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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF HAWAI'I

TONY KORAB, TOJIO CLANTON, KEBEN ENOCH, CASMIRA AGUSTIN, ANTONIO IBANA, AGAPITA MATEO, and RENATO MATEO, each individually and on behalf of those persons similarly situated, Plaintiffs, vs. PATRICIA MCMANAMAN in her official capacity as Director of the State of Hawaii Department of Human Services; and KENNETH FINK in his official capacity as State of Hawai'i, Department of Human Services, Med-QUEST Division Administrator, Defendants.		CIVIL NO. 10-00483 JMS KSC MEMORANDUM IN OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION RE: NEW RESIDENTS [DKT. NO. 63]; DECLARATION OF JOHN F. MOLAY; DECLARATION OF KENNETH FINK; EXHIBITS A-E; CERTIFICATE OF SERVICE Hearing Date: June 2, 2010 Time: 9:00 a.m. Judge: Hon J. Michael Seabright

TABLE OF CONTENTS

SECTION		PAGE
Table of Authorities		iii
1.	Question Presented	1
2.	Underlying Facts	1
3.	Plaintiffs Do Not Understand the Immigrant Health Initiative	2
4.	Plaintiffs Are Not Entitled to the Injunction They Seek	5
A.	The Plaintiffs Have Not Demonstrated a Likelihood of Success on the Merits	7
(1)	BHH Does Not Discriminate Based on Alienage Against Aliens and in Favor of Citizens	8
(2)	The Federal Government, Not the State, Has Chosen to Exclude New Residents From Medicaid Coverage	13
(3)	The Centers for Medicare & Medicaid Services Has Prohibited Coverage for New Residents in QUEST, QExA, QUEST-Net, and QUEST-ACE	15
(4)	The Equal Protection Clause Does Not Require That the State Create a Health Care Program for Aliens Whom Congress Has Chosen Not to Cover	18
(5)	To the Extent the State Has Chosen to Create a Program Just for Aliens, It is Subject to a Rational Basis Standard of Review	22
(6)	There is a Rational Basis for the State to Provide to Non-Eligible Aliens With Different Benefits Than It Provides to Those Who Are Eligible for Federally-Funded Benefits	29
B.	The Balance of Equities Does Not Favor Plaintiffs	31

C. An Injunction Is Not In the Public Interest 32

5. Conclusion 32

TABLE OF AUTHORITIES

CASES	PAGE(S)
Aleman v. Glickman, 217 F.3d 1191 (9th Cir. 2000)	21
Aliessa v. Novello, 96 N.Y.2d 418, 752 N.E.2d 1085 (Ct. App. 2001)	25, 27
Avila v. Biedess, 78 P.3d 280 (Ariz. Ct. App. 2003)	28
Baehr v. Lewin, 74 Haw. 530 (1993)	29, 30
Ball v. Rodgers, 492 F.3d 1094 (9th Cir. 2007)	13
Children's Hosp. & Health Ctr. v. Belshe, 188 F.3d 1090 (9th Cir. 1999)	13
City of Chicago v. Shalala, 189 F.3d 598 (7th Cir. 1999)	21
Dandridge v. Williams, 1397 U.S. 471 (1970)	18
Dep't of Health Servs. v. Sec'y of Health & Human Servs., 823 F.2d 323 (9th Cir. 1987)	13
Doe v. Comm'r of Transitional Assistance, 773 N.E.2d 404 (Mass. 2002)	7, 11, 21, 23, 24
FCC v. Beach Commc'ns, Inc., 508 U.S. 307, 313 (1993)	30
GoTo.com v. Walt Disney Company, 202 F.3d 1199, 1210 (9th Cir. 2000)	6

Graham v. Richardson,
403 U.S. 365 (1971) 9, 10, 18, 19, 20

Heller v. Doe,
509 U.S. 312 (1993) 29, 30

Huang v. Holiday Inns, Inc.,
954 F.Supp. 352 (C.D. Cal. 1984) 31

Hong Pham v. Starkowski,
2009 WL 5698062 8, 21

Hong Pham v. Starkowski,
2011 WL 1124005 7, 9, 10, 11

Khrapunskiy v. Doar,
909 N.E.2d 70 (N.Y. 2009) 7, 21, 28, 29

Lewis v. Thompson,
252 F.3d 567 (2d Cir. 2001) 21

Lopez v. Heckler,
725 F.2d 1489 (9th Cir. 1984) 6

Mathews v. Diaz,
426 U.S. 67 (1976) 20

Nyquist v. Mauclet,
432 U.S. 1 (1977) 10

Pharm. Research & Mfrs. of Am. v. Thompson,
354 U.S. App. D.C. 150, 313 F.3d 600 (D.C. Cir. 2002) 15

PG Const. Co. v. George & Lynch, Inc.,
834 F.Supp. 645 (D. Del. 1993) 32

Robert F. Kennedy Med. Ctr. v. Leavitt,
526 F.3d 557 (9th Cir. 2008) 15

Rodriguez v. United States,
169 F.3d 1342 (11th Cir. 1999) 21

Rose v. City of Los Angeles,
814 F.Supp.2d 878 (C.D. Cal. 1993) 5

Soskin v. Reinertson,
353 F.3d 1242 (10th Cir. 2004) 7, 11, 12, 22, 24, 25, 26, 27

Spry v. Thompson,
487 F.3d 1272 (9th Cir. 2007) 13, 15

United States v. Nutri-Cology, Inc.,
982 F.2d 394, 397 (9th Cir. 1992) 6

University of Texas v. Camenisch,
451 U.S. 390 (1981) 6

Winter v. Natural Resources Defense Council, Inc.,
129 S.Ct. 365 (2008) 6, 31

STATUTES PAGE(S)

8 U.S.C. § 1601 28, 30

8 U.S.C. §§ 1611, *et. seq* 13

8 U.S.C. § 1611 13, 18

8 U.S.C. § 1613 14, 17, 18

8 U.S.C. § 1621 22

8 U.S.C. § 1622 22, 23

8 U.S.C. § 1641 13, 14

OTHER AUTHORITY	PAGE(S)
62 Fed. Reg. 46,256 (August 26, 1997)	14
HAR §17-1722.3-12	5
HAR §17-1722.3-32, *et seq*.	5
HAR § 17-1722.3-33	2
Pub. L. No. 111-3 § 214	14

MEMORANDUM IN SUPPORT

1. Question Presented

The question presented in this Motion is: Should this Court grant the New Residents request for an injunction requiring the State of Hawaii to provide the same level of medical assistance benefits to them, where prior to the creation of BHH the New Residents received no medical assistance benefits from the State?

