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IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

THE ARC OF CALIFORNIA; UNITED CEREBRAL PALSY ASSOCIATION OF SAN DIEGO,

Plaintiffs,

v.

TOBY DOUGLAS, in his official capacity as Director of the California Department of Health Care Services; CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICE; TERRI DELGADILLO, in her official capacity as Director of the California Department of Developmental Services; CALIFORNIA DEPARTMENT OF DEVELOPMENTAL SERVICES; and DOES 1-100, inclusive,

Defendants.

2:11-cv-02545-MCE-CKD

MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF DEFENDANTS' RENEWED MOTION TO DISMISS PLAINTIFFS' VERIFIED COMPLAINT AND PETITION PURSUANT TO FED. R. CIV. PROC. 12(b)(6)

Date: November 1, 2012
Time: 2:00 p.m.
Courtroom: 7
Judge: Hon. Morrison C. England

Action Filed: September 28, 2011

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INTRODUCTION

Plaintiffs, the ARC of California (an organization of providers, local ARCs, families and individuals with intellectual and developmental disabilities) and the United Cerebral Palsy Association (UCP) of San Diego (a service provider), lack standing to assert that the Department of Health Care Services (DHCS) and Department of Developmental Services (DDS) violated federal Medicaid provisions. In California, individuals with intellectual and developmental disabilities have an *entitlement* to services and supports under the Lanterman Act. Because of this state-law-created entitlement, the State of California provides all eligible individuals with services and supports at its *own expense*, using the State's general fund revenue. Medicaid's Home and Community Based (HCBS) waiver program—which Plaintiffs assert is being violated by the State—therefore, simply serves as a mechanism by which the State can use to recoup a portion of the general fund dollars it spends on services and supports. Reductions in the amount of State revenue paid to regional centers does not equate to a violation of federal Medicaid provisions, including 42 U.S.C. § 1396a(a)(30)(A) (Section 30(A). Further, portions of the complaint relating to these rate reductions are moot since the statutory provisions sunset on June 30, 2012. Thus, Plaintiffs lack standing to allege violations of federal Medicaid provisions because they have not identified any specific injury to persons with developmental disabilities or providers that are causally connected to the State's alleged failure to comply with federal Medicaid law.

Moreover, Plaintiffs fail to state a cause of action challenging the State's compliance with federal Medicaid Act provisions, including Section 30(A), because such claims cannot be brought under 42 U.S.C. § 1983. Thus, the only remaining vehicle that Plaintiffs may arguably use is the Supremacy Clause. However, because the Centers for Medicare and Medicaid Services (CMS) approved California's HCBS waiver program, the sole proper means for any challenge of the State's compliance with Medicaid provisions is a review of HHS's determination through the Administrative Procedures Act. *Douglas v. Independent Living Center*, 132 S.Ct. 1204, 1210 (2012). Plaintiffs also lack standing and cannot satisfy the prima facie elements of a claim under the Americans with Disabilities Act (ADA) and Rehabilitation Act (RA). Lastly, Plaintiffs' state

law claims are barred by the Eleventh Amendment. Accordingly, this action should be dismissed in its entirety without granting plaintiffs leave to amend.

STATEMENT OF FACTS

A. Statutory Background

1. Federal Medicaid Act Provisions and HCBS Waiver Provisions.

Medicaid is a cooperative federal-state program that provides federal financial assistance to participating states to reimburse certain costs of medical treatment for the poor, elderly, and disabled, as part of the Medicaid Act. 42 U.S.C. § 1396; formerly 19 U.S.C. § 1915. A state's participation in Medicaid is voluntary, but if it chooses to participate, it must comply with the Medicaid Act and implementing regulations promulgated by the Secretary of Health and Human Services (HHS). See *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990). Administration of the Medicaid program is entrusted to the Secretary of HHS, who in turn exercises her authority through the Centers for Medicare and Medicaid Services (CMS). *Arkansas Dept. of Health and Human Services v. Ahlborn*, 126 S. Ct. 1752, 1758 (2006).

In 1981, in response to the fact that a disproportionate percentage of Medicaid resources were being used for long-term institutional care and studies showing that many persons residing in Medicaid-funded institutions would be capable of living at home or in the community if additional support services were available, Congress authorized the home and community-based services (HCBS) waiver program. 42 U.S.C. § 1396n (*previously known as* 19 U.S.C. § 1915c); *Sanchez v. Johnson*, 416 F.3d 1051, 1054 (9th Cir. 2005). The HCBS program allows a state to seek funding for a variety of noninstitutional care options to be provided for persons who would otherwise be eligible for Medicaid benefits only in an institution, but who would benefit from living at home or in a community setting. 42 U.S.C. § 1396n(c)(1); *Sanchez,* 416 F.3d at 1054. To obtain a waiver, the State must certify that the program is cost-neutral in that the cost of providing services and supports to individuals enrolled in the waiver program will be less than or equal to the cost of placing an individual in an institution. 42 U.S.C. § 1396n(c)(2)(D); *Sanchez*, 416 F.3d at 1054.

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For states to be eligible for the HCBS waiver, they must submit an application to CMS for review. 42 U.S.C. § 1396n; 42 C.F.R. § 430.25. Under the HCBS waiver, three requirements of the federal Medicaid statute set forth in 42 U.S.C. § 1396a are waived: 1) statewideness; 2) comparability of services; and 3) income and resource rules. 42 U.S.C. § 1396n(c)(3). All other requirements of the Medicaid Act are deemed satisfied upon CMS's approval of the waiver request. 42 C.F.R. § 400.200; 42 C.F.R § 430.25(g)(1). Subject to termination at any time, a waiver shall be for an initial term of three years, and upon submission of a waiver application request by a state, it shall be extended for additional five year period unless the Secretary determines that the State did not meet its assurances in the previous waiver period. 42 U.S.C. § 1396n(c)(3).

In this matter, CMS approved California's HCBS waiver program, including the rates paid to regional centers, on March 26, 2012, for an additional term of five years.[1] (See Defendants' Request for Judicial Notice (RJN) Exhibits G and H.)

2. California's Lanterman Developmental Disabilities Services Act.

a. Entitlement to Free Services and Supports

Compared to other states, California is unique because it has made a statutory commitment to pay for supports and services for persons with intellectual and developmental disabilities from its general funds. Cal. Welf. & Inst. Code §§ 4500 et seq. (the Lanterman Act). California enacted the Lanterman Act in 1967 to prevent or minimize the institutionalization of developmentally disabled persons,[2] and their dislocation from family and community, to enable them to approximate the pattern of everyday living of nondisabled persons of the same age and to lead more independent and productive lives in the community. *Clemente v. Amundson,* 60

[1] CMS approved California's HCBS waiver application extension on September 30, 2011. See Docket No. 43, Ex. B – CMS Letter.

