



ADMINISTRATIVE COMPLAINT

By U.S. Mail and Email (ocrmail@hhs.gov)

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Re: Inadequate Access to Health Care Violates Latino Civil Rights in California's Medi-Cal Program

I. INTRODUCTION

This administrative complaint challenges ongoing civil rights violations in Medi-Cal, California's Medicaid program. The Medicaid Act is intended to ensure that state programs like Medi-Cal provide access to medical services equal to the access that other Americans have, notwithstanding the low income of those who qualify for Medi-Cal.

Medi-Cal's inadequate, extremely low reimbursement rates—in both the fee for service and managed care settings—and its failure to adequately monitor access to medical care, effectively deny the full benefits of the Medi-Cal program to the more than seven million Latino enrollees who rely on Medi-Cal for their healthcare. Over the past fifteen years, the level of Medi-Cal reimbursements has fallen in tandem with a rise in the number and proportion of Latinos covered by the Medi-Cal program. Today, no other type of health insurance in California covers a population that is so heavily Latino. The separate and unequal system of healthcare thus violates the protections of Title VI of the Civil Rights Act and the

Department of Health and Human Services' implementing regulations, as well as Section 1557 of the Affordable Care Act, as described below.

II. PARTIES

This administrative complaint is filed by complainants Saul and Analilia Jimenez Perea as well as Jose A. Berumen (collectively, "Complainants"), all Latino Medi-Cal enrollees, on behalf of a class of Latino, non-elderly adult Medi-Cal enrollees pursuant to Title VI, HHS regulations, and Section 1557.¹

Complainants and the class bring this complaint against Respondents Diana S. Dooley, the Secretary of the California Health and Human Services Agency ("CHHSA") and Jennifer Kent, Director of the California Department of Health Care Services ("DHCS"), as well as CHHSA and DHCS (collectively, "Respondents").

In her role as Secretary, Ms. Dooley oversees the setting the fee for service and capitated managed care Medi-Cal reimbursement rates that this complaint challenges, and supervises the Medi-Cal program under the authority of the Governor. Cal. Health & Safety Code §§ 12850, 12850.4. Reporting to CHHSA, DHCS is California's designated "single state agency," designated to administer or supervise the administration of the Medicaid program under Title XIX of the Social Security Act. Ms. Kent, as Director of DHCS, is responsible for setting the fee for service and capitated managed care Medi-Cal reimbursement rates that this complaint challenges and, under Ms. Dooley, is responsible for administering the Medi-Cal program and ensuring that Medi-Cal beneficiaries in managed care plans have proper access to services. Cal. Welf. & Inst. Code § 10721.

III. SUMMARY OF CLAIM

Title VI provides comprehensive protections against discrimination in the use of federal funds, mandating that "[n]o person . . . shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." 42 U.S.C. § 2000d. Section 1557 of the Affordable Care Act ("ACA"), 42 U.S.C. § 18116, prohibits any health program or activity that

¹ For purposes of this charge, "non-elderly adult" means individuals that are 19 to 64 years old. There is also evidence of discrimination against other Medi-Cal beneficiaries that Complainants are investigating, including against children and elderly adults, and Complainants will supplement this complaint if appropriate.

receives federal financial assistance from discriminating on the basis of, among other things, race, color, or national origin.

Medi-Cal receives federal financial assistance, and the overly low reimbursement rates it sets for many medical services, combined with its failure to provide adequate monitoring and enforcement, result in discrimination against California's Latino enrollees. As described below, the Medicaid Act requires that Medi-Cal recipients receive medical assistance with "reasonable promptness" and that state officials set rates sufficient to ensure that health care is made available to Medicaid enrollees "at least to the extent" such care is available to other members of the "general population." As construed by the federal government, the "general population" includes individuals with health care covered by Medicare and by employer-sponsored plans.

Respondents, however, have declined to set fee-for-service and managed care rates for Medi-Cal enrollees high enough to achieve availability of medical care comparable to that provided to individuals covered by Medicare or employer-sponsored health plans. Further, Medi-Cal recipients do not receive reasonably prompt medical assistance; they must often wait exceptionally long periods of time to receive the medical assistance they need and have requested through the Medi-Cal program.

California has nearly the lowest reimbursement rates of any Medicaid program in the nation, both for fee for service and in managed care. See below, Section VI.B. These low rates negatively impact Complainants and similarly situated Latino Medi-Cal enrollees in both the primary care and specialty care settings.

First, Complainants allege that the low rates Respondents have set for primary care result in denying access to Complainants and similarly situated Latino Medi-Cal enrollees. Medi-Cal's low primary care rates—a fraction of the reimbursement rates providers earn from Medicare or employer-sponsored plans—deter physicians from serving sufficient numbers of Medi-Cal enrollees. Indeed, the primary care reimbursement rate is lower in many cases than the providers' cost of providing care. As a result, Medi-Cal enrollees have inadequate access to comprehensive, high-quality preventive primary care via family medicine or internal medicine physicians. Such access is a critical component of health care services that would otherwise help keep Medi-Cal enrollees out of emergency rooms and hospitals for avoidable reasons through earlier diagnoses and overall improvement of health status.

Similarly, reimbursement rates for medical specialties under Medi-Cal are significantly lower than rates for the same care provided to Medicare beneficiaries and those with private insurance. These insufficient reimbursements mean that, even if an enrollee does have a regular source of primary care, when that physician needs to refer a patient for more complex procedures or diagnoses, the patient often has to wait for months for an appointment because of the dearth of specialty providers willing to take Medi-Cal's low payments. This can result in people suffering undue pain and hardship, and developing serious complications while waiting for specialty care, often ending up in an emergency room or with exacerbated disabling or damaging conditions.²

Latino Californians are over-represented among Medi-Cal enrollees when compared to other racial and ethnic groups. In 2014, an estimated 7.3 million Latinos received their healthcare through Medi-Cal, which has become the single largest source of health care insurance for Latinos in California.³ Medi-Cal's low reimbursement rates, and the lengthy delays that enrollees must endure before receiving medical assistance, "exclude[]" Latino Californians "from participation in" the Medi-Cal program, "den[y]" them the "benefits of" that program, and "otherwise subject[]" them to discrimination" in violation of Title VI, HHS regulations and Section 1557.