- This Court should answer that question in the negative because:
- Plaintiffs have failed to show a likelihood of success on the merits;
- The balance of equities favors the Defendants; and
- It is not in the public interest to issue the injunction.

2. Underlying Facts

The term "New Residents" as applied in the present lawsuit refers to non-pregnant legal immigrants, age nineteen or older, who have been legally residing in the United States for less than five years. See Declaration of Kenneth Fink in support of Defendants' Opposition to Plaintiffs' Motion for Preliminary Injunction, hereafter Fink Dec. at 3. Since 1996, New Residents have not been eligible for the federal Medicaid program and have not received state-funded medical assistance benefits through the QUEST, QExA, QUEST-Net, QUEST-ACE, fee-for service, or SHOTT programs, collectively referred to as the Other Programs by Plaintiffs. See Declaration of Kenneth Fink in support of Defendants' Motion for Summary Judgment, filed

April 28, 2011, hereafter MSJ Fink Dec. The Basic Health Hawaii (BHH) program is a state-funded medical assistance program only for certain aliens, including New Residents, who are ineligible for the federal Medicaid program. MSJ Fink Dec. On July 1, 2010, BHH was implemented and New Residents became eligible for BHH, subject to the program limitations. MSJ Fink Dec. Certain New Residents were deemed into BHH pursuant to HAR § 17-1722.3-33(b). MSJ Fink Dec. The New Residents that were deemed into BHH and have continued to meet the eligibility requirements have received state-funded BHH benefits from the State of Hawaii since July 1, 2010. MSJ Fink Dec. Should this Court decide to restore the *status quo* that existed on June 30, 2010, the New Residents would no longer be eligible to receive state-funded medical assistance benefits from the State of Hawaii. MSJ Fink Dec.

3. Plaintiffs Do Not Understand the Immigrant Health Initiative

In response to the enactment of PRWORA and recognizing the impact this federal legislation would have on the health care safety-net, the Hawaii legislature appropriated funds for the safety-net providers who would otherwise have provided uncompensated care to the affected population. This provider subsidy was called the Immigrant Health Initiative (IHI), and the State contracted with an entity to disperse the funding to safety-net providers. Fink Dec. at 3-4.

Plaintiffs suggest that New Residents who became ineligible for federally funded medical assistance as a result of PRWORA would have had no access to

care absent the existence of IHI. This is incorrect. The IHI contract is simply a mechanism for the DHS to transfer funds appropriated by the Hawaii State Legislature to the safety-net providers who would, regardless of the existence of the IHI, be treating the additional New Residents who became newly uninsured due to PRWORA. Fink Dec. at 4.

As a subsidy to providers, the IHI funds are consumed as uncompensated care is provided to patients. IHI is not a medical assistance program. Individuals do not receive any benefit package. In fact, no individual related to IHI receives an eligibility determination by the State, is entered into a State information system, or receives an eligibility identification card. IHI does not exist in statute or administrative rule; it is simply an appropriation that gets dispersed by a contractor to safety-net providers. Fink Dec. at 4.

The DHS believes that the Hawaii Primary Care Association ("HPCA"), has been awarded the IHI contract since 1997, and DHS has recently received State Procurement Office approval to sole source the IHI contract to the HPCA using Rainy Day funds appropriated through Act 191, Session Laws of Hawaii 2010. The HPCA's mission is "to improve the health of communities in need by advocating for, expanding access to, and sustaining high quality care through the statewide network of community health centers." Exhibit A (http://hbe.ehawaii.gov/documents/business.html?fileNumber=73741D2).

The community health centers are federally qualified health centers ("FQHCs"), "non-profit organizations [that] exist in federally-recognized areas where residents have barriers to getting health care." Exhibit B (http://www.hawaiipca.net/9/what-are-chcs). FQHCs "provide services *to all* with fees adjusted based on ability to pay." Exh. C. (http://bphc.hrsa.gov/about/index.html) They serve people of all ages, with or without health insurance, and of all races and ethnicities. *Id.* The FQHCs provide primary care services to uninsured or underinsured New Residents as part of their mission "to establish access to primary health care services for everyone." Exhibit D (http://www.hawaiipca.net/22/mission). This is possible because over one third of the FQHCs' income in Hawaii comes from private and government grants and contracts, such as the IHI. Exhibit E (http://www.statehealthfacts.org/profileind.jsp?ind=428&cat=8&rgn=13).

Therefore, it is clear that New Residents were never excluded from obtaining services from FQHCs, either before or after enactment of PRWORA. Neither IHI nor BHH had any impact on a New Resident's ability to receive services from a FQHC.

Unlike IHI, BHH does provide medical assistance to legal aliens ineligible for Medicaid. Upon implementation of BHH, certain legal aliens, including New Residents receiving a State human services benefit were deemed into BHH and not

subject to the enrollment limit. HAR §17-1722.3-32, *et seq*. BHH is a new and additional benefit, and it is voluntary. Deemed individuals can disenroll. Fink Dec. at 5; HAR §17-1722.3-12(4).

As BHH is an additional benefit, it is curious that Plaintiffs claim that New Residents were deemed "into an even more inadequate health benefits program, BHH." Plaintiffs' Memorandum in Support at 3. BHH provides some services that are not available through FQHCs, and New Residents who use up their allotted BHH benefits still have access to all of the services that are available through the FQHCs. If the New Resident is enrolled in BHH and has not used up his allotted BHH benefits, then the FQHC may bill the BHH health plan. If the New Resident is uninsured or has exhausted his BHH benefits, then the FQHC may be reimbursed through IHI, provided there are contract funds remaining. Again, the appropriations for IHI are limited, and the DHS will not pay the HPCA any more than the amount appropriated by the Legislature.