[2] Section 4512, subdivision (a) defines "developmental disability" as "a disability which originates before an individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals, but shall not include other handicapping conditions that are solely physical in nature."

Cal.App.4th 1094, 1097 (1998); *Ass'n for Retarded Citizens v. Department of Developmental Services,* 38 Cal.3d 384, 388 (1985). To effectuate this purpose, the Lanterman Act gives developmentally disabled persons an *entitlement to services and supports at the State's expense*.[3/4] *Ass'n for Retarded Citizens,* 38 Cal.3d at 391. California is one of only a few states that has such an entitlement. In all other states, community-based services are often limited to only those individuals eligible for an HCBS waiver. Because of this entitlement to services and supports paid for by the State's general funds, enrollment in the HCBS waiver program is therefore entirely voluntary. §§ 4501, 4502(a). Many of the disabled persons eligible for services under the Lanterman Act do not have the level of impairment that would qualify them for matching funds from the federal government under the HCBS waiver program. *Sanchez*, 416 F.3d at 1065, n. 8.[5] Further, only seventy percent of these disabled persons qualify for Medicaid funding on the basis of financial need. *Id*. The matching funds California receives through the waiver are equal to approximately half of the costs of the services the regional centers provide. *Sanchez*, 416 F.3d at 1065. Since California provides these services and supports at the State's expense, irrespective of the waiver, the practical effect is that the HCBS waiver serves as a potential funding source the State can utilize to recoup from the federal government a portion of the general fund revenues spent to purchase supports and services for those consumers that qualify under the waiver program. § 4659(a).

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[3] Section 4512, subdivision (b) defines "services and supports" as "specialized services and supports or special adaptations of generic services and supports directed toward the alleviation of a developmental disability or toward the social, personal, physical, or economic habilitation or rehabilitation of an individual with a developmental disability, or toward the achievement and maintenance of independent, productive, normal lives." The services potentially available "include, but are not limited to," treatment, therapy, training, care, education, recreation, and transportation. § 4512(b); see also §§ 4648(a), 4686, 4687, 4688, 4689. Other services, specifically including supported living services, "may be provided ... when necessary." § 4648(a)(14).

[4] Under the Lanterman Act, "[t]he State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge." § 4501. The State also recognizes that "[p]ersons with developmental disabilities have the same legal rights and responsibilities [as those] guaranteed all other individuals by the United States Constitution and laws and the Constitution and laws of the State of California." § 4502. Statutory rights include "[a] right to treatment and habilitation services and supports in the least restrictive environment" at state expense. §§ 4502(a), 4620, 4646–4648; see also *Ass'n for Retarded Citizens,* 38 Cal.3d at 389.

[5] Unless otherwise indicated, all references are to California's Welfare and Institutions Code.

b. The Roles of DHCS, DDS and Regional Centers

In California, DHCS is the state agency responsible for administering the federal Medicaid program, referred to as Medi-Cal in California. DHCS administers the HCBS Waiver through an Interagency Agreement with DDS. § 4500, *et seq*.

DDS, however, is responsible for coordinating the provision of services and supports to persons with developmental disabilities under the Lanterman Act, including those that are covered under the HCBS waiver. §§ 4434, 4780. DDS has jurisdiction over the execution of the laws relating to the care, custody, and treatment of developmentally disabled persons (often called "consumers"). § 4416. Accordingly, DDS is charged with (1) monitoring the regional centers to ensure that they comply with federal and state law, and (2) taking action to support the centers in achieving compliance and in providing "high quality services and supports to consumers and their families." §§ 4434(a)-(b), 4500.5(d), 4501.

To carry out its function, the Lanterman Act obligates DDS to contract with regional centers to provide developmentally disabled individuals with "access to the services and supports best suited to them throughout their lifetime." § 4620. DDS is authorized to promote uniformity and cost-effectiveness in the operation of regional centers. *Ass'n for Retarded Citizens,* 38 Cal.3d at 389, citing §§ 4631(a), 4681, and 4780.5; *See also* §§ 4620, 4621, 4629, 4648(a). Because the state is only the payer of last resort, the regional centers are required to "identify and pursue all possible sources of funding" for services, including but not limited to, governmental or other entities or programs required to provide or pay the cost of providing services" and "private entities, to the maximum extent they are liable for the cost of services...." § 4659(a); see also §§ 4683, 4684.

However, the responsibility of DDS "does not extend to the control of the manner in which [regional centers] provide services or in general operate their programs." *Ass'n for Retarded Citizens,* 38 Cal.3d at 389-90. Rather, the network of 21 regional centers, operated by private nonprofit community agencies, is responsible for determining eligibility, assessing needs and coordinating the provision of services directly to individuals with developmental disabilities and their families within a defined geographical area. § 4620 et seq. The Department allocates

funds to the centers for operations and the purchasing of services, including funding to purchase community-based services and supports. §§ 4620, 4621, 4787. A regional center's budget is compromised of two portions: operational expenditures (i.e. for cost of overhead and administrative needs) and purchase of services (i.e. used to purchase services through contracts with vendors). § 4620; Cal.Code Regs., tit. 17, §§54326.

c. Consumers' Entitlement to Services Is Based on Their Individual Program Plan

Once a person requests assistance through a regional center and is found to be developmentally disabled, an individual program plan (IPP) must be prepared. §§ 4642, 4643, 4646(c), 4647. The rights of developmentally disabled persons and the obligations of the state toward them are implemented through the IPP, which specifies the services and supports each consumer is qualified for. (§§ 4646, 4647; *Ass'n for Retarded Citizens*, 38 Cal.3d at 390.) The determination of which services and supports are provided shall be made on the basis of the needs and preferences of the consumer, as decided upon by agreement of the planning team which includes a regional center representative (i.e. a service coordinator) and the consumer (or when appropriate, the consumer's family) and includes consideration of a range of service options proposed by IPP participants, the effectiveness of each option in meeting the goals stated in the individual program plan, and the cost-effectiveness of each option. §§4512(b), 4646(a). Only the services and supports included in a consumer's IPP will be provided. §4512(b).

d. Service Providers

The State provides funding to the regional centers, which in turn purchases services from service providers (vendors) within that area. Cal.Code Regs., tit. 17, §§ 50601-50612, 54326, 56013. Any business or entity that wishes to provide services for consumers within the region must contract with the regional center. *Id.* In contracting with vendors, a regional center must comply with the Lanterman Act and the regulations. *Id.* Because there is an entitlement to services and supports in California, there is no distinction between the vendors that provide services to consumers that qualify under the HCBS waiver and those that do not. *Id.* Since the providers of services are one and the same, there is no classification under state or federal law

that refers to "HCBS providers." (See Complaint, pp. 2-18.)

