; *ILC, (*Ninth Circuit decision Sept. 17, 2008, in Appeal 08-56061; District Court decision Aug. 18, 2008, Case 2:08-cv-03315 CAS).

2. **The Director is collaterally estopped from claiming, objecting, or raising in this case, again, the frivolous claim** that in every case the District Court must do a "preemption analysis" of Congress' intent to create a preemption in favor of Medi-Cal beneficiaries, (which is to say, a "preemption analysis" which is other than an analysis to simply determine if the new Medicaid rate in question violates or was enacted in violation of the EEQA factors of Sec. 30A). *See*, *ILC*, (Ninth Circuit decision Sept. 17, 2008, in Appeal 08-56061; District Court decision Aug. 18, 2008, Case 2:08-cv-03315 CAS).

3. **The Director is collaterally estopped from claiming, objecting, or raising in this case, again, the frivolous claim** that a rate set by Medicaid rate-setter in the Ninth Circuit need not bear any reasonable relationship to providers' costs to furnish quality services. *See*, *Orthopaedic Hosp.,* 197 F.3d at 1500; *Clayworth,* 295 F.Supp.2d at 1128; *ILC,* (District Court order Aug. 18, 2008, in Case 2:08-cv-03315 CAS).

4. **The Director is collaterally estopped from claiming, objecting, or raising in this case, again, the frivolous claim** that *Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir.2005), which is applicable solely to § 1983 cases, is applicable to Supremacy Clause preemption cases, and that *Sanchez* precludes any relief in this Supremacy Clause preemption case. *See*, *ILC* decision of Sept. 17, 2008, (Ninth Circuit,, Appeal 08-56061); *ILC* decision of August 18, 2008, (C.D.Cal., Case 2:08-cv-03315 CAS).

5. **The Director is collaterally estopped from claiming, objecting, or raising in this case, again (!), the frivolous claim** that the Director may, in an *ex post facto* analysis of the new rate, evaluate the new rate on the basis that, (as per the outdated views of the U.S. Secretary of Health and Human Services' *amicus* brief to the U.S. Supreme Court in the *Orthopaedic Hosp.* case), (1) there is no floor to Medicaid rates but only a ceiling above which rates may not be set, (2) that providers' costs need not be considered by a Medicaid rate-setter; (3) that factors which are relevant to consideration of rates set under 42 U.S.C. § 1396a(a)(13), or under the Boren Amendment, are relevant to determining if a new rate complies with Sec. 30A (an entirely different statute); and (4) that statements in the Congressional record in relation to termination of the Boren Amendment require the

Director not to consider costs at all in evaluating a new Sec. 30A rate. *See*, *Orthopaedic Hosp.,* 197 F.3d at 1500; *Clayworth*, 295 F.Supp.2d at 1128; and particularly, *ILC,* (Ninth Circuit, Sept. 17, 2008, in Appeal 08-56061); and *ILC* order Aug. 18, 2008, (C.D.Cal., Case 2:08-cv-03315 CAS).

6. **The Director is collaterally estopped from claiming, objecting, or raising in this case, again, the frivolous claim** that the Eleventh Amendment bars a suit for prospective relief as in the case at bar. (*See*, the Sept. 17, 2008 *ILC* decision of the Ninth Circuit, (Appeal 08-56061); and the Aug. 18, 2008 order to issue injunction in the *ILC* case (2:08-cv-03315 CAS, C,D.Cal.).

4. The analysis of Toby Douglas ("Douglas Study") to attempt to show that the AB 1183 reduced rate is sufficiently high to meet the substantative standards of Sec. 30A. must be stricken, and not considered on such issue.

This Douglas Study is only relevant on the completely separate issue of irreparable injury; namely, does the 5% rate reduction have a likelihood of reducing access to prescription drugs by, *inter alia*, causing pharmacies to stop, or at least limit, dispensing prescription medications to Medi-Cal beneficiaries.

See, Plaintiff's discussion of this issue prior in this brief. *See, Orthopaedic Hosp.,* 197 F.3d at 1500; and *ILC,* (injunctions issued Aug. 18, 2008 and Nov. 17, 2008).

5. The Douglas Study is neither principled or reasonable, in that it does not address the basis upon which the Plaintiffs assert that the 5% rate reduction has a likelihood of reducing access by, *inter alia*, causing pharmacies to stop, or at least limit, dispensing prescription medications to Medi-Cal beneficiaries.