4. Plaintiffs Are Not Entitled to the Injunction They Seek

As noted above, prior to BHH the New Residents did not receive medical assistance benefits, which they are now seeking this Court to order the State to provide. Initially, Defendants wish to remind the Court that the purpose of injunctive relief is to prevent future harm. *Rose v. City of Los Angeles*, 814 F.Supp.2d 878, 884-885 (C.D. Cal. 1993). The purpose of a preliminary injunction

is to preserve the status quo, not provide affirmative relief. *University of Texas v. Camenisch*, 451 U.S. 390 (1981); *Lopez v. Heckler*, 725 F.2d 1489 (9th Cir. 1984) (purpose is to preserve the status quo pending a final determination on the merits). The term "status quo" refers to the last uncontested status. *GoTo.com v. Walt Disney Company*, 202 F.3d 1199, 1210 (9th Cir. 2000). Providing the relief requested by Plaintiffs goes far beyond the purpose of a preliminary injunction because it awards the New Residents benefits which they did not have prior to the institution of the action.

To obtain such an injunction Plaintiffs are required to meet the four-part test traditionally used by the Ninth Circuit: Likelihood of success on the merits; Possibility of irreversible injury absent an injunction; Balance of the harms; and Public interest. *United States v. Nutri-Cology, Inc.*, 982 F.2d 394, 397 (9th Cir. 1992). *Winter v. Natural Resources Defense Council, Inc.*, 129 S.Ct. 365 (2008) (Issuance of a preliminary injunction based only on a showing of irreparable harm is inconsistent with the Supreme Court's characterization of injunctive relief as a extraordinary remedy that may be granted upon a clear showing that the plaintiff is entitled to such relief.)

Based on the facts presented, Plaintiffs are not entitled to a preliminary injunction because:

- They cannot show a likelihood of success on the merits;

- The balance of the equities tips in their favor; and
- The issuance of an injunction is in the public interest.

A. The Plaintiffs Have Not Demonstrated a Likelihood of Success on the Merits

Congress, not Defendants, has elected to exclude certain aliens -- including New Residents -- from coverage in federal public benefit programs such as Medicaid. Nothing in the Equal Protection Clause requires the State to affirmatively provide benefits that the federal government denies to aliens, nor does it require the State, if it chooses to provide benefits, to provide the same level that it provides under the Medicaid program with federal support. In other words, "the equal protection clause does not require the state to treat individuals in a manner similar to how others are treated in a different program governed by a different government." *Hong Pham v. Starkowski*, 2011 WL 1124005 at 10 (citing *Doe v. Comm'r of Transitional Assistance*, 773 N.E.2d 404, 414 (Mass. 2002), *Soskin v. Reinertson*, 353 F.3d 1242 (10th Cir. 2004), *Khrapunskiy v. Doar*, 909 N.E.2d 70 (N.Y. 2009)). "[A] state does not discriminate against aliens when it treats aliens covered under an alien-only benefit program differently from the way in which citizens and other aliens are treated under a separate, federal-state benefit program." *Id.* at 13.

Even if treating aliens in an alien-only benefit program differently from citizens in a federal-state benefit program is found to be discrimination based on alienage, BHH passes muster under rational basis review, which is all that is

required when the State is not excluding individuals based on alienage but providing state-funded benefits to aliens who do not qualify for Medicaid coverage. To the extent that New Residents believe they should receive benefits comparable to those provided to citizens and other qualified aliens under Medicaid, their remedy is with Congress, not this Court.

(1) BHH Does Not Discriminate Based on Alienage Against Aliens and in Favor of Citizens.

Plaintiffs have relied on *Hong Pham v. Starkowski*, 2009 WL 5698062 (unreported) (Conn. Super. Dec. 18, 2009), in which the state of Connecticut had a state-funded medical assistance program for certain aliens who were ineligible for federal Medicaid. Like the present case, the plaintiff and class members were legal aliens who were in need of nonemergency medical assistance because they were indigent and ineligible for such assistance through the federal Medicaid program. *Id*. at 1. The Connecticut state legislature effectively eliminated the state program under which the plaintiff and class members had been receiving the benefits in response to budgetary constraints. *Id*. Again, as in this action, the plaintiffs claimed this decision discriminated against them on the basis of alienage, in violation of federal law. *Id*. The trial court declared that the state legislative classification in that case distinguishes between citizens who are eligible for federal Medicaid and aliens who are not. Therefore, this was a classification based on alienage that requires strict scrutiny standard of review. 2009 WL 5698062 at 14.

However, the Connecticut Supreme Court recently overturned this decision in *Hong Pham v. Starkowski*, 2011 WL 1124005 (April 5, 2011)[1]. The Connecticut Supreme Court rejected the plaintiff's argument in a well-reasoned opinion:

> We conclude that, in substantially eliminating [the state program], the state did not draw a classification on the basis of alienage because that program does not benefit citizens as opposed to aliens. To draw a classification on the basis of alienage, the state statute in question typically must afford some benefit to citizens but deny that benefit to at least some aliens because of their status as noncitizens.

Id. at 8.

The Connecticut Supreme Court reviewed United States Supreme Court cases following *Graham v. Richardson*, 403 U.S. 365 (1971), a cased heavily relied upon by Plaintiffs, and determined that the Supreme Court found discrimination based on alienage in *state* programs that favored citizens over aliens on the basis of an individual's citizenship status. *Id.* Specifically, each case cited, including *Graham*, involved situations where a state discriminated against aliens in programs that included citizens. None compared aliens in an aliens-only program

[1] The Connecticut Supreme Court incorrectly described this court's earlier order for preliminary injunction as relating to "a Hawaii law that rendered the plaintiffs, who all were aliens in need of public medical assistance, ineligible for certain state funded medical programs (old programs) that formerly had provided assistance to both aliens and citizens. That law placed the plaintiffs in a different state funded program that provided less assistance than citizens continued to receive under the state's old programs." *Hong Pham*, 2011 WL 1124004 at 16. In fact, citizens have always been eligible for the federal Medicaid benefit, and the aliens in question were eligible for state-funded medical assistance. The aliens were never removed from a state funded program that served citizens.

with citizens who were eligible for a federal or federal-state program from which the alien was barred. *Id*.