As part of the contracts for provision of services, providers knowingly enter into contracts in which payments are dependent on state funding. For example, California Code of Regulations, title 17, section 50609 states in part that:

> The regional center/provider contract shall include, but not be limited to, the following fiscal or fiscally related provisions:
>
> (c) A provision specifying that payment under the contract is dependent upon availability of state funding.

California Code of Regulations, title 17 section 54326 also states in part that:

> (a) All vendors shall:
>
> > (12) Agree to accept the rate established, revised or adjusted by the Department as payment in full for all authorized services provided to consumers . . .

3. Relevant Reimbursement Payment Reductions

Plaintiffs seek to enjoin four bills that have been enacted by the Legislature since 2009 that they assert have had the effect of reducing or freezing rates to HCBS providers. These payment reductions applied to all regional centers from purchases of services funds, and were made across the board regardless of whether the consumers received Medi-Cal or was enrolled in the HCBS waiver. First, SBX 3 6 enacted a 3% reduction in reimbursements effective as of February 1, 2009, through June 30, 2010. (See Request for Judicial Notice (RJN) Exh A.). Second, SB 853 enacted a 1.25% reduction effective as of July 1, 2010, through June 30, 2011. (See RJN, Exh B.) The third bill was AB 104, which extended the two previous reductions through June 30, 2012, and also and changed the half-day billing rule so that if a consumer was present less than 65% of the program day, regional centers would only be paid for half day. (See RJN, Exh C.) The last bill raised by Plaintiffs is ABX 4 9, which sets forth 14 unpaid holidays that vendors are not reimbursed for their services. (See RJN, Exh D.) These payment reductions to the regional centers were made across the board regardless of whether or not the consumers qualified for the waiver. (RJN, Ex. A, SBX 36, Sec. 10; Ex. B, SB 853, Sec. 164; Ex. C, AB 104, Sec. 24).

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Importantly, the language of SBX 3 6 (3% reduction), SB 853 (1.25% reduction), and AB 104 (which extended the previous reductions through June 30, 2012) provides regional centers with an exemption from reduced payments. Specifically, these statutes all provide that:

> "regional centers shall reduce all payments for these services and supports paid from purchase of services funds for services….unless the regional center demonstrates that a nonreduced payment is necessary to protect the health and safety of the individual for whom the services and supports are proposed to be purchased, and the State Department of Developmental Services has granted prior written approval."

The 4.25% reductions implemented by SBX 3 6 and SB 853, and extended by AB 104 through June 30, 2012, have expired. (RJN, Ex. A, SBX 36, Sec. 10; Ex. B, SB 853, Sec. 164; Ex. C, AB 104, Sec. 24).

STANDARD OF REVIEW

Federal Rule of Civil Procedure 12(b)(6) provides for motions to dismiss for "failure to state a claim upon which relief can be granted." Fed. R. Civ. Proc. 12(b)(6). A motion to dismiss under Rule 12(b)(6) will be granted where, accepting as true the material allegations in the complaint, plaintiff is not entitled to any legal remedy. *De La Cruz v. Tormey*, 582 F.2d 45, 48 (9th Cir. 1978). If the complaint lacks either a cognizable legal theory or sufficient facts to support a cognizable legal theory, the complaint is deficient and defendant is entitled to judgment as a matter of law. *Balistreri v. Pacifica Police Dep't*, 901 F.2d 696, 699 (9th Cir. 1990).

In ruling on a motion to dismiss, the court may only appropriately consider the complaint, any evidence in documents attached or referred to in the complaint, and any matters that are judicially noticed pursuant to Federal Rule of Evidence 201. *Paulemon v. Tobin*, 30 F.3d 307, 308-309 (2d Cir. 1994); *Mir v. Little Co. of Mary Hospital*, 844 F.2d 646, 649 (9th Cir. 1988).

ARGUMENT

I. PLAINTIFFS LACK STANDING BECAUSE THE CLAIMS ARE NOT RIPE FOR ADJUDICATION AND NO ACTUAL INJURY HAS BEEN ALLEGED.

A. Plaintiffs' Claims Are Not Ripe for Adjudication.

Two factors are considered in determining whether a case is ripe: (1) the fitness of the issues for judicial decision; and (2) the hardship to the parties of withholding court consideration.

Yahoo! Inc. v. La Ligue Contre Le Racisme Et L'Antisemitisme, 433 F.3d 1199, 1211 (9th Cir. 2006). The ripeness doctrine is peculiarly a question of timing, designed to separate matters that are premature for review because the injury is speculative and may never occur, from those cases that are appropriate for federal court action. *Wolfson v. Brammer*, 616 F.3d 1045, (9th Cir. 2010), citing *Nat'l Park Hospitality Ass'n v. Dep't of Interior*, 538 U.S. 803, 808 (2003). By avoiding premature adjudication, the ripeness doctrine prevents courts from becoming entangled in abstract disagreements. *Id*.

Plaintiffs, who consist of providers and individual consumers, have failed to identify any specific services or supports available under the HCBS waiver that have been denied to them as a result of the reductions to the regional centers. Because there is a statutory safeguard that permits a regional center to apply for an exemption from the reduction if the health and safety of its consumers are jeopardized, Plaintiffs' claims of injury as a result of any reductions are speculative and premature, at best. There is no allegation that any regional center has applied for the exemption, let alone been denied the exemption. Until the statutory exemption is applied for and denied, there is no issue fit for judicial resolution under any statute or cause of action.[6] *Valerie G, supra,* 12 F. Supp. 2d 1007, 1016, *aff'd*, 307 F.3d 1036.

Further, there is no hardship to Plaintiffs in withholding a judicial decision for two reasons. First, there is no remedy this Court could issue to address Plaintiffs' purported injury because the rate reductions have sunset. Second, since the administrative process may resolve any alleged injuries they suffer, to the extent any injuries actually exist. Therefore, this Court should dismiss this action in entirety because it is centered on premature claims unfit for judicial resolution.