The low reimbursement rates for primary and specialty care, as well as the lengthy delays in provision of medical assistance to Medi-Cal recipients, therefore cause an adverse disparate impact on Latino Medi-Cal enrollees. The adverse impact on Latinos, as explained below, takes the form of adverse health outcomes

² Janet M. Coffman et al., California HealthCare Foundation, Physician Participation in Medi-Cal: Ready for the Enrollment Boom? 4-5 (Aug. 2014), <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20P/PDF%20PhysicianParticipationMediCalEnrollmentBoom.pdf>.

³ This figure was calculated using the California Health Interview Survey's ("CHIS's") estimate of Latinos' share of Medi-Cal enrollees across all age groups in 2014 (63.2 percent) and DHCS's July 2015 measure of total Medi-Cal certified eligibles, i.e., "those beneficiaries deemed qualified for Medi-Cal by a valid eligibility determination and who have enrolled into the program," as of July 2014. See UCLA Center for Health Policy Research, CHIS, <http://healthpolicy.ucla.edu/chis/data/Pages/GetCHISData.aspx> (comparing "Type of current health insurance coverage – all ages" and "Race – OMB/Department of Finance" datasets for 2014); DHCS, Medi-Cal Certified Eligibles Statewide Pivot as of July 2015 (Nov. 2015), <http://www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal-Certified-EligiblesRecentTrends.aspx>.

CHIS is the largest state health survey in the United States. CHIS data has been collected by the UCLA Center for Health Policy Research since 2001 and includes questions on health insurance status, race/ethnicity, health care needs, and access to health care services.

as well as denial and delay of care resulting in pain and anxiety. For example, a recent study documented that cancer patients on Medi-Cal had lower survival rates, as well as receiving less treatment and later diagnosis for cancer, compared to patients with other forms of coverage.⁴

These low reimbursement rates and failure to monitor and enforce access requirements would be permissible only if Respondents could justify these disparities as necessary or legitimate under the Medicaid Act. They cannot. This course of conduct, therefore, violates the civil rights guarantee that federal financial support for Medi-Cal must not be used to discriminate on the basis of race or ethnicity under Title VI, 42 U.S.C. § 2000d, HHS regulations, and Section 1557.

Respondents' conduct also constitutes intentional discrimination prohibited by Title VI and the HHS Title VI regulations, as described below.

IV. RELIEF REQUESTED

Complainants request that the Office for Civil Rights investigate this complaint and find that Respondents have violated civil rights guarantees. The Office for Civil Rights should order that Respondents raise Medi-Cal reimbursement rates and improve monitoring to ensure the same access to medical care for Medi-Cal enrollees as exists for Medicare beneficiaries and individuals covered by employer-sponsored insurance plans. Specifically, Complainants request that Respondents (1) increase the published fee-for-service reimbursement schedule to provide parity with Medicare rates for primary care and certain medical specialties; and (2) ensure Managed Care Organizations ("MCOs") pay providers at rates that are 100% of the published Medicare fee schedule (or greater).⁵ In addition, Respondents should be required to implement—through DHCS and DMHC, which they oversee—improved oversight and monitoring to ensure that regulatory requirements for access to care are enforced for Medi-Cal managed care plans and fee-for-service providers.

⁴ Arti Parikh-Patel et al., UC Davis Institute for Population Health Improvement, Disparities in Stage at Diagnosis, Survival, and Quality of Cancer Care in California by Source of Health Insurance (2015).

⁵ Proposed Medicaid Managed Care regulations would permit the setting of a floor rate by a state at 100 percent of Medicare, so long as room remains for additional market-based negotiation above that floor. California should be required to use the more generous Medicare fee schedule to price the predicted utilization that the capitated rates are based on and then ensure that the rates are in fact paid to providers. If a benefit or service is not included in the Medicare fee schedule, an equivalent amount should be calculated based on an actuarial benchmark.

The relief requested here, while focused on remedying the disparate impact on Latinos caused by Medi-Cal's low reimbursement rates, would benefit all Medi-Cal enrollees.

V. LEGAL BACKGROUND

A. The Medicaid Act.

The Medicaid Act imposes the legal duty on Respondents to ensure that health care be made available to Medi-Cal enrollees to the same extent that care is available to other groups in the general population covered by other forms of health coverage, that care is provided with reasonable promptness, that managed care plans maintain "a sufficient number, mix, and geographic distribution of providers of services," and that MCOs ensure access to services to the same extent as individuals not enrolled in managed care.

Section 30(A) of the Medicaid Act, 42 U.S.C. § 1396a(a)(30)(A), for instance, requires that Respondents assure that Medi-Cal's plans for payments for medical care "are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area" The federal government for many years has interpreted the reference in Section 30(A) to the benchmark of care available to the general population to include the care available under a state's Medicare program or private employer-sponsored plans has considered Medicare and private, employer-sponsored plans to provide benchmarks for Medicaid rate setting.⁶ For example, in order to increase the availability of care for Medicaid enrollees, as part of the ACA Congress recently enacted a temporary program, ended in December 2014, to reimburse Medicaid primary care providers at 100 percent of the reimbursement rate for Medicare providers delivering specific primary care services. *See infra* section VI.B.