The claim of Plaintiffs is based directly on (1) the factual basis established by the Myers and Stauffer survey (the "Meyers Survey), which was done for the Department in 2006, and (2) upon pharmacy owner declarations, to the effect that virtually **all brand drugs** as well as **many high cost generic drugs** will be reimbursed by Medi-Cal to pharmacies, under the 5% reduced rate, at less than their cost to acquire-and-dispense, so that many if not most pharmacies throughout California will simply, *inter alia*, stop dispensing most brands, and many generics, when the 5% rate cut starts March 1, 2009, -- **just as pharmacies did** when the 10% reduced rates commenced on July 1, 2008.

Thus, the Court should know that in the Meyers Survey that 304 California

pharmacies produced usable invoices for both single source and generic drug purchases from wholesalers, for a 15-day survey period (Nov. 1 - 15, 2006); which were matched with the top 1000 single source drugs, and the top 1000 generic drugs, (ranked by total reimbursement for the calendar year ending 2006).[12]

The Myers Survey then tabulated the costs to pharmacies to acquire these top-ranked single source drugs in **Exhibit 17** of the Myers Survey, (Pages 168-174 of the Douglas Declaration, **Doc. 24-5**), and found that:

"(T)he average acquisition cost was 79.0% of the AWP;"[13]

-- which acquisition cost is **more than** the 78.85% of AWP which Medi-Cal will be reimbursing pharmacies for their cost to acquire brand drugs under the 5% reduced payment rate of AB 1183.

This Myers Survey finding that the cost to acquire brands is 79% of AWP, is so important factually that Plaintiffs hereby attached a copy of this Page 6 of the Myers Survey, as **Exhibit D** attached to this Reply brief: so that the Director cannot argue at the motion hearing that the cost to acquire brand drugs is less than 79% of AWP.

(Also, the Myers Survey tabulated invoices submitted to acquire brand drugs, and set forth a table of the invoice costs to acquire brands, in **Exhibit 17** of the Myers Survey, (found at Pages 168-174 of the Douglas Declaration). Once again, the Myers Survey summary of this tabulation states that the Average cost of the 304 sampled pharmacies to acquire brand drugs in the year 2006, was **79% of AWP.**

(Again, this Exhibit 17 of the Myers Survey is so important that Plaintiffs here attach Exhibit 17 as **Exhibit E** to this Reply brief, -- in which, in Page 7 of Exhibit 17, the Myers Survey, from actual invoices, found unequivocally that the cost to acquire brands is **79% of AWP, -- which is more cost to pharmacies to acquire brands,** than the **78.85% of AWP** which is all that Medi-Cal is going to pay pharmacies for brand drug acquisition, under the

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[12] **Pages 6-7** of Myers Survey (Pages 78-79 of Douglas Declaration).

[13] **Page 6** of Myers Survey, (Page 78 of Douglas Declaration).

5% rate cut of AB 1183.)

Also, as the Court well knows from the prior 10% rate cut case, pharmacies also suffer a loss of at least **$4.70 per prescription,** under the 5% rate cut, due to the fact that currently it costs pharmacies $11.59 to dispense a prescription, compared to the only $6.89 payment they will be receiving from Medi-Cal to cover dispensing costs, (called the "dispensing fee"), under the 5% rate cut.[14]

Therefore, with a loss on both the acquisition and the dispensing sides of the Medi-Cal reimbursement equation, on virtually every brand prescription under the 5% rate cut, it is obvious that pharmacies will do exactly what they did during July-September 2008: stop dispensing brands to Med-Cal patients, when the 5% rate cut commences on March 1, 2009!

Also, the pharmacy declarations, which Plaintiffs have filed in this case, establish that pharmacies are again going to stop dispensing brands to patients, altogether, in the Medi-Cal fee-for-service program, when the new 5% rate cut starts in March 2009.

Thus, *inter alia*, millions of Medi-Cal beneficiaries throughout the state will be injured and threatened with injury, from being unable to obtain most brand drugs, and many generic drugs, in the Medi-Cal fee-for-service program; hence, requiring injunction to save them from such dire injury.

6. The fact that pharmacies will not be reimbursed their costs to acquire-and-dispense brand drugs, under the 5% rate cut, is admitted by the Director in his Opposition papers.

Thus the Douglas Study itself **admits that**, -- as claimed by Plaintiffs, -- that brands will only be reimbursed **at less than the cost of pharmacies to acquire-and-dispense brands** under the 5% rate cut.