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[6] The courts have regularly applied ripeness to bar Plaintiffs' claims where potential injuries are purely conjectural because they turn on issues of fact that are subject to an individualized administrative review process. *See, e.g.*, *Summer H. v. Fukino*, No. 09-00047 SOM/BMK, 2009 WL 1249306, at *6-7 (D. Haw. 2009); *see also Valerie G. v. Wilson*, 12 F. Supp. 2d 1007, 1016 (N.D. Cal. 1998) ("[A]n issue is not ripe for federal adjudication if a plaintiff has not applied for benefits sought through available administrative channels."), *aff'd*, 307 F.3d 1036 (9th Cir. 2002).

B. Plaintiffs' Lack Standing to Challenge Defendants' Compliance with Medicaid Act Provisions.

To have standing, ARC and UCP *each* must show: 1) they have suffered an "injury in fact"—an invasion of a legally protected interest which is (a) concrete and particularized, meaning that the injury must affect the plaintiff in a personal and individual way; and (b) actual or imminent; 2) that there is a causal connection between the injury and the conduct complained of, i.e. the injury has to be fairly traceable to the challenged action of the defendant, and not the result of the independent action of some third party not before the court; and 3) it must be likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision. *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-561 (1992).

1. Plaintiffs Alleged Injury Is Purely Speculative.

Plaintiffs' complaint is void of any particular and concrete injury. Rather, Plaintiffs allegations that the reductions to regional centers has resulted in a decline of HCBS waiver services is highly speculative because services and supports are provided at the State's expense, regardless of HCBS waiver participation. In other words, the State provides the same services to consumers and pays the same rates to providers, irrespective of whether a particular consumer is enrolled in the HCBS waiver. Thus, whether the State has or has not complied with federal law is irrelevant to the services the consumer receives or the payment the provider is given. Accordingly, Plaintiffs have not, nor can they, demonstrate any injury to consumers enrolled in the waiver as a result of reductions to regional centers because of this entitlement.

Further, there are no allegations of individuals being denied any required services through the regional centers or that providers have gone out of business. There are no claims that the regional centers sought an exemption on behalf on behalf of any consumers that was denied. Plaintiffs' failure to allege particular and actual harm is especially glaring considering the reductions were in place for nearly three years. And, now that the rate reductions pled in the Complaint have expired, Plaintiffs have alleged no resulting injuries that can be attributed only to the half-day billing rule or the unpaid holidays. Moreover, with respect to alleged harm to "HCBS providers," no such designation exists in California since vendors' contract directly with

regional centers and provide services regardless of waiver enrollment. Payments are also made to vendors, regardless of which funding source is used to recoup the general fund dollars. In the absence of these allegations, it follows that the statutory exemption is accomplishing its intended purpose—preventing harm by safeguarding the health and safety of the individual consumers. Thus, Plaintiffs' do not allege any particularized, concrete injury.

2. There is No Causal Connection between Any Alleged Injury and the Reductions to Regional Centers.

Plaintiffs also fail to demonstrate a causal connection between their alleged reductions in HCBS waiver services that is traceable to the State's implementation of the reductions to regional centers' purchase of services budget. Significantly, because California law provides a mechanism for regional centers to maintain full funding, Plaintiffs' claims that failure to comply with federal law has resulted in reduced services and supports is unsupportable and attenuated. Similar to the argument above, because there is an entitlement to services in California, no qualified consumer is denied, irrespective of waiver enrollment. *Sanchez*, 416 F.3d at 1065, n.8. Moreover, the causal connection between the reductions and alleged harm to "HCBS providers," a term created by Plaintiffs' from whole cloth, is nonexistent. As set forth above, there is no such classification in California because vendors contract directly with the regional center and provide services to all who are eligible. Lastly, because the rate reductions are no longer valid, Plaintiffs have utterly failed to show any connection between any purported injuries to HCBS consumers and service providers as a result of the half-day billing rule and the unpaid holidays.

Thus, without identifying the types of services denied or other specific injury suffered, Plaintiffs have failed to even remotely correlate the reductions to the regional centers with any alleged harm.

3. Plaintiffs Have No Redressable Remedy.

Plaintiffs also cannot show there is a redressable remedy this Court can provide because the availability of the exemption is incumbent upon the regional centers to apply for it. Only once it is denied and the administrative remedy has been exhausted, could the Court even remotely provide a redressable remedy. Also, the only party who could potentially challenge the

denial of the administrative remedy would be a regional center, none of whom are plaintiffs in this action. Lastly, because the percentage reductions are expired, there is no judicial remedy this Court can provide to resolve those claims.

Therefore, each of the plaintiffs has failed to allege the necessary elements for standing. Accordingly, Plaintiffs' lack standing to challenge any alleged violation by the Defendants under the Medicaid Act.

II. TWO OF PLAINTIFF'S CLAIMS INVOLVING STATUTORY RATE REDUCTIONS HAVE SUNSET, MAKING PORTIONS OF PLAINTIFF'S COMPLAINT MOOT.

Mootness can be characterized as the doctrine of standing set in a time frame: the requisite personal interest that must exist at the commencement of the litigation (standing) must continue throughout its existence (mootness)." *Cook Inlet Treaty Tribes v. Shalala*, 166 F.3d 986, 989 (9th Cir. 1999) (internal quotation marks omitted). Mootness is a jurisdictional issue, and federal courts have no jurisdiction to hear a case that is moot, that is, where no actual or live controversy exists. *Id*. "If there is no longer a possibility that an appellant can obtain relief for his claim, that claim is moot and must be dismissed for lack of jurisdiction." *Ruvalcaba v. City of L.A.*, 167 F.3d 514, 521 (9th Cir. 1999).

Presently, two provisions that lie at the heart of Plaintiff's complaint have sunset—SBX 3 6 (the 3% reduction), SB 853 (the 1.25% reduction). Based on the operative complaint, there is no relief that Plaintiffs could obtain from this Court to stop the percentage reductions because the provisions sought to be enjoined have already expired. Moreover, because the two state statutory rate reductions at issue apply to services rendered prior to July 1, 2012, any judicial relief granted would be barred by the 11th Amendment. *Edelman v. Jordan* (1976) 415 U.S. 651, 663-664. The federal courts have held that with respect to the Medicaid program, retroactive relief that is barred by the 11th Amendment is defined by date of service, meaning that a federal court may not grant relief with respect to services rendered in the past. *Kimble v. Solomon* (4th Cir. 1979) 599 F.2d 599, 604-606, *Wisconsin Hosp. Assn. v. Reivitz* (7th Cir 1987) 820 F.2d 863, 867, *New York City Health and Hospitals Corp. v. Perales* (2nd Cir. 1995) 50 F.3d 129 , 135.