⁶ *See, e.g.*, H.R. Rep. No. 101-247, at 390-91 (1989), *reprinted in* 1989 U.S.C.C.A.N. 1906, 2116-117 (access for Medicaid beneficiaries must equal or exceed access for other public and privately insured individuals; access by the uninsured is not to be part of the comparison); *Oklahoma Chapter of American Academy of Pediatrics v. Fogarty*, 366 F. Supp. 2d 1050, 1104 (N.D. Okla. 2005) (discussing same); *see also* Medicaid Regulations: Reorganization and Rewriting, 43 Fed. Reg. 45,176, 45,258 (Sept. 29, 1978); Medicaid Program: Revisions to Medicaid Payments for Hospital and Long-Term Care Facilities, 52 Fed. Reg. 28,141-01, 28142 (July 28, 1987); Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 80 Fed. Reg. 67,576, 67,578 (Nov. 2, 2015) (final rule with comment period) (to be codified at 42 C.F.R. pt. 447).

In addition to Section 30(A), the Medicaid statute requires that states “provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals.” 42 U.S.C. § 1396a(a)(8). Thus, states and their contracting entities must ensure that individuals who have requested Medicaid services do not experience unreasonably long delays before obtaining them.

Further requirements pertain to Medicaid MCOs as well.⁷ 42 U.S.C. §§ 1396b(m)(1)(A)(i), (2)(A) and 42 C.F.R. §§ 438.206, 438.207 require equal access between managed care enrollees and others and set a standard for actuarial soundness for capitation payments under managed care risk arrangements. 42 U.S.C. § 1396u-2(b)(5) mandates as well that MCOs assure that they “offer[] an appropriate range of services and access to preventive and primary care services,” and “maintain[] a sufficient number, mix, and geographic distribution of providers of services.”

B. Title VI.

Title VI of the Civil Rights Act of 1964 provides a clear and comprehensive prohibition of discrimination in the use of federal funds. *See* 42 U.S.C. § 2000d (“No person . . . shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.”). The Medi-Cal program is jointly funded by federal and state funds. Title VI and its implementing regulations apply because Respondents receive federal funds to operate the Medi-Cal program.

C. ACA Section 1557.

Section 1557 of the ACA prohibits a similarly broad range of discrimination in any health program which receives federal funding under the ACA:

[a]n individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 . . . be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or

⁷ Claimants contend that Section 30(a) applies equally to Medicaid managed care and fee for service, notwithstanding CMS’s proposed regulations to the contrary. Nothing in 30(a) exempts its requirements that rates be adequate to assure access to services from applying to the rates that managed care plans pay to providers.

activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments).

42 U.S.C. § 18116(a). Medi-Cal is a covered program under Section 1557, as is true under Title VI, because it is paid for in part with federal funds. Accordingly, Medi-Cal cannot, consistent with the ACA, discriminate on the basis of race or national origin.

Evidence sufficient to make out a Title VI violation also establishes a Section 1557 violation. Section 1557 requires that “[t]he enforcement mechanisms provided for and available under [] title VI . . . shall apply for purposes of violations of this subsection.” *Id.* Accordingly, Section 1557 must be interpreted to provide for disparate impact or disparate treatment claims brought on behalf of a class or by a third party.

VI. DISCUSSION

A. Background of Complainants.

1. Saul and Analilia Jimenez Perea.

Saul Jimenez Perea is 31 years old. Since his birth, Mr. Jimenez Perea has had cerebral palsy and has been semi-paraplegic. Saul attends a program for disabled adults during the day. His mother, Analilia Jimenez Perez, works full time in a health clinic. She also dedicates significant time to organizing and coordinating Mr. Jimenez Perea’s care.

Mr. Jimenez Perea has a history of severe seizures that have required frequent hospitalizations. Until he was 21, 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, however, Mr. Jimenez Perea lost his CCS coverage and support from Shriner’s. About eight years ago, after some struggles to find coverage, his social worker helped him enroll in regular, full-scope Medi-Cal. As part of the mandatory enrollment into Medi-Cal managed care, he was enrolled into the Partnership HealthPlan of California (“PHC”) about three years ago.

At the time Mr. Jimenez Perea enrolled in PHC, he was having seizures every month, which were so severe that they regularly sent him to the emergency room. Mr. Jimenez Perea's seizures resulted from a change in his medication from Tegretol XR to a generic seizure-control medication, as PHC would not cover the Tegretol. Mr. Jimenez Perea was supposed to see a neurologist every 6 to 12 months, but his mother could not find anyone willing to see him. She pleaded with PHP to cover the Tegretol, but PHC repeatedly refused.

Eventually, she received a referral from Mr. Jimenez Perea's primary care physician to another neurologist, to see what could be done to address his frequent seizures. Even with this referral, however, Mr. Jimenez Perea was unable to see a neurologist for more than a year and a half. The neurologist from UCSF to whom Mr. Jimenez Perea was referred never had any available appointments, and the office told his mother to keep calling back every two to three weeks to see where she was on the waiting list. Eventually, she secured another referral from the primary care clinic, but then Mr. Jimenez Perea had to wait another three months for his appointment. He finally saw the neurologist on October 30, 2015.

Mr. Jimenez Perea also needs to see an ophthalmologist because hypertension arising from his cerebral palsy has put 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, however, saying he could no longer afford to take Medi-Cal. 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 over a year for his needed ophthalmologist visit.

Mr. Jimenez Perea also has hepatitis. Prior to his enrollment in PHC, he was able to see a nurse practitioner 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 and he would have to go elsewhere. He had to wait for an appointment at a federally qualified health center, which receives additional reimbursements. Once again, Mr. Jimenez Perea had to wait many months for the treatment that he needed as a result of his Medi-Cal status.

Ms. Jimenez Perea has often sought help from her son's social workers, and they have endeavored to assist, including by calling Medi-Cal on her son's behalf. But despite their efforts to help Mr. Jimenez Perea find referrals and needed care,

their assistance has not made it possible for him to get the care he needs when he needs it. Further, as a medical assistant for a community health clinic, Ms. Jimenez Perea is frequently in the position of trying to help clients get care through PHC, and has found that the repeated “no’s” can be insurmountable.