***See*,** Page 38 of the Douglas Declaration, (which is attached as **Exhibit C** to this Reply brief, and marked so as to be easily readable), where Deputy Director Douglas admits that pharmacies will **only be reimbursed 97.8% of their costs** to acquire-and-dispense brands under the 5% cut.

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[14] **This is admitted** by the defendant, at Page 37 of the Douglas Declaration.

Thus, Deputy Director Douglas admitted, at page 38 of the Douglas Declaration, (which is **Exhibit C** attached to this Reply brief), that:

> "[T]he Department estimates that aggregate reimbursement for single source drugs will compensate **at least 97.8 percent** of pharmacy costs for single source drugs after a 5% payment reduction is imposed."

NOTE: This is an **admission** by the Director that pharmacies will lose money on every brand drug dispensed by them under the 5% rate cut, -- **which is exactly what Plaintiffs are contending** in this within 5% rate cut suit; and which loss per brand prescription will cause pharmacies throughout the state to refuse to dispense brands, under the 5% rate cut, (just as they refused to dispense brands during the period the 10% rate cut was not enjoined).

Conclusion on this sub-point;

The Director's own Study admits that brands cannot be dispensed by pharmacies, except at a loss, under the 5% rate cut of AB 1183; so that therein, -- just as predicted by (1) Richard D. Wilson, C.P.A., and (2) the pharmacy owners who have filed supporting declarations herein, -- it is **inevitable** that pharmacies throughout the state **will refuse to dispense brands** in the Medi-Cal fee-for-service program, once the vicious and cruel 5% rate cut starts on March 1, 2009. **The District Court, in the August 2008 injunction in the prior 10% rate cut suit, (Case 2:08-cv-03315 CAS), addressed this same spurious claim of the Director, -- i.e., that it "does not matter" that pharmacies lose money on virtually every brand prescription under reduced rates, -- by rejecting this La La Land theorem of the Director.**

Thus the District Court, the Honorable Christina A. Snyder, ruled on this very point in issuing injunctions against the 10% rate cut in August and November of 2008:

> "Medi-Cal Policy Branch Chief Kevin] Gorospe states that according to T. Allen Hansen, the manager for the Myers and Stauffer Study, on average, Medi-Cal reimburses $84.62 for prescription drugs, while on average, it costs a pharmacy $77.03 to acquire and dispense a drug. After the ten percent reduction, Medi-Cal will, on average, reimburse pharmacy providers $76.16, thereby 'compensating in the aggregate 99 percent of provider costs.' [Citation to the Record.] First, as noted above, the evidence shows that many pharmacy providers will be unable to continue

> providing medications to Medi-Cal patients if they lose any further Medi-Cal funding. Secondly, it appears that after the ten percent rate reduction, . . . thirty-two percent, of the top 278 single source (patented brand name) drugs at the National Drug Code level, will be reimbursed in an amount below a pharmacy's costs. . . . Among the single source drugs that will be reimbursed below cost are antipsychotic drugs, antiretroviral drugs, anticonvulsant drugs, and antineoplastic drugs. Id. Because these single source drugs are protected by competition by patents, there are no available generic alternatives. **There can be little or no doubt that Medi-Cal patients will be harmed if these necessary drugs are placed outside of their reach.**" (Pages 14-15 of August 18, 2008 Order Granting in Part and Denying in Part Petitioner's Motion for Preliminary Injunction.)
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> **- (End of quotation from August 18, 2008 order in Case 2:08-cv-03315 (CAS) -**

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7. There is no "rule" in Sec. 30A cases, (unlike whatever may be the rule in Boren Amendment cases), that "typically" courts find Sec. 30A complied with if rates "compensate" providers in the "aggregate 85% to 95% of aggregate provider costs." (*See,* the Douglas Study, [Page 35 of Toby Douglas Declaration], where this preposterous humbug claim is asserted as if it were mint gold.)

The bad faith of the Director in asserting that Boren Amendment cases rule this Sec. 30A case is evidenced by the simple fact that the Director is **unable to cite a single case decision which holds that Boren Amendment rules apply in Sec. 30A cases.**

As pointed out by Stephen Schondelmeyer, professor of pharmaceutical management, College of Pharmacy, Univ. of Minnesota, in the 10% rate cut case, (2:08-cv-03315 CAD):

> "The application of the Boren Amendment to suggest or determine a 'range of reasonableness' for payment of prescription drugs under Medi-Cal is inappropriate for several reasons, including (1) the Boren Amendment was repealed in 1997; (2) the statutory language of the Boren Amendment was specifically applied to 'rates of payment under the plan for **hospital services, nursing facility services,** and **services of intermediate care facilities** for the mentally retarded" and did not directly, or indirectly, apply to payment rates of community pharmacies for prescription drugs; and (3) the cost structure of inpatient facilities (i.e., hospitals, nursing facilities, and intermediate care facilities for the mentally retarded) are **fundamentally different** from the cost structure of community pharmacies with respect to a variety of economic factors including cost-to-charge ratios, distribution of expense categories,

variation of expenses across facilities, and other factors."[15] [16] (Boldface emphasis supplied.)