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To the extent Plaintiffs assert that a new 1.25% reduction is in place and therefore the reduction and injury continues, the proper procedure for challenging that reduction would be through an amended complaint. In this case, Plaintiffs presently have no basis to make such a challenge since that provision is not part of the operative complaint, nor have they alleged any causally connected, corresponding injury. Accordingly, to the extent the Court may find Plaintiffs' have standing, the portions of the complaint relative to these provisions must be dismissed since there is no actual, live controversy this Court can resolve.

III. PLAINTIFFS ARE BARRED FROM BRINGING SUIT UNDER 42 U.S.C. § 1983 CHALLENGING THE STATE'S COMPLIANCE WITH SECTION 30(A) OR ANY NEED FOR STATE PLAN AMENDMENT PRE-APPROVAL.

Plaintiffs are barred from using 42 U.S.C. § 1983 as a vehicle to bring a suit challenging a state's alleged violations of the Medicaid Act. Plaintiffs allege that DHCS and DDS: 1) failed to obtain federal approval before modifying the reimbursement rates; 2) implemented the reductions without giving consideration to the factors in Section 30(A); 3) failed to consider the impact of the reduction in payments on the safeguards required by the HCBS waiver program; and 4) failed to conduct or consider appropriate rate studies in modifying the reimbursement rates. (Compl. ¶ 31.) All of these claims are foreclosed under 42 U.S.C. § 1983.

A. No Private Right of Action to Challenge SPA Preapproval.

In the recent Ninth Circuit decision, *Developmental Services Network v. Douglas (DSN)*, 666 F.3d 540 (9th Cir. 2011), the Court squarely held that providers do not have an individual right of action under § 1983 to enforce any SPA pre-approval requirement, assuming *arguendo* that such a requirement exists. *Id*.

B. No Private Right of Action to Challenge Section 30(A).

Similarly, Plaintiffs have failed to state a cause of action challenging any provisions of Section 30(A) because the Ninth Circuit has already barred the use of § 1983 for a private cause of action challenging the State's compliance with the requirements of Section 30(A). *Sanchez,* 416 F.3d at 1060; *Ball v. Rodgers,* 492 F.3d 1094, 1107-1109 (9th Cir. 2007). Therefore, Plaintiffs have failed to state a claim under § 1983.

/ / /

C. A State May Implement Amendments To Its State Plans Prior To CMS Approval.

Significantly, the federal government clarified in a Supplemental Letter Brief filed in the consolidated case of *Douglas v. Independent Living Center of Southern California*, 132 S.Ct. 1204, 1210 (2012), that a State may implement amendments to its State Plans prior to CMS approval.[7]/[8] The federal government's position on this issue has been longstanding. See *Illinois Council on Long Term Care v. Miller*, 579 F. Supp. 1140, 1147 (N.D. Ill. 1983)(quoting USDHHS)(HHS said "the Medicaid Act should be construed so as to allow states the flexibility to implement Medicaid state plan amendments prior to federal approval.")[9] Therefore, no prior state plan amendment (SPA) approval is required, nullifying Plaintiffs' claim.

Accordingly, Plaintiffs do not have a private right of action under 42 U.S.C. § 1983 to enforce Section 30(A) or to enforce any purported SPA pre-approval requirement. Therefore, all such portions of the Complaint must be dismissed for failure to allege a proper cause of action.

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[7] In an accompanying Request for Judicial Notice, at Exhibit F, Defendants' request this Court take judicial notice of the Solicitor General's Supplemental Letter Brief filed November 18, 2011, in the consolidated case of *Douglas v. Independent Living Center of Southern California*, No. 09-958 (U.S. February 26, 2010), *Douglas v. California Pharmacists Ass'n*, No. 09-1158 (U.S. March 24, 2010), and *Douglas v. Santa Rosa Memorial Hospital, et al.*, No. 10-283 (U.S. August 27, 2010). To the extent Plaintiffs assert the federal government's position is not entitled to deference, such arguments fail. The Ninth Circuit and the U.S. Supreme Court has held that the federal government's interpretation of its own statutorily authorized regulation is not only entitled to deference, it is controlling unless it is plainly erroneous or inconsistent with regulations. *M.R. et al, v. Dreyfus*, 9th Cir. No. 11-35026 (December 8, 2011) at *39-40; *Chase Bank USA v. McCoy,* 131 S. Ct. 871, 881-82 (2011); *Chevron U.S.A. v. Natural Res. Def. Council* (1984) 467 U.S. 837, 844-845; *Auer v. Robbins,* 519 U.S. 452, 461 (1997).

[8] Although the Ninth Circuit stated in *DSN* that a State must obtain approval of its SPA prior to implementing, this portion of the opinion was dicta and not necessary to the court's ultimate decision, which was to vacate the district court's decision and hold that no private right of action under section 1983 existed. Further, the Court did not have the benefit of the Solicitor General's letter brief before it issued its decision, which is why the *DSN* decision makes no mention of the brief or its contents.

[9] The federal government's interpretation of its own statutorily authorized regulation is not only entitled to deference, it is controlling unless it is plainly erroneous or inconsistent with regulations. *Chase Bank USA,* 131 S. Ct. at 881-82; *Chevron U.S.A.,* 467 U.S. at 844-845; *Auer,* 519 U.S. at 461.

IV. PLAINTIFFS CANNOT USE THE SUPREMACY CLAUSE TO ALLEGE VIOLATIONS OF THE MEDICAID ACT BECAUSE CMS HAS ALREADY DETERMINED THAT DEFENDANTS COMPLIED WITH THE ACT'S REQUIREMENTS.

Even assuming Plaintiffs have Article III standing, the only remaining vehicle Plaintiffs may arguably use to challenge Defendants' action under the Medicaid Act is the Supremacy Clause. Based on the recent United States Supreme Court case of *Douglas,* 132 S.Ct. 1204, this too fails as a matter of law because the Supremacy Clause does not create a cause of action to enforce Section 30(A). Rather, because CMS approved the HCBS waiver program in California on March 26, 2012, the sole proper means for any challenge of the State's compliance with Medicaid provisions is a review of HHS's determination through the Administrative Procedures Act (APA). (See RJN, Ex. G.)

A. CMS Approved California's HCBS Waiver Program

CMS, the federal agency tasked with administration of the Medicaid program, has determined that California's HCBS Waiver complies with all necessary Medicaid Act provisions, and on that basis, approved the waiver in California.