2. Jose A. Berumen.

Jose A. Berumen is a 61-year-old, Latino resident of Oakland. He has been employed as a janitor at a restaurant since approximately 2008. He used to receive medical coverage from his employer, through which he had a primary care physician he saw on a regular basis for such things as periodic checkups, medical tests, and preventive care. He obtained referrals from his primary care physician to specialists as needed, including a cardiologist for heart problems, and was able to get appointments.

His employer, however, dropped Mr. Berumen from coverage on February 20, 2014. The employer told him that he qualified for Medi-Cal because of his low income. Mr. Berumen enrolled in Medi-Cal through Blue Cross soon after the loss of his employer-sponsored coverage because he had a hernia operation scheduled to be performed on March 20, 2014 at the Eden Medical Center in Castro Valley.

At an appointment for blood work and X-rays shortly before the date of the operation, Mr. Berumen told the nurse that he was a Medi-Cal patient. The nurse then informed him that the urologist would not accept patients with Medi-Cal coverage and canceled the surgery. The nurse instructed Mr. Berumen to visit the Alameda Medi-Cal office to ask for the name of a surgeon who would accept Medi-Cal patients. Mr. Berumen did so, but was not given the name of a surgeon.

Mr. Berumen was suffering great pain, and thus asked his primary care physician for another referral, but the doctor was initially unable to identify a physician who would perform the surgery for a Medi-Cal patient. The doctor’s nurse informed Mr. Berumen that the doctor was losing money on caring for him. The doctor said that he would continue providing care to Mr. Berumen for the time being because he had been his patient for a number of years. Meanwhile, the hernia grew more and more painful. The primary care physician told Mr. Berumen to rest and take Advil to deal with the pain while he tried to identify a surgeon to perform the hernia operation.

Finally, in November 2014 his primary care physician identified a surgeon at San Leandro Hospital. Mr. Berumen called the surgeon’s office, which gave him an appointment for January 2015, the earliest available date. The office assured him that the surgeon accepted Medi-Cal patients. When he went to the

appointment, however, the doctor's medical assistant informed Mr. Berumen that the office would not accept Medi-Cal.

Mr. Berumen's primary care physician told him that there were no other surgeons he could refer him to for hernia surgery. In June 2015, the primary care physician informed Mr. Berumen that he himself could no longer afford to provide Mr. Berumen care.

Meanwhile, on June 5, 2015, the Mercury News published an article that identified Mr. Berumen as a Medi-Cal patient who had been waiting for a hernia operation for over a year. Shortly after the article appeared, the Medi-Cal office (which he had called over a year before) referred him to La Clínica de la Raza ("La Clínica") in East Oakland for medical care. La Clínica has referred him to a specialist for his hernia surgery, which occurred November 13, more than a year and a half after the originally scheduled operation. Mr. Berumen has been unable to work due to the pain from the hernia, but is hoping to return to work soon.

* * * *

Each complainant, in short, has been "excluded from participation in" the Medi-Cal program, "denied the benefits of" that program, or "otherwise subjected . . . to discrimination" in violation of Title VI, HHS regulations, and Section 1557.

B. Low Reimbursement Rates Limit Access to Care for Medi-Cal Enrollees.

1. Background on Medi-Cal Rate Setting in California.

Medi-Cal rates in California are set differently based on two payment mechanisms: (1) fee for service; and (2) managed care.

In the fee for service mechanism, the State sets per-service reimbursement rates for a particular procedure, treatment, or service. These rates are near the lowest in the country relative to Medicare rates. Medi-Cal's 2014 reimbursement rate for primary care was just 42 percent of Medicare's, ranking *forty-ninth* out of fifty Medicaid programs in the United States. For all services, including both primary and specialty care, the ratio of Medi-Cal fee for service reimbursement to Medicare reimbursement in California was 14 percent below the national average ratio.⁸ This ratio ranks *forty-eighth* out of fifty Medicaid programs in the United

⁸ This gap would be even wider if California were not factored into the national average.

States.⁹ Notably, these numbers have likely only worsened in 2015, given reductions implemented this year.¹⁰

In managed care, which now covers about 77 percent of the Medi-Cal population,¹¹ plans are reimbursed on a capitated basis with a set amount per member per month regardless of the amount of services provided to that individual. Pursuant to federal regulation, the State is required to set capitation rates for MCOs sufficient to cover a minimum level of services for the populations enrolled in each MCO. Once these capitation rates are set, CMS reviews them to determine whether they are “actuarially sound.” In other words, it reviews them to determine whether they are sufficient to provide the minimum level of services predicted by a third-party actuarial contractor. Additionally, under the Medicaid law, the MCO must also make services available to the same extent as they would be available to Medi-Cal fee-for-service beneficiaries (and thus to the same extent as required by § 30(a)). See 42 U.S.C. § 1396b(m)(1)(A)(i).

Although the rates paid to MCOs are proprietary, it is widely recognized that they are set arbitrarily low due to the use of the low Medicaid fee-for-service fee schedule as a benchmark, or another set of benchmarks provided by plans that may be even lower than the Medicaid fee-for-service fee schedule.¹² Further, the evidence will show that the State typically reverse engineers its capitation rates from budgetary decisions, first deciding how much money to allot for Medi-Cal managed care, then coming up with capitation rates within that budget by manipulating the potential prices for services such that the predicted utilization (from the actuaries) when combined with pricing information, will be within

⁹ See Stephen Zuckerman et al., The Urban Institute, Reversing the Medicaid Fee Bump: How Much Could Medicaid Physician Fees for Primary Care Fall in 2015 14 tbl.A.2 (Dec. 2014), <http://www.urban.org/research/publication/reversing-medicaid-fee-bump-how-much-could-medicaid-physician-fees-primary-care-fall-2015>.

¹⁰ See David Gorn, *Primary Care Medi-Cal Providers About to Be Hit by Double Rate-Cut Whammy*, California Healthline (Dec. 8, 2014), <http://www.californiahealthline.org/capitol-desk/2014/12/primary-care-medical-providers-about-to-be-hit-by-double-ratecut-whammy>.