8. The Director's "Separation of Powers" objection is frivolous, without merit.

First: No order is sought to order the California Legislature to enact penny one for the Medi-Cal program. **Second**: The Medicaid program is entirely voluntary on the part of the State. The State may elect at any time to stop appropriating funds for the state's Medicaid program; and to cease thereby receiving matching federal funds to operate the Medi-Cal program.

9. Plaintiffs have met the tests for a preliminary injunction, and the balance of hardships, and public interest tests, which have been prior set forth by the District Court in its Aug. 18, 2008 order for preliminary injunction, (at Pages 5 and 20-21) in the *ILC* case, (2:08-cv-03315 CAS).

The Director is collaterally estopped from contending that different tests apply in the case at bar.

10. The unrebutted declarations supporting preliminary injunction establish that pharmacies will stop dispensing brands, -- particularly antipsychotic brands such as Risperdal, Zyprexa, Seroquel, Abilify, and Geodon which keep psychotic patients stabilized in the community, without harm to others.

Thus, the unrebutted declarations of pharmacy owners submitted by Plaintiffs show:

RICHARD D. WILSON, C.P.A. San Francisco	The 5% reduction in the dispensing fee, from $7.25 to only $6.88 per prescription in the Medi-Cal fee-for-service pharmacy program will increase the pharmacy loss, on the dispensing side of the equation, from the current $3.56 dispensing fee loss per prescription to at least $4.61 pharmacy loss per prescription, on average.

[15] *See,* further analysis by Professor Schondelmeyer, (¶¶ 10 - 13 of Supplemental Declaration of Stephen W. Schondelmeyer, (the "Schondelmeyer Declaration"), (being Document 100 in the *ILC* case, (2:08-cv-03315 CAS).

[16] Judicial notice has been separately requested of ¶¶ 9 - 13 of the Schondelmeyer Declaration.

RICHARD D. WILSON, C.P.A. (Continued)	The Myers Survey found that for the 304 pharmacies that provided invoice data, the average acquisition cost to acquire brand products in 2006 was 79% of AWP, which is more than the amount of .7885 of AWP which pharmacies will be receiving from the Department under the 5% rate reduction, to reimburse them for their costs to acquire the drug products dispensed. Pharmacies will suffer a financial loss, on average, to acquire and dispense all or most brand drugs acquired-and-dispensed by them under the new 5% rate reduction in the Medi-Cal fee-for-service program, and will therefore be forced to stop dispensing many if not most brand products, under the 5% rate reduction. The Myers Survey shows that pharmacies will also suffer a negative gross profit (i.e., loss) in respect to their cost to acquire 40, or 20%, of the 200 top selling multi-source drug products which are not subject to a FUL payment limit, in the Medic-Cal program, under the 5% rate reduction. As a result of above facts, many, if not most pharmacies will cease dispensing a large number of brand drugs and a large number of generic drugs in the Medi-Cal fee-for-service program, under the 5% rate reduction. Further, many independent pharmacies will be forced to quit the pharmacy business altogether or go bankrupt. Or, at the very least, these pharmacies will not fill many brand and generic drugs.
ODETTE LEONELLI, Pharm.D. Owner of Kovacs Frey Pharmacy Redondo Beach	During July 2008, when the 10% rate cut started, I turned away Medi-Cal patients because I was not able to fill their prescriptions at a loss. At the beginning of August 2008, the same Medi-Cal patients turned away in July came back, with the same prescriptions unfilled, because they were physically or emotionally unable to deal with the change of Pharmacy or with the pace of the Chain Pharmacy. The same thing as above, happened again at the start of September 2008, because at the start of September 2008 we