Where, as here, Congress has given an agency authority to regulate a subject matter, it is appropriate for courts to give deference to that agency's resolution of issues related thereto. *U.S. v. W. Pac. R.R. Co.,* 352 U.S. 59, 64-65 (1956) (recognizing an agency's power to determine issues "that have been placed in the special competence of that administrative body" in the context of primary jurisdiction). An agency's input helps "to produce better informed and uniform legal rulings by allowing courts to take advantage of an agency's specialized knowledge, expertise, and central position within a regulatory regime." *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 673 (2003) (regarding primary jurisdiction).

Congress has clearly vested HHS with the authority to enforce the Medicaid Act and to grant waivers to its requirements. 42 U.S.C. §§ 1396a(b), 1396c, 1396n. CMS only approves a waiver if it has determined that a state complies with the Act. 42 C.F.R. §§ 430.25(g). CMS also has the authority to revoke a waiver if it determines that a state is not in compliance with the Act and its waiver requirements. 42 C.F.R. §§ 441.302, 441.304. Further, HHS has developed a comprehensive regulatory scheme delineating the requirements of the HCBS waiver program.

See, e.g., 42 C.F.R. §§ 430.25, 441.300-310. It describes in detail the information required for the initial application process and for the required annual reports. *See*, 42 C.F.R. §§ 441.302 (describing assurances required); 441.302(h) (requiring annual reports regarding assurances); 441.303 (description of supporting documentation required).

CMS has evinced its determination that DHCS and DDS complied with all Act requirements by virtue of its continued approval of California's HCBS waiver program, including the previous 4.25% rate reduction to regional centers' purchase of services budget. (See RJN, Ex. G and Ex. H.) A review of these regulations refutes Plaintiffs' contentions that Defendants had to take additional steps beyond those found in the waiver approval process to comply with any state plan requirements allegedly found in Section 30(A) of the Medicaid Act. First, the requirements in the waiver application encompass the factors set forth in Section 30(A).[10] The waiver program requires Defendants to provide information about 1) methods for assessing financial accountability and cost-neutrality; 2) information regarding the utilization of services by consumers, including the number of participants and information regarding the utilization of specified services; and 3) assurances that the state will protect the health and welfare of beneficiaries, including assurances that the state will provide ongoing assessment of a consumer's need for services, and a plan for evaluation. 42 C.F.R. §§ 441.302-303. Thus, the waiver application incorporates the factors found in Section 30(A).

Second, the regulations make clear that a separate study regarding "efficiency, economy, and quality of care" is *optional*, and not required, in the context of waiver applications. 42 C.F.R. § 441.303(g) ("The State, at its option, may provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost neutrality.") Thus, there is no study requirement under the HCBS waiver program.[11] HHS' interpretation and application of its

[10] Section 30(A) requires the state plan to: "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. § 1369a(a)(30)(A).

[11] Moreover, a study is not required under 30(A). In December 2010, in response to the U.S. (continued…)

own regulations is entitled to deference. *Chase Bank,* 131 S. Ct. at 881-82; *Auer v. Robbins,* 519 U.S. at 461 (1997) (federal agency's interpretation of regulation entitled to deference unless "plainly erroneous or inconsistent with the regulation").

Plaintiffs' allegations that the Defendants did not consider the health and welfare of beneficiaries must be rejected for a further reason. The language of the reimbursement reductions themselves compels a contrary conclusion. A regional center can seek an exemption from the reimbursement reductions if necessary to protect the health and safety of the individual for whom the services and supports are proposed to be purchased. (RJN, Ex. A, SBX 36, Sec. 10; Ex. B, SB 853, Sec. 164; Ex. C, AB 104, Sec. 24). Plaintiffs have never asserted that any regional center has applied for, or been denied, this exemption. Further, Plaintiffs have not alleged, nor can they, that the half-day billing rule or the unpaid holidays violates any provision of the Medicaid Act because the statutes at issue relate to state law and regional centers. As such, they cannot show any correlation with these specifics statutes and the alleged harm to HCBS consumers.

Thus, Plaintiffs have failed to state a claim upon which relief can be granted under the Medicaid Act because CMS has already found that the HCBS waiver program is in compliance with the Social Security Act provisions. Indeed, in this case, CMS specifically inquired about the 4.25% rate reductions and still granted California's waiver application. (See RJN, Exhibit H.) In addition, there is no separate study requirement, and the State's rate reimbursements specifically protect the health and safety of beneficiaries.

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Supreme Court's invitation, the United States submitted an amicus brief in *Independent Living* that rejected the Ninth Circuit's interpretation of Section 30(A), including its requirement that rates bear a reasonable relationship to costs. (RJN, Ex. E, Amicus Curiae Brief for the U. S. at p. 7-10, *Maxwell-Jolly v. Indep. Living Ctr. of So. Cal*., No. 09-958 (S. Ct. Dec. 3, 2010) ["The court of appeals erred in affirming its prior reading of section 1396a(a)(30)(A) as imposing on States an obligation to consider cost studies to ensure that payment rates bear a reasonable relationship to providers' costs."].) The Ninth Circuit and the U.S. Supreme Court has held that the federal government's interpretation of its own statutorily authorized regulation is not only entitled to deference, it is controlling unless it is plainly erroneous or inconsistent with regulations. *M.R. et al, v. Dreyfus*, 9th Cir. No. 11-35026 (December 8, 2011) at *39-40; *Chase Bank USA v. McCoy,* 131 S. Ct. 871, 881-82 (2011); *Chevron U.S.A. v. Natural Res. Def. Council* (1984) 467 U.S. 837, 844-845; *Auer v. Robbins,* 519 U.S. 452, 461 (1997) (federal agency's interpretation of its own regulation entitled to deference unless "plainly erroneous or inconsistent with the regulation" or is a "*post hoc* rationalization" advanced by an agency seeking to defend past agency action against attack.)

B. Review of CMS's Approval Under the APA is the Sole Remedy Available to Plaintiffs to Challenge DHCS and DDS Compliance with the Medicaid Act.

By approving California's HCBS waiver program, the federal government has made clear its determination that it complies with all necessary provisions of the Medicaid Act. Such action is equivalent to SPA approval because the precise State policy has been approved by the federal government. Therefore, as suggested by the majority opinion in *Douglas,* this Court should hold that the sole proper means for challenging the rates is a review of HHS's determination under the APA. *Douglas*, 132 S. Ct. at 1210 (fact of SPA approval "may require respondents now to proceed by seeking review of the agency determination under the Administrative Procedure Act, 5 U.S.C. § 701 et seq., rather than in an action against California under the Supremacy Clause").