¹¹ DHCS, Medi-Cal Certified Eligibles Statewide Pivot as of July 2015 (Nov. 2015), <http://www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal-Certified-EligiblesRecentTrends.aspx>.

¹² See, e.g., *Do Medi-Cal Rates Ensure Access to Care?: Joint Oversight Hearing Before the S. Health & Ass. Health Comms.*, 2015-16 Sess. (Cal. Mar. 4, 2015), <http://senate.ca.gov/media/joint-legislative-oversight-hearing-do-medi-cal-rates-ensure-access-care?type=video>; Agenda, *Do Medi-Cal Rates Ensure Access to Care?: Joint Oversight Hearing Before the S. Health & Ass. Health Comms.*, 2015-16 Sess. (Cal. Mar. 4, 2015), http://shea.senate.ca.gov/sites/shea.senate.ca.gov/files/medi-cal_rates_briefing_paper_final.pdf.

budget. Finally, the State typically selects rates that are at the lower of the range of rates recommended by the actuary.¹³

2. Restricted Access for Medi-Cal Beneficiaries.

The data show that non-elderly adults enrolled in Medi-Cal have substantially less access to health care than Medicare beneficiaries, individuals covered by private insurance plans and/or other groups in the general population. The experiences of Mr. Jimenez Perea and Mr. Berumen are not unusual, and apply to Medi-Cal fee for service and managed care enrollees alike.

Data from the UCLA Center for Health Policy Research's California Health Interview Survey ("CHIS") shows that in 2011-2012, just after the ACA's passage, but before the federally-funded Medicaid primary care fee increase or insurance expansion occurred, Medi-Cal beneficiaries faced significant barriers to obtaining care, with more than twice the proportion of Latino Medi-Cal enrollees not having a usual source of care compared to other groups. Non-elderly adult Medi-Cal beneficiaries overall were 13 percent less likely to have a usual source of care, compared to their counterparts with employer-based insurance.¹⁴

In 2013, on the eve of the implementation of the Affordable Care Act, the care available to non-elderly adult Medi-Cal enrollees was worse than the care available to those covered by employer-sponsored insurance plans. Medi-Cal enrollees faced disparities at levels that were statistically significant for such measures of availability of care as (a) not having a usual source of care other than an emergency room; (b) not having a personal physician as the main medical provider; (c) difficulty getting a needed doctor's appointment; (d) difficulty finding a doctor who would see them or accept their health insurance; (e) difficulty communicating with their doctors; (f) being less likely to receive flu

¹³ See, e.g., Mercer, DHCS Capitated Rate Development Division & Mercer All Plan Meeting (Dec. 14, 2012), http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Fin_Rpts/DHCS_CRDD_MercerAllPlanRateMtg12-14-12.pdf (discussing rate-setting process); Mercer, State of California – Medi-Cal Rate Development for Seniors and Persons with Disabilities (SPD) (Jan. 25, 2011), http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Fin_Rpts/All-PlanMtgPresentation_01-25-2011.pdf (same).

¹⁴ UCLA Center for Health Policy Research, CHIS, <http://healthpolicy.ucla.edu/chis/data/Pages/GetCHISData.aspx> (comparing Current Coverage by Usual Place to Go When Sick, ages 19-64) (actual numbers are 18.7 percent and 8.1 percent, respectively).

vaccinations; (g) not having a doctor visit in the last year; and (h) delaying medical care because of cost.¹⁵

The ACA increased enrollment in Medi-Cal, but, as implemented by California, the ACA did not resolve pre-existing access problems. As a result of the Healthy Families transition, ongoing enrollment, and the ACA, over 4 million people enrolled in Medi-Cal over the past two years.¹⁶ A two-year, federally-funded increase in the Medi-Cal reimbursement for primary care to 100 percent of the Medicare reimbursement rate during 2013 to 2014 was allowed to expire without Respondents maintaining the increase through use of state funds (as done by fifteen other states). The increase was applicable to both fee for service and managed care populations and designed to improve access. This short-term investment in increasing primary care provider rates did not result in a sustainable increase in primary care access for Medi-Cal beneficiaries. The State implemented it late (going into effect in 2014 and retroactively reimbursing providers by paying the difference between the Medicare and Medicaid fee schedules after the fact). And, the additional investment of funds ended on December 31, 2014.¹⁷ Thus, regardless of whatever minimal increase in services may have occurred in 2014, it is likely that availability of primary care services for Medi-Cal enrollees has returned to pre-2014 levels.

Indeed, the Medi-Cal provider to population ratio was already substandard, but with the increase in enrollment and withdrawal of the temporary rate increase the gap can be expected to widen even further.¹⁸

¹⁵ See Sharon K. Long, PhD & Nathaniel Anderson, California HealthCare Foundation, *Medi-Cal Versus Employer-Based Coverage: Comparing Access to Care* 7-8 (July 2015), <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20M/PDF%20MediCalAccessComparedUrban.pdf>.

¹⁶ California HealthCare Foundation, *Medi-Cal Enrollment Growth Could Strain California's Budget*, California Healthline (July 20, 2015), <http://www.californiahealthline.org/articles/2015/7/20/medical-enrollment-growth-could-strain-state-budget>; Scott Graves, California Budget & Policy Center, *Medi-Cal and the Governor's Proposed 2015-16 Budget: Health Care Reform Boosts Enrollment and Federal Funding*, California Budget Bites (Jan. 23, 2015), <http://calbudgetcenter.org/blog/medi-cal-and-the-governors-proposed-2015-16-budget-health-care-reform-boosts-enrollment-and-federal-funding/>.

¹⁷ Medi-Cal's failure to continue the primary care increase past 2014 was anticipated to result in a net 59 percent decrease in primary care physician rates from 2014. Zuckerman, *supra* note 9, at 7 tbl.1.