Therefore, the Connecticut Supreme Court noted that the state program that was eliminated provided assistance only to those aliens who are barred by the federal government from participating in federal Medicaid and that no citizens received benefits under Connecticut's program, as in the present case. *Id*. The *Hong Pham* Court stated that that the relevant question in determining if state action discriminates on the basis of alienage is not "whether the state is taking action that harms only aliens but, rather, whether the state program provides a benefit to citizens that it does not provide to some or all aliens because of their status as noncitizens." (citing *Nyquist v. Mauclet*, 432 U.S. 1 at 3-4, 12 (1977); and *Graham*, *supra*. at 367-68, 376) *Id*. The *Hong Pham* Court then concluded that:

> Because only aliens, and not citizens, ever have benefited from [the state benefit program], and because no citizens presently receive assistance under the program, the state is not providing a benefit to citizens that it is withholding from the class members and is not treating aliens disparately as compared to citizens. **We therefore conclude that § 64 of Spec. Sess. P.A. 09–5 does not discriminate against aliens in favor of similarly situated citizens and, therefore, does not create a classification based on alienage.**

Id. (emphasis added) Accordingly, the court in *Hong Pham* did not need to determine whether rational basis review or strict scrutiny applied. *Id.* at 21.

Other appellant court decisions that have explicitly considered the question of whether a statutory limitation in a program that serves only

aliens discriminates against aliens and in favor of citizens have all ruled that such statutory limitations do not discriminate against aliens. In *Doe*, a Massachusetts statute created a special, alien-only cash assistance program for qualified aliens who were made ineligible for assistance under the federal TANF program by the PRWORA five year rule, but imposed a statutory durational residency requirement in Massachusetts such that not all qualified aliens who were made ineligible for TANF could qualify for the alien-only state benefit program. The court held that the statutory limitation "does not discriminate against aliens in favor of citizens." *Doe*, 773 N.E. at 411.

Similarly, in *Soskin*, the Tenth Circuit addressed Colorado's discretionary election to cut back on the scope of aliens who would be eligible to participate in Colorado's federal Medicaid program. Federal Medicaid law requires the states to cover "qualified aliens" who are otherwise eligible for assistance in their state Medicaid program (including by meeting the five year rule, if applicable), but affords the states the option to define additional groups of lawfully-admitted aliens as being eligible to participate in the federal program. Colorado initially elected to cover a more expansive group of aliens, but then, faced with a budget crunch, cut back to the mandatory group of "qualified aliens." Notwithstanding that the federal Medicaid program serves both eligible citizens and eligible aliens, the option

to serve additional aliens only applied to, and only benefited, aliens. Under these circumstances, *Soskin* followed *Doe*, and ruled that "[a] state's exercise of the federal option to include fewer aliens in its alien-only program, then, should not be treated as discrimination against aliens as compared to citizens." *Id.* at 1255-56.

Likewise, in this case, the State is not affording a benefit to citizens that is not available to aliens. Citizens are eligible for federal Medicaid, which by federal law excludes the New Residents. BHH is a benefit offered only to certain aliens, and not to citizens. The State did not draw classifications between citizens and aliens; it drew classifications between residents who were eligible for Medicaid and those who were ineligible. The reasoning of *Doe* and *Soskin* regarding the absence of discriminatory treatment between aliens and citizens in a limitation to a program that serves only aliens fully applies to the facts of this case.

Plaintiffs contend that Hawai'i is drawing impermissible classifications between citizens and aliens because BHH provides less medical coverage than federal benefit programs provide to citizens under Medicaid. However, "[t]hat aspect of the discrimination is Congress's doing," *Soskin*, 353 F.3d at 1256, when it excluded Plaintiffs from Medicaid and refused to provide states with any federal funding for Plaintiffs' medical care. By contrast, Hawai'i remains committed to furnishing health care benefits to New Residents that Congress has turned its back on, despite the State's current budget crisis.

(2) The Federal Government, Not the State, Has Chosen to Exclude New Residents From Medicaid Coverage

The Medicaid program, established in 1965, is "a cooperative federal-state program that directs federal funding to states to assist them in providing medical assistance to low-income individuals." *Ball v. Rodgers*, 492 F.3d 1094, 1098 (9th Cir. 2007) (citation and quotation marks omitted). "A state is not required to participate in Medicaid, but once it chooses to do so, it must create a plan that conforms to the requirements of the Medicaid statute and the federal Medicaid regulations." *Dep't of Health Servs. v. Sec'y of Health & Human Servs.*, 823 F.2d 323, 325 (9th Cir. 1987). In return for its conformity with federal requirements, participating state governments get partial reimbursement, in the form of "federal financial participation" or "FFP" from the federal government. *Spry v. Thompson*, 487 F.3d 1272 , 1273 (9th Cir. 2007); *Children's Hosp. & Health Ctr. v. Belshe*, 188 F.3d 1090, 1093 (9th Cir. 1999).

As part of the Personal Responsibility Work Opportunities Reconciliation Act (PRWORA), enacted in 1996, Congress directed that eligibility for Medicaid and other federal benefit programs be limited to "qualified aliens." 8 U.S.C. §§ 1611, *et. seq.* With limited exceptions, PRWORA provides that "an alien who is not a qualified alien [hereinafter, "nonqualified alien"] . . . is not eligible for any Federal public benefit." 8 U.S.C. § 1611(a); *see* 8 U.S.C. § 1641(b). Thus, Congress has decreed that any noncitizen who does not satisfy the definition of

qualified alien or meet one of the exceptions is ineligible for Medicaid, even if he or she meets all other Medicaid eligibility requirements.

Qualified aliens include legal permanent residents, asylees, refugees, certain aliens granted temporary parole into the United States for a period of at least one year, aliens whose deportation has been withheld, aliens granted conditional entry, aliens who are Cuban and Haitian entrants, and certain aliens and their children who have been battered or subjected to extreme cruelty. 8 U.S.C. § 1641(b)-(c).

While qualified aliens are generally eligible for federal benefits, PRWORA provides that those who entered the United States after August 22, 1996 (the date of PRWORA's enactment), are ineligible for any "Federal means-tested public benefit" for a period of five years following their date of entry. 8 U.S.C. § 1613(a). Refugees, asylees, and veterans and their families are exempted from the waiting period. *Id*. at § 1613(b). Medicaid is a means-tested program, and the U.S. Department of Health and Human Services has confirmed that qualified aliens applying for Medicaid are subject to the five-year waiting period. 62 Fed. Reg. 46,256 (August 26, 1997). Thus, most qualified aliens entering the U.S. after August 22, 1996, including the New Residents, must wait five years to become eligible for Medicaid.[2]

[2] Recent legislation made an exception to this bar for pregnant women and children. Pub. L. No. 111-3 § 214. Hawai'i immediately took advantage of this provision to include these groups in Medicaid.