As the majority in *Douglas* observed, recognizing a standalone cause of action once SPA approval has occurred, would be *at best* "inefficient" and "redundant." *Douglas*, 132 S. Ct. at 1210. Of even more concern, it would lead to inconsistency and confusion, and undermine "the uniformity that Congress intended by centralizing administration of the federal program in [HHS]." *Id.* As a practical matter, if, after CMS approval, Plaintiffs may assert *both* an APA claim against the federal government, and a separate Supremacy Clause cause of action against the States, the APA review process will be rendered superfluous. Plaintiffs will have little incentive to sue *both* the federal government *and* the State if they can achieve the same result through one suit (*i.e.*, an injunction against implementation of a Medicaid reform). Given the options, Plaintiffs would be far more likely to sue the State alone under a Supremacy Clause theory, in a forum where the federal government will not be present to explain and defend its own decisions, and argue for the proper level of deference. Such private suits raise the specter of inconsistent interpretations of the federal law and the State's obligations under that law – exactly what Congress sought to avoid by centralizing enforcement in HHS. *Douglas*, 132 S. Ct. at 1211; *Astra,* 131 S. Ct. at 1349.

Thus, limiting post-CMS approval to suits with APA claims against the federal government is essential if Congress's intentions with respect to centralized administrative enforcement are to be respected and protected. *See Wyeth*, 555 U.S. 565 (recognizing centrality

of congressional intent to preemption analysis). By design, the APA imposes important parameters that effectuate Congress's intent regarding the judiciary's role in review of agency decision making (e.g., who may sue; what may be reviewed; applicable legal standards).[12] Permitting such claims to proceed without the interference of private claims that Congress itself did not authorize is consistent both with congressional intent for centralized enforcement of the Medicaid Act *and* current practice. *See, e.g. Indep. Acceptance*, 204 F.3d 1247 (Medicaid provider-initiated for APA review of Secretary's approval of various SPAs); *Newton-Nations v. Betlach*, 660 F.3d 370 (9th Cir. 2011); *Pharm. Res. Mfrs. Am. v. Thompson*, 362 F.3d 817 (D.C. Cir. 2004).[13]

C. There Is No Private Right of Action Under the Supremacy Clause.

Even if CMS had not approved California's HCBS waiver, Plaintiffs' challenge fails because there is no private right of action available to them under the Supremacy Clause where Congress has not vested them with such a right.

There is no language in Section 30(A) to suggest that Congress intended to create a private right of action to enforce its provisions, any alleged rate study requirements contained therein, or the State's obligation to obtain prior federal approval before making reimbursement reductions. "Like substantive federal law itself, private rights of action to enforce federal law must be created by Congress." *Alexander v. Sandoval*, 532 U.S. 275, 286 (2001). Particularly when Spending Clause provisions are involved, clear evidence of congressional intent to create a private right of action is required. *See Gonzaga Univ. v. Doe*, 536 U.S. 273, 280 (2002). Rather, HHS is responsible for enforcing the provisions of the Social Security Act. 42 U.S.C. §§

[12] APA claims are limited, *inter alia*, in terms of who may bring them, (*i.e.*, parties within a statute's zone of interests), and what evidence may be considered. 5 U.S.C. §§ 702, 706(2)(E); *Ass'n of Data Processing Serv. Orgs. v. Camp,* 397 U.S. 150, 153-54 (1970); *Camp v. Pitts*, 411 U.S. 138, 142 (1973); *Phoenix Mem'l Hosp. v. Sebelius*, 622 F.3d 1219, 1225 (9th Cir. 2010) ("Under the APA, we review an agency's final decision for substantial evidence based on the administrative record."). In addition, APA claims are generally reviewed according to the highly government-deferential "arbitrary and capricious" standard. 5 U.S.C. § 706(2)(A).

[13] DHCS does not, however, concede that private parties, such as individual Medicaid providers, are "adversely affected or aggrieved by agency action within the meaning of" § 30(A), and therefore disputes that they have standing to bring an APA claim. *See* 5 U.S.C. § 702.

1396a(b), 1396c. If it finds that the State is in noncompliance with the Social Security Act, the remedy is the State's loss of funding. 42 U.S.C. § 1396c; see also 42 C.F.R. § 430.35.

Thus, as the dissenting justices said in *Douglas*, "when Congress did not intend to provide a private right of action to enforce a statute enacted under the Spending Clause, the Supremacy Clause does not supply one of its own force." *Id.*, dissenting slip op. at 9 (Roberts, C.J., dissenting).

Accordingly, Plaintiffs cannot use the Supremacy Clause to bring this cause of action where Congress has not created such a right.

V. PLAINTIFFS LACK STANDING AND FAIL TO SATISFY THE PRIMA FACIE ELEMENTS OF A CLAIM UNDER THE AMERICANS WITH DISABILITIES ACT AND SECTION 504 OF THE REHABILITATION ACT.

A. Plaintiffs Do Not Have Standing to Bring An ADA or RA Cause of Action.

It is well-established that "standing is not dispensed in gross." *Lewis v. Casey,* 518 U.S. 343, 358, n.6 (1996). Rather, "a plaintiff must demonstrate standing for each claim he seeks to press and for each form of relief that is sought. *Davis v. Fed. Election Comm'n*, 554 U.S. 724, 734 (2008) (citing *DaimlerChrysler Corp. v. Cuno,* 547 U.S. 332, 352 (2006)); *see also Maya v. Centex Corp.*, 658 F.3d 1060, 1068-69 (9th Cir. 2011). The Ninth Circuit has recognized in the ADA context that the standing inquiry is necessarily tethered to the definition of discrimination under the ADA. *See Chapman v. Pier 1 Imports (U.S.) Inc.*, 631 F.3d 939, 947 (9th Cir. 2011)

Plaintiffs cannot establish standing to pursue their ADA and RA claims. They have failed to meet their burden of showing that a reduction in reimbursement to regional centers, which are not a party to this action, will disproportionately restrict or degrade availability of services and supports to HCBS consumers when there is an exemption in place. This is particularly significant since California's Lanterman Act provides services to all eligible consumers, regardless of enrollment in the waiver program. Similarly, unless and until Plaintiffs allege a regional center has applied and been denied the exemption, they fail to show any disproportionate restrictions or degradations to the services and supports under the HCBS waiver program.

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B. Plaintiffs Fail to Satisfy the Prima Facie Elements of an ADA and RA Cause of Action.

Even if Plaintiffs establish standing, they cannot satisfy the necessary elements under the ADA and RA.