¹⁸ See Coffman, *supra* note 2; DHCS, *ACA Increased Medicaid Payment for Primary Care Physicians*, https://files.medi-cal.ca.gov/pubsdoco/aca/aca_form_landing.asp (last visited Dec. 11, 2015); Zuckerman, *supra* note 9.

Newer data demonstrates the current disparities in access for both primary care and specialty care. In 2014, approximately 3 times as many Medi-Cal recipients aged 19 to 64 reported difficulty finding both primary care and specialty care compared to their counterparts with employer-sponsored health insurance.¹⁹

3. Evidence that Low Reimbursement Rates Limit Medi-Cal Beneficiaries' Access to Care.

Both the fee-for-service and managed care rates fail to ensure equal access to quality care for Medi-Cal enrollees, as the insufficient reimbursements make it difficult to enlist Medi-Cal primary care and specialty care providers.²⁰

Participation in Medi-Cal by providers is low when compared to commercial insurance and Medicare. A third more physicians were caring for commercially insured patients as compared to Medi-Cal, and 12 percent more were caring for Medicare patients.²¹ Only 62 percent of providers in California reported a willingness to accept new Medi-Cal patients, 21 percent less than those accepting new Medicare patients, and 27 percent less than those accepting commercially insured patients.²² Indeed, the ratio of Medi-Cal participating primary care physicians was *below* the one primary care physician per 2000 patient threshold statewide.²³ Certain specialties are very unlikely to accept Medi-Cal patients, such as general internal medicine, family medicine, and psychiatry.²⁴

¹⁹ UCLA Center for Health Policy Research, CHIS, <http://healthpolicy.ucla.edu/chis/data/Pages/GetCHISData.aspx> (comparing Current Coverage by Difficulty finding primary care, ages 19-64, 2014 dataset); *id.* (comparing Current Coverage by Difficulty finding specialty care, ages 19-64, 2014 dataset).

²⁰ See Benjamin D. Sommers et al., *Reasons for the Wide Variation in Medicaid Participation Rates Among States Hold Lessons for Coverage Expansion in 2014*, 31:5 Health Affairs 909, 912-14 (May 2012) (increased Medicaid reimbursement linked to better access to health professionals for Medicaid enrollees).

²¹ Coffman, *supra* note 2, at 5.

²² *Id.* at 10.

²³ *Id.* at 3, 8-9 (35 to 49 FTE primary care physicians participating in Medi-Cal per 100,000 Medi-Cal enrollees, i.e., one FTE primary care physician per 2041 to 2857 Medi-Cal enrollees).

²⁴ *Id.* at 6. Specifically, the study found physician acceptance rates for Medi-Cal patients in general internal medicine of 65 percent, family medicine of 64 percent, and psychiatry of just 47 percent. *Id.* In comparison, those three specialties accept Medicare patients at higher rates of 93 percent, 89 percent, and 58 percent, respectively. *Id.*

Paying 100 percent of Medicare's fee schedule would draw significant numbers of physicians across multiple specialties into Medi-Cal networks. Physicians providing care through both fee for service and managed care cite low Medi-Cal reimbursements as a serious problem limiting their willingness to care for Medi-Cal patients. Reimbursements are not only lower than Medicare or private insurance, but also often well below the physicians' costs of providing care. Physicians therefore have to cross-subsidize their Medi-Cal patients using payments from higher-income patients who pay out of their own pockets, or have employer-based insurance or unsubsidized private plans, resulting in most physicians having Medi-Cal enrollees as fewer than thirty percent of their patients.²⁵ Physicians have less room to cross-subsidize Medi-Cal patients today than in the past because insurers have lowered many reimbursements for private plans.²⁶

National studies show that physicians' acceptance of Medicaid patients increases as Medicaid payment rates increase. Office-based primary care physicians accept new patients at levels that correlate with payment rates: 88 percent of primary care providers accept new self-pay patients, 81 percent accept new private insurance patients, 71 percent accept new Medicare patients, and 66 percent accept new Medicaid patients.²⁷ Acceptance rates by primary care physicians of new Medicaid patients have been found to be higher in states where the ratio of Medicaid to Medicare fees was higher.²⁸ Increasing that ratio predicted an increase in the percentage of primary care physicians accepting new Medicaid patients.²⁹

²⁵ *Id.* at 7-8.

²⁶ Mark H. Showalter, *Physicians' Cost Shifting Behavior: Medicaid Versus Other Patients*, 15.2 *Contemporary Economic Policy* 74 (Apr. 1997), <http://search.proquest.com/openview/849f4a8a3b69e0bcdd4ca83e5d42737b/1?pq-origsite=gscholar>; Austin B. Frakt, *How Much Do Hospitals Cost Shift? A Review of the Evidence*, 89:1 *Milbank Quarterly* 90 (Mar. 2011), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3160596/>.

²⁷ Sandra L. Decker, *In 2011 Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, but Rising Fees May Help*, 31:8 *Health Affairs* 1673, 1675 Ex. 1 (Aug. 2012), <http://content.healthaffairs.org/content/31/8/1673.full.pdf+html>.

²⁸ *Id.* at 1678 Ex. 4.

²⁹ *Id.* at 1676.,

C. Disparate Outcomes for Medi-Cal Patients.

As a result of the low access that Medi-Cal enrollees have to primary care, many Medi-Cal recipients are not referred to specialists for treatment of acute conditions and illnesses. Chronic conditions and illnesses thus go untreated or are not adequately treated. Substantially fewer physicians provide care to Medi-Cal enrollees than Medicare beneficiaries in every major medical specialty except two.³⁰ The two exceptions are obstetrics/gynecology and pediatric care, specialties that the Medicare population is unlikely to need to the same extent as Medi-Cal beneficiaries.