(3) The Centers for Medicare & Medicaid Services Has Prohibited Coverage for New Residents in QUEST, QExA, QUEST-Net, and QUEST-ACE

Medicaid is overseen at the federal level by the Department of Health and Human Services ("HHS") through HHS's Centers for Medicare and Medicaid Services ("CMS"). See *Robert F. Kennedy Med. Ctr. v. Leavitt*, 526 F.3d 557, 558 (9th Cir. 2008). Section 1115 of the Social Security Act authorizes the Secretary to approve experimental or demonstration projects to encourage states to adopt innovative programs that are likely to assist in promoting the objectives of Medicaid. *See* 42 U.S.C. § 1315(a). *See generally Spry v. Thompson*, *supra*; *Pharm. Research & Mfrs. of Am. v. Thompson*, 354 U.S. App. D.C. 150, 313 F.3d 600, 602 (D.C. Cir. 2002). Under an approved Section 1115 demonstration project, a State can be given the authority to modify its Medicaid program to provide benefits, use delivery systems (such as managed care), or cover groups that would not otherwise be eligible for Medicaid. *See Spry*, *supra* at 1273-74. Once the waiver is granted, the State is subject to "Special Terms and Conditions" or STCs that govern how the waiver program will operate.

Hawai‘i has a Section 1115 waiver from CMS which enables it to provide, with federal matching funds, several different health care benefit packages to different populations in the State. The original QUEST waiver was implemented in 1993, and it gave the State the authority to provide Medicaid state plan benefits through managed care to Medicaid enrollees who were covered under Medicaid's various coverage categories for children and parents. The State also received

authority to cover certain groups (with federal funding) who were not otherwise eligible for Medicaid. These are known as "demonstration-eligibles" because they are made eligible for coverage pursuant to the Section 1115 demonstration project. As it has developed over time, the principal non-Medicaid group eligible for QUEST coverage is non-disabled, childless adults with incomes below the federal poverty level. Under the terms of the waiver, that group is subject to an enrollment cap, although there are various exceptions to imposition of the cap.

In 1996, the State implemented the "QUEST-Net" program through its Section 1115 demonstration program. QUEST-Net provides full Medicaid coverage to children and a less comprehensive package of benefits to adults who otherwise have too much income or assets to qualify for Medicaid. Adult enrollment in QUEST-Net is limited to those who previously had QUEST coverage but no longer meet those eligibility requirements.

When the QUEST demonstration project was renewed in 2006 as "QUEST Expanded" ("QEx") the State received the authority to cover additional adults through "QUEST Adult Coverage Expansion" or "QUEST-ACE," which provides coverage to adults who cannot be enrolled in QUEST due to the enrollment cap. Benefits under QUEST-ACE are equivalent to those available under QUEST-NET.

Most recently, the waiver was renewed to include "QUEST Expanded Access" or "QExA." QExA adds institutional and home-and-community-based

long term care benefits to the QUEST benefit package to individuals who qualify for Medicaid coverage in an aged, blind, or disabled eligibility group.

The STCs for both the QEx waiver, granted in 2006, and the QExA waiver, granted in 2008, state that all requirements of the Medicaid programs expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable to the waiver shall apply. (See Exhibits C at 2 and D at 7 to Docket Number 8-5) The State's 1115 waivers do not, and cannot, waive the restriction imposed by the PRWORA that New Residents are ineligible for federal Medicaid for a period of five years following their date of entry. 8 U.S.C. § 1613(a). Therefore, although the waivers do provide federal funding for some groups not otherwise eligible for Medicaid, the terms of the waivers make clear that there is no federal funding available for New Residents.

Although prohibited by PRWORA and the terms of its waivers from extending Medicaid coverage to New Residents, the State, nonetheless, chose to provide health benefits using only state tax dollars, without federal financial participation, as follows:

First, alien children and pregnant women who were not eligible for enrollment in Medicaid but who otherwise met QUEST eligibility criteria were provided the equivalent of full QUEST coverage. (See footnote 1, above)

Second, New Residents who otherwise meet the eligibility criteria for enrollment in QUEST, QUEST-Net, QUEST-ACE, or QExA are to be provided benefits through BHH.

(4) The Equal Protection Clause Does Not Require That the State Create a Health Care Program for Aliens Whom Congress Has Chosen Not to Cover

When Congress passed the PRWORA, it excluded certain groups of aliens, including New Residents, from receiving federal public benefits such as Medicaid. *See* 8 U.S.C. §§ 1611(a), 1613(a). Nothing in federal or state law, including the PRWORA and the equal protection clauses of the United States constitutions, **requires** the State to create its own benefit program for these aliens whom Congress has excluded from coverage.

The Fourteenth Amendment provides that "[n]o state . . . shall deny to any person within its jurisdiction the equal protection of the laws." U.S. Const. amend. XIV, § 1. The word "person" in this context includes "lawfully admitted resident aliens as well as citizens of the United States and entitles both citizens and aliens to the equal protection of the laws of the State in which they reside." *Graham*, 403 U.S. at 371. "Under traditional equal protection principles, a State retains broad discretion to classify as long as its classification has a reasonable basis [i.e. rational basis review]." *Id* "This is so in 'the area of economics and social welfare.'" *Graham*, 403 U.S. at 371 (quoting *Dandridge v. Williams*, 397 U.S. 471, 485 (1970)). However, "classifications based on alienage, like those based on

nationality or race, are inherently suspect and subject to close judicial scrutiny [i.e. strict scrutiny]." *Id*. at 372.

The Supreme Court's decision in *Graham*, *supra*, held that States on their own cannot treat aliens differently from citizens without a compelling justification. *Id*. at 372-76. *Graham* resolved a consolidated appeal of two cases in which legal aliens challenged welfare programs in Arizona and Pennsylvania on equal protection grounds. *Id*. at 366-69. Arizona limited eligibility for federally funded programs for persons who were disabled, in need of old-age assistance, or blind, to U.S. citizens and persons who had resided in the U.S. for at least 15 years. *Id*. Pennsylvania limited eligibility for a state-funded welfare program to residents who were U.S. citizens or who had filed a declaration of intention to become citizens. *Id*. at 368. The Supreme Court observed that "the Arizona and Pennsylvania statutes in question create two classes of needy persons, indistinguishable except with respect to whether they are or are not citizens of this country." *Id*. at 371. Notably, *Graham* was decided before the PRWORA restricted the eligibility of aliens for federal public benefits. Consequently, the Court reviewed these classifications under strict scrutiny and concluded "that a State's desire to preserve limited welfare benefits for its own citizens is inadequate to justify Pennsylvania's making non-citizens ineligible for public assistance, and Arizona's restricting benefits to citizens and longtime resident aliens." *Id*. at 374.