ODETTE LEONELLI, Pharm.D. (Continued)	were still being paid only 90% of the regular Medi-Cal payment for our Medi-Cal prescriptions. So my chronically ill or disabled patients who are Medi-Cal, who get their monthly medications at the first of each month, were forced to go three months without their medications, because of the 10% Medi-Cal rate cut. Going three months without their medications put them in grave danger, and some of them were hospitalized as a result. Under this 5% rate reduction, my pharmacy will still be unable to dispense most brand prescriptions, and many generic prescriptions, because the reimbursement paid me by Medi-Cal for cost-to-acquire these drug products is more than what I have to pay my wholesaler to acquire them. As a result my pharmacy will once again be unable to dispense these medications to Medi-Cal patients, -- especially, to those chronically ill or disabled who need and get their monthly prescriptions for their medications filled at the start of each month. They are physically or emotionally unable to deal with this change in Pharmacy and be enable to cope with the pace in Chain Pharmacy. Once again, by going without their monthly medications, they will be put into grave danger again, and, again, some will wind up in hospitals, and, once again, cause me great emotional distress. Unless the 5% rate cut is stopped, my pharmacy will be bankrupted if I continue in business, so, I will have to close my pharmacy before I become bankrupt.
SHARON STEEN Plaintiff Owner Central Pharmacy Santa Monica	My pharmacy has a contract with the California Department of Health Services and dispenses hundreds of different psychiatric medicines. A substantial part of my pharmacy's business is delivering prescriptions to elderly or disabled persons in their homes who are Medi-Cal beneficiaries in the Medi-Cal fee-for-services program. 95% of our deliveries are to persons who are

SHARON STEEN (Continued)	home-bound, and about 5% of our deliveries are to facilities. After AB 5 took effect, my pharmacy ceased dispensing many prescription items, including psychiatric medicines, because the loss to my pharmacy was too great to dispense such items. I will no longer accept Medi-Cal patients if the 5% budget cut to pharmacies goes into effect. These cuts will result in Central Pharmacy being reimbursed at less than its costs to acquire drugs. Patients will be severely limited as to where they will be able to get their prescriptions filled if these cuts are implemented, Given the rates of reimbursement, I doubt they will be able to get their medicines. The following are some of the most common drugs for mental health patients that Medi-Cal patients will not obtain from Central Pharmacy should the 5% rate cut become effective: **Drug:** **Average Wholesale Price** Zyprexa 20mg tab AWP=$914.81/30 tabs Seroquel 200mg tab AWP=$932.59/ 100 tabs Abilify 20mg tab AWP=$673.93/ 30 tabs Geodon 80mg cap AWP=$519.19/ 60 caps Lamictal 25mg tab AWP=$505.80/ 100 tabs Risperdal 4mg tab AWP= $879.23/ 60tabs Wellbutrin XL 150mg tab AWP= $522.59/ 90 tabs Effexor XR 75mg cap AWP= $372/23/ 90caps Lexapro 20mg tab AWP=$332.14/ 100tabs Seroquel 400mg tab AWP=$1437.03/ 100tabs
DAVID JEHA Owner Park Rexall Pharmacy El Sobrante	My pharmacy will react to the 5% cut by not accepting Medi-Cal patient any longer. In this economical down turn, I cannot afford to take the loss.

GEORGE R. DAVIS Owner DeWitts' Drugstore Chowchilla	When the State cut Medi-Cal reimbursement by 10% on July 1, 2008, my pharmacy sent medical prescriptions elsewhere and continued that practice until the injunction blocking the cuts was issued on August 18, 2008. My pharmacy will react to the 5% cut by not being able to fill Medi-Cal prescriptions.
DAVID MEDINA Owner of Creekside Pharmacy Santa Rosa	When the State cut Medi-Cal reimbursement by 10% on July 1st 2008, my pharmacy was forced to severely limit deliveries, stopped accepting new Medi-cal patients, limited the amount of Treatment Authorization Requests (TARs) we could process. My pharmacy turned away new clients. These new clients would not be able to get their medications in specialized packaging and started to miss doses of their medications. Pharmacy will react to the 5% cut by no longer accepting new Medi-cal patients, stop delivery services, stop specialized packaging, stop TAR processing. My pharmacy is the major provider of AIDS medication in Sonoma County. If the 5% cut goes into effect my pharmacy will be forced to stop dispensing AIDS medications to existing patients as was already was forced to do when the 10% cut was in effect. Additionally, my pharmacy would also be forced to stop dispensing any brand name antipsychotropics to its mental health patient. Examples of these medications are: Geodon, Abilify, ClozariI, Zyprexa, Risperdal, Seroquel, Lamictal, Depakote. Another problem is the mandatory dispensing of branded drugs which have generic equivalents. While there is an alternative, less expensive option, the State of California has contracted with certain brand name manufacturers and does not reimburse for the generic equivalent.