A recent study, conducted by UC Davis researchers, shows significant disparities in access to cancer care for Medi-Cal enrollees and less favorable outcomes than those covered by other forms of insurance.³¹ Medi-Cal patients with breast, colon, and rectal cancer were found to be more likely to be diagnosed at advanced stages of the disease, less likely to get recommended treatments, and had less favorable survival rates than persons with other sources of insurance. For example, Medi-Cal patients were particularly unlikely to be diagnosed at early stages of breast and lung cancer; particularly likely to be diagnosed at late stages of breast, colon, and rectal cancer; and particularly unlikely to receive recommended radiotherapy for breast cancer. Overall, the study is “consistent with previous studies which have reported poorer survival and higher proportions of late stage at diagnosis among Medicaid recipients across several cancer types.”³²

D. Lack of Monitoring and Enforcement.

In implementing the Medi-Cal program for MCOs, DHCS has set standards requiring readily available access to care.³³ For example, all Medi-Cal MCOs must have at least one full-time equivalent physician for every 1,200 enrollees, and one primary care provider for every 2,000 enrollees.³⁴ Further, time and distance between primary care providers’ offices and enrollees’ residences must be no

³⁰ Coffman, *supra* note 2, at 11 fig.9.

³¹ Parikh-Patel, *supra* note 4.

³² *Id.* at 31.

³³ See, e.g., DHCS, COHS Boilerplate, Ex. A, Att. 9 § 3 (2014) (sample DHCS contract with plans incorporating Knox-Keene standards from 28 Cal. Code Regs. § 1300.67.2), <http://www.dhcs.ca.gov/provgovpart/Documents/COHSBoilerplate032014.pdf>.

³⁴ *Id.* at Ex. A, Att. 9 § 3.A.2; 22 Cal. Code Regs. § 53853(a).

greater than 30 minutes or 10 miles, while maximum allowable appointment wait times are 48 hours for urgent primary care, 10 business days for routine primary care, and 15 business days for specialty care.³⁵ Complainants and thousands like them, however, have had to wait many months, or even years, for their needed appointments.

As recent reports by the California State Auditor and Legislative Analyst's Office document, these clear standards are not met or enforced for many Medi-Cal enrollees, and delay in receiving medical care is common. Additionally, monitoring for these and other network adequacy requirements occurs only in retrospect, with few immediate remedies available to patients suffering from delays in medical care, a lack of timely access to appointments, and rejections by providers unwilling to treat Medi-Cal patients.³⁶

E. Medi-Cal's Inadequate, Low Rates, Combined with the Lack of Monitoring and Enforcement, Have a Disparate Impact on Latinos.

The low reimbursement rates described above—including within fee for service and managed care—along with the lack of monitoring and enforcement, have an adverse, disparate impact on Latinos because this racial group is disproportionately represented among Medi-Cal enrollees.

Latinos are heavily overrepresented among the Medi-Cal population. For non-elderly adults, Latinos were about 57 percent of Medi-Cal enrollees in 2014, compared to only 38 percent of California's total non-elderly adult population.³⁷ For all age groups, Latinos were about 63 percent of Medi-Cal enrollees in 2014,

³⁵ COHS Boilerplate, *supra* note 33, at Ex. A, Att. 9 § 3.A.2; see HHS, Office of Inspector General, State Standards for Access to Care in Medicaid Managed Care (September 2014).

³⁶ Cal. State Auditor, Report 2014-134, Improved Monitoring of Medi-Cal Managed Care Health Plans is Necessary to Better Ensure Access to Care (June 2015), <https://www.auditor.ca.gov/pdfs/reports/2014-134.pdf>; see also Legislative Analyst's Office, Access to Care in Medi-Cal: Focusing Oversight on Managed Care (Mar. 4, 2015), <http://www.lao.ca.gov/handouts/health/2015/Access-to-Care-in-Medi-Cal-Focusing-Oversight-on-Managed-Care-030415.pdf> (criticizing lack of monitoring and collection of data by DHCS and DMHC).

³⁷ UCLA Center for Health Policy Research, CHIS, <http://healthpolicy.ucla.edu/chis/data/Pages/GetCHISData.aspx> (comparing "Type of current health insurance coverage - all ages" and "Race - OMB/Department of Finance," ages 19-64, 2014 dataset).

compared to only 39 percent of California's total population.³⁸ This amounted to approximately 7.3 million Latino Medi-Cal enrollees in 2014.³⁹

Moreover, Medi-Cal is the largest single source of healthcare coverage for California Latinos. 37 percent of Latinos of all ages were enrolled in Medi-Cal in 2014, compared to 17 percent of Asians and 10 percent of Whites.⁴⁰ Low Medi-Cal reimbursement rates therefore adversely affect Latinos more than any other group.

In contrast, Whites and Asian-Americans are over-represented among Medicare beneficiaries and individuals covered by private insurance, the forms of coverage the Medicaid Act establishes as comparators for availability of care. Whites and Asian-Americans, while only a combined 52 percent of California's population, are 81 percent of Medicare beneficiaries and 62 percent of individuals covered by employer-sponsored plans. Latinos are 39 percent of California's population, but only 12 percent of Medicare beneficiaries and 29 percent of individuals covered by employer-sponsored plans.⁴¹

Medi-Cal fee for service rates relative to Medicare have fallen as Medi-Cal has increasingly become disproportionately Latino. Between 2001 to 2014, the percentage of Latinos as a share of Medi-Cal enrollees has grown from less than 50 percent to over 63 percent. In absolute numerical terms, the number of Latino beneficiaries grew from about 2.6 million to about 7.3 million by 2014.⁴²

³⁸ *Id.* (all ages).

³⁹ *See supra* note 3.

⁴⁰ UCLA Center for Health Policy Research, CHIS, <http://healthpolicy.ucla.edu/chis/data/Pages/GetCHISData.aspx> (comparing "Type of current health insurance coverage – all ages" and "Race – OMB/Department of Finance," all ages, 2014 dataset).

⁴¹ *Id.* (aggregating both "Medicare & Others" and "Medicare only" populations).