In *Graham*, the statutes in question provided public assistance to citizens but denied the same assistance to aliens simply on the basis of their citizenship status. *Id.* at 376. *Graham* is not applicable here, however, where it is Congress, not the State, that has excluded aliens from federally funded Medicaid coverage, and the State is providing a state-funded benefit that is separate and distinct from federal Medicaid.

In a case decided three years after *Graham*, the Supreme Court held that the federal government may treat aliens differently from citizens so long as the classification satisfies rational basis review. *Mathews v. Diaz*, 426 U.S. 67, 78-83 (1976). In that case, the Court upheld Congress's decision to "condition an alien's eligibility for participation in [Medicare] on continuous residence in the United States for a five-year period and admission for permanent residence." *Id*. at 69. The Court emphasized Congress's broad constitutional power over naturalization and immigration and noted that "the responsibility for regulating the relationship between the United States and our alien visitors has been committed to the political branches of the Federal Government." *Id*. at 80-81. Therefore, the Court applied rational basis review and held that "it is unquestionably reasonable for Congress to make an alien's eligibility [for federal Medicare benefits] depend on both the character and the duration of his residence." *Id*. at 82-83.

Following *Mathews*, lower courts have uniformly applied rational basis review to uphold federal statutes that exclude certain aliens from various welfare

programs, even if those programs are administered by the States. *See, e.g.*, *Lewis v. Thompson*, 252 F.3d 567, 582 (2d Cir. 2001) (upholding under rational basis review PRWORA restrictions on alien eligibility for state-administered pre-natal Medicaid benefits); *Aleman v. Glickman*, 217 F.3d 1191, 1197 (9th Cir. 2000) (same for food stamps); *City of Chicago v. Shalala*, 189 F.3d 598, 603-05 (7th Cir. 1999) (same for supplemental social security income and food stamps); *Rodriguez v. United States*, 169 F.3d 1342, 1346-50 (11th Cir. 1999). Thus, the PRWORA provisions that exclude New Residents from receiving federal Medicaid benefits are clearly constitutional.

The Equal Protection Clause does not require States to fill in the gaps where Congress has excluded aliens from federal benefits but has given states discretion to furnish aliens with such benefits using state funds. *See, e.g.*, *Hong Pham v Starkowski*, 2011 WL 1124005 at 10 (Conn.) ("[T]he equal protection clause does not require the state to treat individuals in a manner similar to how others are treated in a different program governed by a different government."); *Khrapunskiy*, 909 N.E.2d at 77 ("Simply put, the right to equal protection does not require the State to create a new public assistance program in order to guarantee equal outcomes . . . . Nor does it require the State to remediate the effects of the PRWORA."); *Doe v. Comm'r of Transitional Assistance*, 773 N.E.2d 404, 414 (Mass. 2002) (finding that Massachusetts was not required to establish a state-funded program where the PRWORA barred qualified aliens from receiving

federal temporary assistance for needy families until they had resided in the U.S. for five years but gave states discretion to provide such benefits to those aliens using state funds); *see also Soskin*, 353 F.3d at 1255 (holding that states do not discriminate against aliens in violation of the Equal Protection Clause when states choose not to provide aliens with the maximum benefits permitted by federal law).

(5) To the Extent the State Has Chosen to Create a Program Just for Aliens, It is Subject to a Rational Basis Standard of Review

In the PRWORA, Congress not only specified the categories of aliens that were eligible and ineligible for federal benefit programs, it also included rules governing coverage of aliens by state or local benefit programs. The statute defines a "state or local public benefit" as a "health . . . benefit for which payments or assistance are provided to an individual, household, or family eligibility unit" that is provided "by an agency of a State or local government or by appropriated funds of a State or local government." 8 U.S.C. § 1621(c)(1)(B).

The PRWORA does not require states to create benefit programs for aliens whom Congress has barred from receiving federal coverage. However, if states choose to commit their own resources to establish programs that help fill in those coverage gaps that Congress created, the PRWORA does delineate some eligibility rules for aliens. The statute provides that state programs may not exclude certain groups of qualified aliens, *see* 8 U.S.C. § 1622(b), but must exclude other groups, *see id*. § 1621(a). New Residents are not among the groups that must be included or excluded. Instead, the PRWORA gives states the discretion to determine the

eligibility of such aliens, including the New Resident Plaintiffs, for state-funded benefits. *See id*. § 1622(a) ("a State is authorized to determine the eligibility for any State public benefits of an alien who is a qualified alien . . . ").

Several courts have addressed whether States that maintain state benefit programs may constitutionally exclude those aliens for whom Congress has made coverage optional. These courts have applied rational basis review where a State has created an optional state-funded benefit program exclusively for aliens and where it has decided to terminate such a program. In 2002, for example, the Massachusetts Supreme Court upheld as constitutional a state law that created a supplemental state-funded welfare program with a six-month residency requirement to provide benefits for aliens who became ineligible after the PRWORA imposed the five-year residency requirement for federally funded benefits. *Doe v. Comm'r of Transitional Assistance*, 773 N.E.2d 404, 406, 414-15 (Mass. 2002). The court found that "the Massachusetts Legislature was not required to establish the supplemental program" for aliens who did not meet the federal criteria and concluded that, having done so, its six-month waiting period was based on residency, not alienage, and thus was not subject to strict scrutiny. *Id*. at 411, 414-15. In concluding that rational basis review applied, the court also considered:

> the context in which the supplemental program was enacted; its purpose and the clearly noninvidious intent behind its promulgation; the effect of its implementation on mitigating the harm to qualified alien families that might otherwise be without substantial assistance

> for five years under the requirements of the welfare reform act [PRWORA]; and the potential harm to those families if the Legislature could only choose to create an all-or-nothing program as a remedy to their disqualification from federally funded programs.

Id. at 414.