NANCY DUNKEL, R.Ph. Owner Elmore Pharmacy Red Bluff	When the State cut Medi-Cal reimbursement by 10% on July 1, 2008, my pharmacy was unable to fill prescriptions that were below our cost. If the 5% rate cut goes into effect, I will not be able to accept new Medi-Cal patients and will not be able to fill all Medi-Cal prescriptions. If I cannot remain profitable, the pharmacy will close.
THU-HANG TRAN, Pharm.D., Owner of Tran Pharmacy Garden Grove Also: President, Vietnamese American Pharmacy Association (VAPA)	VAPA has 80 members of Vietnamese origin in the pharmacy profession. 20 of our members own and operate retail pharmacies in Orange County, California. All VAPA pharmacies are providers in the Medi-Cal fee-for-service program. The Tran Pharmacy, and VAPA pharmacies, also participate in the Medi-Cal managed care program of Orange County Health Authority, which does business as "CalOptima." However, there is a broad range of psychotropic prescriptions which are excluded, or "carved out," from coverage by CalOptima, and are instead filled by pharmacies such as Tran Pharmacy and the pharmacy members of VAPA, which are paid for under the Medi-Cal fee-for-service program. (Herein, the "Medi-Cal carve-out formulary.") The clientele of the Tran Pharmacy and of VAPA pharmacies are predominately Vietnamese who escaped to the United States. Many were boat people who escaped in open boats, many of which were intercepted by pirates who committed atrocities upon the victims in the boat, leaving unforgettable nightmares of recollected terror. Many of them were prisoners of the Communist regime in Vietnam for years, in "Reeducation Camps," surviving on a handful of rice a week and suffering innumerable beatings as well as psychological torture, with everlasting psychological injury they carry to this day. As a result, Vietnamese who escaped and settled in Orange County, have a dramatically higher incidence of mental illness and incurable psychosis, -- with a need and volume of prescriptions of psychotropic medicines, which are included in the Medi-Cal carve-out formulary.

THU-HANG TRAN, Pharm.D. (Continued)	However, under the new 5 percent pharmacy rate reduction which is to start on March 1, 2009, the Tran Pharmacy and most VAPA pharmacy members will be forced to, and will, cease dispensing most if not all of the medicines in the Medi-Cal carve-out formulary, due to the fact that the cost to Tran Pharmacy, and to the members of VAPA, to acquire and dispense the psychotropic medicines in the Medi-Cal carve-out formulary, will be more than what Medi-Cal will now pay them, under the drastic 5% rate cut. This will have immediate and dire adverse effects on a large portion of the CalOptima patients of the Tran Pharmacy, and of the patients of the members of VAPA, who receive these Carve-out psychotropic medicines under the Medi-Cal fee-for-service program. Many would wind up either in Emergency Rooms, -- often only after injuring themselves or others, -- or in long-term care institutions, which Vietnamese abhor because the tradition is that the family cares for family members, not public institutions. These expensive psychotropic drugs upon which my pharmacy loses money, if it dispenses the medicine, include top selling brand medicines such as Zyprexa, Risperdal, Seroquel, Moban, and Parnate. Therefore my pharmacy, and most if not all the members of VAPA, will stop dispensing these five brand drugs, prescriptions of psychotropic medicines, which are included in the and the other 6 generic drugs on the Medi-Cal carve-out formulary, if the 5% rate is not stopped. Also, as the Myers and Stauffer survey conducted in 2006 reported, the overhead cost to dispense a prescription was $10.81; which Richard D. Wilson, C.P.A., in his declaration filed in this case, reports has increased, by inflation through the end of 2008, to $11.49, per prescription. Therefore pharmacies lose $4.61 on every prescription they dispense, on the overhead-reimbursement side of the transaction, under Medi-Cal fee-for service; including the Tran Pharmacy and the members of VAPA. I have attached a chart which shows that for 11 of the list of 25 (medicines in the Medi-Cal carve-out formulary, that my pharmacy is paid less than what it costs my pharmacy to acquire and dispense the medication.