⁴² *See* CMS, MSIS Table, Medicaid Beneficiaries by Race/Ethnicity (2001), https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/Downloads/MSIS_Tables/MSIS2001Table14.zip (omitting "Not Identified" from total beneficiaries); DHCS, Trend in Medi-Cal Program Enrollment – Most Recent 24 Months (Dec. 2013), http://www.dhcs.ca.gov/dataandstats/statistics/Documents/1_historic_trend.xls (5,212,139 total beneficiaries in January 2001); *supra* note 3 (7.3 million Latino beneficiaries in 2014).

Meanwhile, Medi-Cal reimbursement rates as a share of Medicare rates declined from 65 percent in 2001 to 52 percent in 2014.⁴³

Table 1		
Year	Latinos as % of Medi-Cal Population	Medicaid-Medicare Fee Index - All Physician Specialties
2001	49.6%	65%
2003	53.8%	59%
2005	55.3%	58%
2007	57.1%	57%
2009	57.9%	56%
2011	58.1%	54%
2013	66.2%	51%
Analysis of CMS Medicaid Statistical Information System (MSIS) and California Health Information Survey (CHIS) data. Medicaid-Medicare Fee Index percentages derived from Lewin Group and Urban Institute Studies.		

In 2015, the Medi-Cal reimbursement rates have dropped even lower as a percent of Medicare rates. With state roll-backs of the ACA-mandated primary care fee bump and implementation of previously withheld rate cuts, it can be estimated that Medi-Cal rates will be just *44 percent* of Medicare rates effective January 1, 2015.⁴⁴ Meanwhile, Medi-Cal remains a disproportionately Latino health insurance program.

The lower Medi-Cal reimbursement rates today compared to the rates paid by other plans and even Medi-Cal rates in the past have an adverse, disparate impact on Latino non-elderly adults. The data strikingly illustrates that current

⁴³ Joel Menges et al., The Lewin Group, Comparing Physician and Dentist Fees Among Medicaid Programs 3, 22 Ex. G (June 2001), <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20ComparingPhysicianAndDentistFees.pdf>; Zuckerman, *supra* note 9.

⁴⁴ See *supra* note 10.

Latino Medi-Cal recipients are adversely impacted by current low reimbursement rates compared to past Medi-Cal recipients, when Latinos were not such a large majority of enrollees and reimbursement rates were higher relative to Medicare rates.

Medi-Cal, as presently implemented, on the one hand, and the ways that most non-Latino Californians obtain health care, particularly employer-sponsored plans and Medicare, on the other hand, are separate and unequal ways of obtaining health care in California. Latino Medi-Cal enrollees, as a consequence of this separate and unequal system, are effectively denied full participation in and the full benefits of the Medi-Cal program. Such a deleterious impact on a group defined to such a high degree by race or ancestry is only permitted if Respondents can justify the disparity as necessary or legitimate under the Medicaid Act.

F. There Is No Discernible Justification for the Disparate Impact Caused by Low Medi-Cal Reimbursement Rates.

Under Title VI, the HHS Title VI regulations, and Section 1557, a showing of disparate impact shifts the burden to Respondents to justify the adverse disparate impact on Latino Medi-Cal enrollees as necessary or legitimate under the Medicaid statute.

Complainants respectfully submit that Respondents are unable to justify the adverse disparate impact of denial and delay of care and adverse health consequences because a key purpose of the Medicaid Act is to provide Medicaid enrollees with the access to health care afforded other members of the general population irrespective of poverty.

As noted above, Respondents have failed to comply with their federal statutory duty to set primary and specialty care reimbursement rates at a level “sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area,” as required by the Medicaid Act. *See* 42 U.S.C. § 1396a(a)(30)(A). They have not ensured that “[medical] assistance shall be furnished with reasonable promptness to all eligible individuals.” 42 U.S.C. § 1396a(a)(8). They have not ensured that managed care plans “maintain[] a sufficient number, mix, and geographic distribution of providers of services.” 42 U.S.C. § 1396u-2(b)(5)(B). Nor have they taken any steps to monitor and verify—much less to justify—that primary and specialty care are available to complainants and the class under DHCS’s own time/distance, wait time, enrollment per provider, and other standards of accessibility. *See supra* section VI.D. Rather than

permitting the disparate impact on Latinos to continue, the Medicaid Act makes clear that there is no justification.

G. The Record Also Demonstrates Intentional Discrimination.

The record demonstrates as well that Respondents engaged in intentional discrimination. Where official action has a racially disparate impact, and “a clear pattern, unexplainable on grounds other than race, emerges from the effect of the state action even when the governing legislation appears neutral on its face,” that gives rise to a strong inference of intentional discrimination. *Village of Arlington Heights v. Metropolitan*, 429 U.S. 252, 266-67 (1977).

Here, intentional discrimination is evident in the stark differences in reimbursement rates for Medi-Cal (a program overwhelmingly enrolling low-income Latino people), as compared to the rates for Medicare and employer-sponsored insurance plans (programs largely benefitting higher-income, White people). Comparing the higher reimbursement rates when Latinos were a smaller share of Medi-Cal enrollees further demonstrates intentional discrimination. See *Arlington Heights*, 429 U.S. at 266-68. Additional such evidence includes, as described above, the failure to follow appropriate procedures to set rates for managed care and fee-for-service care to provide equal access to medical care; and the failure to follow legally-mandated monitoring and enforcement procedures. See *id.* (substantive and procedural departures relevant to intent inquiry).

VII. CONCLUSION

Under 45 C.F.R. § 80.7(c), the Office for Civil Rights must undertake a prompt investigation of this Complaint. Based on the evidence discussed in this complaint and the attachments provided, the Office for Civil Rights should find that Respondents have violated Title VI, the HHS Title VI implementing regulations, and section 1557. The Office for Civil Rights should order Respondents to raise primary care and certain specialty care reimbursement rates to assure that Medi-Cal enrollees have access to medical care to the same extent as care is available to Medicare beneficiaries and individuals covered by employer-sponsored health insurance plans.

Respectfully Submitted,

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