Applying the rational basis standard, the court observed that Massachusetts's state benefit program was "consistent with national policies regarding alienage[] and places no additional burdens on aliens beyond those contemplated by the [PRWORA]." *Id*. at 414-15. The court concluded that the program furthered "the Federal policy of self-sufficiency and self-reliance with respect to welfare and immigration by ensuring that aliens first attempt to be self-sufficient before applying for State-funded welfare benefits. In addition, the six-month residency requirement encourages aliens to develop enduring ties to Massachusetts." *Id*. at 415. Finally, the court found that "[t]he fact that the Legislature might have been able to satisfy the requirements of the [PRWORA] in a different way does not mean that the legislative decision to enact [the state program] was irrational or constitutionally impermissible." *Id.*

In 2004, the Tenth Circuit upheld as constitutional Colorado's decision to mitigate a budget shortfall by eliminating its optional coverage of certain aliens from Medicaid (those whom, unlike New Residents, a State may cover under Medicaid). *Soskin*, 353 F.3d at 1246, 1254-57. After conducting an extensive discussion of *Graham* and *Mathews*, the court concluded that neither case determined the result. "Unlike *Graham*, here we have specific Congressional

authorization for the state's action, the PRWORA. Unlike *Mathews*, here we have a state-administered program, and the potential for states to adopt coverage restrictions with respect to aliens that are not mandated by federal law." *Id*. at 1251. Instead, "[t]his case fits somewhere in between." *Id*.

The Tenth Circuit noted that, unlike the federal law at issue in *Mathews*, the PRWORA "gives states a measure of discretion" that can take into account the impact on the state budget. *Id*. That is because states are "addressing the Congressional concern (not just a parochial state concern) that 'individual aliens not burden the public benefits system.'" *Id*. (quoting 8 U.S.C. §1601(4)). The court commented that "[t]his may be bad policy, but it is Congressional policy; and we review it only to determine whether it is rational." *Id*.

Plaintiffs have argued that the Congressional authorization to the states under PRWORA does not constitute a "uniform rule," and therefore strict scrutiny applies. *See*, Doc. 10-1 at 20-22. However, the Tenth Circuit in *Soskin* clearly demonstrates that the uniformity requirement of the Naturalization Clause does not negate the impact of the Congressional authorization, rejecting the concern expressed by *dicta* in *Graham* and by the holding in *Aliessa v. Novello*, 96 N.Y.2d 418, 752 N.E.2d 1085 (Ct. App. 2001). *Soskin* first demonstrates that the Naturalization Clause is not directly applicable to the question of whether a state may condition welfare benefits based on alienage status following the alien's entry into the country because that question is not related to the citizenship process.

Soskin, 353 F.3d at 1256. ("Indeed it is not at all clear how the authority 'to establish a uniform Rule of Naturalization' is being exercised when Congress restricts welfare benefits to aliens on grounds that have no direct relationship to the naturalization process. Whether the alien is seeking naturalization is no a consideration under the PRWORA.") *Soskin* then finds that Congress has other sources of constitutional authority over aliens in addition to the Naturalization Clause and quotes the decision of the United States Supreme Court in *Plyler* for the proposition that "[o]ther sources of Congressional authority include its plenary authority with respect to foreign relations and international commerce, and … the inherent power of a sovereign to close its borders." *Id.* (quoting *Plyler*, 457 U.S. at 225).

Finally, the Tenth Circuit borrowed reasoning from the Massachusetts Supreme Court's *Doe* opinion to explain how equal protection principles apply in cases that fall within the gray area between the bright lines of *Graham* and *Mathews*. The court described what Congress did in the PRWORA as, "in essence," creat[ing] two welfare programs, one for citizens and one for aliens . . . . The decision to have separate programs for aliens and citizens is a Congressional choice, subject only to rational-basis review." *Id*. (citing *Mathews*, 426 U.S. at 78-83). When a state exercises the option to include more or fewer aliens in the aliens-only program, that decision "should not be treated as discrimination against aliens as compared to citizens. That aspect of the discrimination is Congress's

doing . . . ." *Id*. at 1255-56. Thus, the Tenth Circuit held that rational basis review applies to such classifications. *Id.*

The only time a court has applied strict scrutiny and declared a state program unconstitutional occurred when, following passage of the PRWORA, New York created a state-funded medical assistance program for U.S. citizens that completely excluded non-qualified aliens from eligibility. *See Aliessa*, 754 N.E.2d at 1090, 1094-99. The New York program provided the equivalent of Medicaid coverage to citizens that met Medicaid income requirements but did not meet categorical eligibility. The court rejected the state's argument that its exclusion of non-qualified aliens was merely "implement[ing] title IV's Federal immigration policy and should therefore be evaluated under the less stringent 'rational basis' standard." *Id*. at 1095. The court held that Congress's attempt to give states discretion not to extend state benefits to non-qualified aliens "produc[es] not uniformity, but potentially wide variation . . . . Considering that Congress has conferred upon the states such broad discretionary power to grant or deny aliens State Medicaid [i.e., state-funded medical assistance], we are unable to conclude that title IV reflects a uniform national policy." *Id*. at 1098. It held that the state's attempt to exclude non-qualified aliens from its state-only medical assistance program did not pass strict scrutiny and violated the Equal Protection Clause.[3]

[3] An Arizona state court, addressing that State's exclusion of aliens from a program for non-Medicaid eligibles, upheld the constitutionality of the program under strict scrutiny, on the ground that Congress in the PRWORA intended to give States the

However, a subsequent case from New York made clear that, despite the holding in *Aliessa*, "the right to equal protection does not require the State to create a new public assistance program in order to guarantee equal outcomes . . . Nor does it require the State to remediate the effects of the PRWORA." *Khrapunskiy*, 909 N.E.2d at 77.

Plaintiffs allege that, as long as Hawai'i maintains a state-funded program such as BHH, the Equal Protection Clause mandates that Hawai'i provide the same coverage that citizens receive through Medicaid. Otherwise, in Plaintiffs' view, the discrepancy in coverage constitutes discrimination based on alienage and is subject to strict scrutiny.

Plaintiffs' argument is doubly flawed. First, Hawai'i is not distinguishing between groups of people based on their alienage. Rather, the State simply chose to provide a benefit to persons who are ineligible for federal Medicaid due to the impact of PRWORA. Federal program eligibility is not a suspect classification and, thus, only triggers rational basis review.