THU-HANG TRAN, Pharm.D., (Continued)	As indicated above, this will result in a Vietnamese population in Orange County with a much higher incidence of mental illness than other populations, being deprived of necessary psychotropic medications to enable them to live in the community. There will be, in my view, some deaths and certainly injuries from mentally patients of the Tran Pharmacy and of the members of VAPA, acting out; and many will wind up in Emergency Rooms; and many will be forced into long-term institutions in order to obtain their necessary medication for their mental illness; and many will become homeless.
GERALD SHAPIRO, Pharm.D. Plaintiff Owns Uptown Drug & Gift Shoppe Los Angeles	Prescription drugs account for 98% of pharmacy's overall business. Uptown Pharmacy provides medications and care to over 5000 patients in the South Central area of Los Angeles. This area includes Inglewood, Compton, Lynwood, Hawthorne, Downey, Culver City and Long Beach just to name a few. Prescriptions are delivered to people's homes with the average age of 76 years, without charge. Approximately 30% of the shut-in clientele of Uptown Pharmacy are in the Medi-Cal fee-for-service program. Primarily, the new 5% reduced rates will not repay me what it costs my pharmacy to acquire the great majority of brand products from wholesalers, -- which brand products account for about two-thirds of my pharmacy's gross sales, in dollar amount, to Medi-Cal, in a given year. Of the remainder one-third of gross sales amount in the Medi-Cal fee-for-service program, about half, (i.e., one-sixth of my pharmacy's total gross sales amount to Medi-Cal), is derived from multi-sourced drugs, called "generic drugs." Pharmacies, including my pharmacy, average at least a $4.61 loss on the dispensing side of the Medi-Cal rate payment, under the 5% rate cut. This, plus the fact that Medi-Cal will now not even reimburse me what it costs my pharmacy to acquire brand drug products (which account for two-thirds of my gross sales amount received from Medi-Cal), it is impossible for my

GERALD SHAPIRO, Pharm.D. (Continued)	pharmacy to remain in business if the 5% rate cut is not stopped. When my pharmacy ceases to operate due to the 5% rate cut, the 5,000-plus homebounds to whom my pharmacy delivers, free, -- whose average age is 79, -- will have no ability to obtain their medicine elsewhere, because (1) very few chain pharmacy locations deliver, and those few who do charge for the delivery, and (2) the independent pharmacies who also deliver in my pharmacy's delivery area will not be able to continue in business. Based on my years of experience, these shut-ins will not be able to get their medicines from any other pharmacy.
MARTIN KIM, R.Ph. President, Californian Korean Pharmacists Association ("CKPA"), CKPA has 130 member pharmacies who can best be described as small, independently owned pharmacies throughout Southern California.	All CKPA pharmacy members participate in the Medi-Cal fee-for-service program. I have spoken to many members of CKPA, and they are well aware and state to me that they will lose money on every brand drug they dispense, and will also lose money on many, if not a majority, of generic prescriptions dispensed under the 5% rate cut. Many tell me that they will stop participating in Medi-Cal if the 5% rate cut is not stopped, or worse, will simply close their pharmacy. Others tell me that although they will continue in business that, nevertheless, (1) they will not dispense any brands at all to Medi-Cal patients, and (2) will not dispense the many generics which they will have to dispense at a loss, under the 5% rate cut; and, -- if the 5% rate cut is not stopped, they will eventually have to close their pharmacies, also. Also, under the 5% rate cut, members of CKPA will discontinue or limit their practice of seeking to obtain Treatment Authorization Request (TAR) approvals from Medi-Cal for patients who require more than six prescriptions a month or are prescribed a medicine which Medi-Cal will only pay for under a TAR. This is a service provided by independent pharmacies which chains by and large do not.

LISA M. FAAST Owner Faast Pharmacy Bakersfield	Approximately 10 % of business revenue comes from sales of prescription items., of which 9% is Medi-Cal fee-for-service. When the State cut Medi-Cal reimbursement by 10% on July 1, 2008, my pharmacy stopped filling medication for all Medi-Cal patients including CCS, Kern Regional Center and regular Medi-Cal patients. I continued that practice until the injunction blocking the cuts was issued on August 18, 2008. My pharmacy will react to the 5% cut by not accepting new Medi-Cal patients and not filling any brand names.
NORMA VESCOVO Executive Director of plaintiff Independent Living Center of Southern California, Inc., ("ILC") for 34 years. Serves the northern Los Angeles area The ILC is a designated center for independent living, which are community-based organizations established under the California Rehabilitation Act (§ 19800 Welf. & Inst Code) to advocate and provide services to enable people with disabilities to achieve independence, including equal access to society.	The ILC serves over 8,000 individuals with disabilities annually, of which approximately 6,375 receive pharmaceutical services in the Medi-Cal fee-for-service program. The pharmacies the ILC works with are all independent pharmacies, for the reason that chain pharmacies in our area do not perform the level of pharmaceutical services for our disabled clientele that independent pharmacies, in our area, perform. This higher level of service by independent pharmacies for persons with disabilities includes the pharmacist taking the time and trouble to obtain Treatment Authorization Request ("TAR") approvals from a Medi-Cal section so that their disabled patients, in need thereof, can obtain the medicines prescribed for them by their Medi-Cal doctor. And, the independent pharmacies in our area regularly deliver to the disabled community, many of therm quadriplegic or paraplegic, whom the ILC serves, without charge. In contrast, I do not know of a single chain pharmacy in our area will process TARs for our disabled clients, and, very few chain pharmacy locations in our area deliver, and those few chain locations who do deliver charge for their delivery, -- which our disabled clients, living on a small SSP monthly benefit, are unable to pay. During July through the early part of September, 2008, when the 10% rate reduction was in effect in the Medi-Cal fee-for-service