To establish a violation of Title II of the ADA and RA, plaintiffs must show that (1) they are qualified individuals with a disability; (2) that were excluded from participation in or otherwise discriminated against with regard to a public entity's services, programs, or activities, and (3) such exclusion or discrimination was solely by reason of their disability. See *Lovell v. Chandler*, 303 F.3d 1039, 1052 (9th Cir. 2002). The prohibition against discrimination is universally understood as a requirement to provide "meaningful access." *Lonberg v. City of Riverside*, 571 F.3d 846 (9th Cir. 2009) *Crowder v. Kitagawa*, 81 F.3d 1480 (9th Cir. 1996) (the Court determined it more useful to assess whether disabled persons were denied "meaningful access" to state-provided services). Because the ADA and RA have nearly identical language, these two provisions can be evaluated as coextensive with one another. *Sanchez,* 416 F.3d at 1062.

Further, a plaintiff proceeding under Title II of the ADA must, similar to a Section 504 plaintiff, prove that the exclusion from participation in the program was "solely" by reason of disability." *Weinreich v. L.A. County Metro. Transp. Auth*., 114 F.3d 976, 978 (9th Cir. 1997). If the plaintiff does not allege, or cannot prove, that the public entity's challenged actions were solely because of his disability, then the plaintiff has no claim under Title II of the ADA. *Id*. at 978-79.

As to the first element, Plaintiff UCP is not a qualified individual under the ADA or the RA. Rather, UCP is simply a provider of services to the consumers. Section 12131(2) defines "qualified individual with a disability" as "an individual with a disability who, with or without reasonable modifications to rules, policies or practices, removal of architectural barriers, or the provision of auxiliary aides and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity." Therefore, providers of services who treat individuals with developmental disabilities cannot

personally satisfy the first element.

Second, although Plaintiffs generally assert they will suffer a disparate impact, they fail to demonstrate that they were excluded, discriminated against, or otherwise denied meaningful access to services and supports that the State receives funding for through the HCBS waiver. Plaintiffs have no evidence to show a disproportionate burden on them as compared with any other group, thereby negating that any alleged lack of access or exclusion is attributed *solely* to their disability. Plaintiffs have also failed to allege that any consumer has not received the services and supports identified in his or her IPP as a result of any of these reductions. Failure to cite to actual harm suffered, despite the fact that the reductions were in effect for two and half years, is fatal to Plaintiffs' claims. Further, such a claim is especially disingenuous in California since there is an entitlement for all qualifying individuals to services and supports at the State's expense. Therefore, Plaintiffs have failed to show providers or consumers will suffer a disparate impact and that Defendants' challenged actions were solely because of their disability.

Moreover, while some of the programs offered by Defendants under the Lanterman Act receive federal funding, not all the services do. Under the Lanterman Act, DDS contracts with regional centers to ensure that services are being provided to the consumers. The fact that reimbursement for services has been reduced should not affect the regional centers' responsibility to ensure that the consumers receive the required services. In addition, as providers, when Plaintiffs agree to provide services, they knowingly enter into contracts in which payments are dependent on state funding. Cal. Code Regs., tit. 17, §§ 50609, 54326.

Further, the language of the reimbursement reductions themselves ensure that the health and safety of the consumers is protected. A regional center can seek an exemption from the reimbursement reductions if necessary to protect the health and safety of the individual for whom the services and supports are proposed to be purchased. (See, RJN, Exs. A-D [SB 6, Sec. 10; SB 853, Sec. 164; AB 104, Sec. 24]).

Accordingly, even on the bare allegations set forth in the complaint, Plaintiffs' lack standing and fail to satisfy the elements of a prima facie ADA or RA claim.

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VI. PLAINTIFFS' STATE LAW CLAIMS ARE BARRED BY THE ELEVENTH AMENDMENT.

Plaintiffs' state law claims are barred by sovereign immunity and the Eleventh Amendment, regardless of whether Plaintiffs are seeking prospective injunctive relief. *Pennhurst State Sch. v. Halderman*, 465 U.S. 89, 106 (1984). Although the Eleventh Amendment does not bar an action for prospective injunctive relief seeking to compel a state official's prospective compliance with a plaintiff's *federal* rights, it does bar actions seeking to compel state officials to comply with *state* law. *Pennhurst*, 465 U.S. at 104-106.

Here, Defendants did not remove this action from state court nor consent to suit in federal court. *Pennhurst*, 465 U.S. at 99. The state's waiver of sovereign immunity in its own courts is not a waiver of immunity in federal court. *Pennhurst*, 465 U.S. at 100, n.9. Thus, even if an action may be appropriate in state court under California Code of Civil Procedure section 1085, such an action is not appropriate in federal court. Plaintiffs also cannot bring their state law claims under the doctrine of supplemental jurisdiction. The Eleventh Amendment bars the adjudication of supplemental state law claims against nonconsenting state defendants in federal court. *Raygor v. Regents of the Univ. of Minn.*, 534 U.S. 533, 541-42 (2002). Accordingly, Plaintiffs' state law claims should be dismissed.

VII. DECLARATORY RELIEF IS NOT A PROPER CAUSE OF ACTION.

Plaintiffs seek declaratory relief as a cause of action. (Compl., at 15.) Because Plaintiffs do not otherwise state a claim for relief in its complaint, the Federal Declaratory Judgment Act cannot create an independent basis for the Court to exercise jurisdiction in this case. *S. Pac. Co. v. McAdoo*, 82 F.2d 121, 122 (9th Cir. 1936).

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CONCLUSION

Based on the foregoing, Defendants respectfully request this Court grant this motion to dismiss, and dismiss Plaintiffs' action in its entirety.[14]

Dated: September 25, 2012

Respectfully Submitted,

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[14] Although this Court did not issue a scheduling order or other order limiting time to file a dispositive motion, and Plaintiffs have not alleged that Defendants are beyond time since they were fully apprized of this filing, out of an abundance of caution, Defendants' respectfully that this Court use its discretion to accept this filing, to the extent it is beyond time, since no prejudice will befall the Plaintiffs in granting this request.

CERTIFICATE OF SERVICE

Case Name: ***The ARC of California v. Toby Douglas, et al.***
No. 2:11-cv-02545-MCE-CKD

I hereby certify that on **September 25, 2012**, I electronically filed the following documents with the Clerk of the Court by using the CM/ECF system:

MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF DEFENDANTS' RENEWED MOTION TO DISMISS PLAINTIFFS' VERIFIED COMPLAINT AND PETITION PURSUANT TO FED. R. CIV. PROC. 12(b)(6)

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

I declare under penalty of perjury under the laws of the State of California the foregoing is true and correct and that this declaration was executed on **September 25, 2012**, at Sacramento, California.

Donna L. Kulczyk
Declarant

/s/ Donna Kulczyk
Signature