NORMA VESCOVO (Continued)	pharmacy program, my supervisors reported to me that at each of our three larger facilities, several hundred of our SSI clients reported that they were unable to obtain their brand prescriptions, and also were unable to obtain a large percentage of their generic prescriptions, during this period, from either independent pharmacies or chain pharmacies in our area. I understand that Medi-Cal is going to institute a 5% rate payment reduction to pharmacies in the Medi-Cal fee-for-service program. I have spoken with a number of pharmacy owners in our area and they invariably tell me that under the 5% cut, starting March 1, 2009, they will have to cease dispensing nearly all brand prescriptions and also many generic prescriptions, for the reason that for brands, (and for many generic prescriptions also), the 95% of their regular payment from Medi-Cal is not sufficient to cover what they have to pay to acquire the brand drug (or the generic drug, as the case may be). Of special concern to me as chief of the ILC, -- in addition to my concerns about this threat of inability of our disabled clients who are quadriplegic, paraplegic, in constant need of oxygen, and those who are chronically in need of medicines for their chronic conditions and illnesses, -- are the special situations of the hundreds of our psychologically disabled patients, who have to take psychiatric medicines regularly without a break, and do so for a long period of time before improving, if ever, the client's situation. If these special clients cannot get their psychiatric medicine, and get off their regime, it takes a long time for them to come back to get back to the proper treating, -- if they ever come back, -- including starting to take their psychiatric medicine again and get back into the psychiatric medicine regime. And, many of these clients, once their psychiatric medicine regime is interrupted, drift out of their established lives and wind up in Emergency Rooms from acting out behavior, or become or resume being homeless on the street. Also, there are many of our clients who are disabled for psychological reasons, who are on a psychiatric medicine regime which involves taking many medicines for which the purposes for taking are interrelated or inextricable, with any given drug being ineffective without the others.

NORMA VESCOVO (Continued)	So, when these clients are unable to get a brand prescription, which is the key or arch medicine which is required to be regularly taken for the other medicines to have the effect for which they are prescribed, the entire psychiatric medicine regime of the patient becomes ineffective; and some generic substituted for the key brand drug which the pharmacy cannot dispense for cost reasons, does not enable the group of psychiatric medicines to be of any beneficial effect for the client. For the above reason, this State decision to cut pharmacy provider rates in the Medi-Cal fee-for-service program by 5%, starting March 1, 2009, will injure thousands of our disabled SSI clients who are beneficiaries of Medi-Cal, by reducing, preventing, and denying them access to medicines, particularly, brand medicines, and many generic medicines, which are necessary not only for their health but to enable them to continue to live independently in the community, and will drive many of them into institutions to enable them to obtain their indispensable medications, and, to obtain them in a timely enough manner soon enough to prevent or survive life-threatening episodes caused by the conditions which disabled them.
FRANK FORNASERO, Ming & H Pharmacy Bakersfield	With the 10% cut we discouraged new Medi-Cal patients. When the 5% cut is applied we will discourage new Medi-Cal patients and no longer carry medication that we are reimbursed below cost for.

Summary and prayer

For the above reasons, the Plaintiffs respectfully pray that the Plaintiffs' motion for preliminary injunction be granted in whole and in every part; and that the Director be ordered to refrain from implementing § 14105.191, Welf. & Inst. Code, or the 5% pharmacy provider payment reduction in the Medi-Cal fee-for-service program, for services on and after March 1, 2009; together with such other relief as may be just.

Respectfully submitted,

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