Second, as previously discussed, neither the PRWORA nor the Equal Protection Clause compels Hawai'i to create a state-funded benefit program to

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discretion to exclude all but a small group of aliens from their state programs. *See Avila v. Biedess*, 78 P.3d 280, 283 (Ariz. Ct. App. 2003). The PRWORA provides that "a State that chooses to follow the Federal classification in determining the eligibility of such aliens for public assistance shall be considered to have chosen the least restrictive means available for achieving the compelling governmental interest of assuring that aliens be self-reliant in accordance with national immigration policy." 8 U.S.C. § 1601(7).

provide health care coverage for aliens whom Congress has excluded from Medicaid. *See, e.g.*, *Khrapunskiy*, 909 N.E.2d at 77; *Doe*, 773 N.E.2d at 414. It defies logic to interpret equal protection principles as permitting Hawai‘i to provide non-qualified aliens with no medical coverage, but not permitting Hawai‘i to provide them with some medical coverage. To adopt Plaintiffs’ all-or-nothing view and invalidate BHH would create perverse incentives for states -- particularly in times of budgetary crisis -- to eliminate, rather than merely scale back, state-funded medical assistance to non-qualified aliens in order to avoid alleged constitutional infirmity.

(6) There is a Rational Basis for the State to Provide to Non-Eligible Aliens With Different Benefits Than It Provides to Those Who Are Eligible for Federally-Funded Benefits

Defendants’ decision to provide non-eligible aliens with a lesser level of benefits than it provides to those who are eligible for federally-funded Medicaid benefits satisfies rational basis review. “[R]ational-basis review in equal protection analysis is not a license for courts to judge the wisdom, fairness, or logic” of government choices. *Heller v. Doe*, 509 U.S. 312, 319 (1993). Therefore, the state’s decision to provide health benefits to non-eligible aliens through BHH must be upheld “if there is a rational relationship between the disparity of treatment and some legitimate governmental purpose.” *Id*. at 320; *accord Baehr v. Lewin*, 74 Haw. 530, 572 (1993) (“[u]nder the rational basis test, we inquire as to whether a statute rationally furthers a legitimate state interest”).

Furthermore, a State "that creates these categories need not actually articulate at any time the purpose or rationale supporting its classification." *Id.* (quotation omitted). Rather, a classification "must be upheld against equal protection challenge if there is any reasonably conceivable state of facts that could provide a rational basis for the classification." *FCC v. Beach Commc'ns, Inc.*, 508 U.S. 307, 313 (1993); *accord Baehr*, 74 Haw. at 572 ("[o]ur inquiry seeks only to determine whether any reasonable justification can be found for the legislative enactment"). The state "has no obligation to produce evidence to sustain the rationality of a statutory classification"; "[t]he burden is on [Plaintiffs] to negative every conceivable basis which might support it." *Heller*, 509 U.S. at 320.

Although it is under no legal obligation to do so, Hawai'i chose to use state funds to provide health benefits to non-eligible aliens through BHH. While not as comprehensive as the full Medicaid package, it is not illegitimate for the State, in making this determination, to take into account its current budget situation, given Congress's goal in the PRWORA that "individual aliens not burden the public benefits system." 8 U.S.C. § 1601(4); *see also Aleman v. Glickman*, 217 F.3d 1191, 103 (9th Cir. 2000) (recognizing that concern about the fiscal impact of providing benefits constitutes a legitimate government objective). Plaintiffs do not, nor can they, dispute that the state's decision to provide BHH benefits to New Residents, which are generally less comprehensive than the federal Medicaid benefits available to citizens and certain qualified aliens, was rationally related to

these legitimate state and federal governmental interests. Therefore, the state has satisfied rational basis review and has not violated Plaintiffs' rights under the Equal Protection Clause.

B. The Balance of Equities Does Not Favor Plaintiffs

"A preliminary injunction is an extraordinary remedy never awarded as of right." *Winter v. Natural Resources Defense Council, Inc.*, 129 S.Ct. 365, 376 (2008). Defendants believe Plaintiffs understate the effect of the proposed injunction and fail to support their factual assertions with any evidence. Notably, Plaintiffs fail to provide any breakdown of the State's expenditures for the New Residents.[4] Frankly, the monies that the State is spending on non-mandatory medical care for the Plaintiffs each year is a significant amount. Given the pattern of increasing expenditures for medical assistance to those in need, this figure can be expected to grow significantly in coming years.

Since the State of Hawaii cannot indulge in deficit spending, the issuance of the proposed injunction will force the State of Hawaii to consider spending cuts by reducing benefits provided in its Medicaid programs. Alternatively, the State may decide it has no choice but to eliminate medical assistance benefits to Plaintiffs entirely.

[4] The movant has the burden of demonstrating the need for injunctive relief. *Huang v. Holiday Inns, Inc.*, 954 F.Supp. 352, 355 (C.D. Cal. 1984)

C. An Injunction Is Not In the Public Interest

Plaintiffs' discussion of the public interest is simply an appeal for this Court to substitute policy decisions made by the Executive Branch of the government of the State of Hawaii with their view of what appropriate policies should be. There is a strong public policy to be protected in allowing the State of Hawaii to exercise the discretion granted to it by the federal government as to what level of state-funded services should be provided to the Plaintiffs. See *PG Const. Co. v. George & Lynch, Inc.*, 834 F.Supp. 645, 658-659 (D. Del. 1993) (preliminary injunction was denied to bidder on public construction project where bidder's claim was not supported by statute or regulation).

5. Conclusion

Defendants request this Court deny Plaintiffs' request for a preliminary injunction because:

- Plaintiffs have failed to show a likelihood of success on the merits;
- The balance of equities favors the Defendants; and
- It is not in the public interest to issue the injunction.

DATED: Honolulu, Hawaii, May 9, 2011.

/s/ John F. Molay .
JOHN F. MOLAY
Deputy Attorney General
Attorney for Defendants

PATRICIA McMANAMAN and
KENNETH FINK

CERTIFICATION OF LENGTH OF MEMORANDUM

Pursuant to L.R. 7.5 counsel for Defendants hereby certifies the length of the Memorandum in Support of Defendants' Motion for Partial Summary Judgment to be 7,782 words, using the word count feature of Word 2007.

DATED: Honolulu, Hawaii, May 9, 2011.

/s/ John F. Molay .
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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF HAWAI'I

TONY KORAB, TOJIO CLANTON and KEBEN ENOCH, each individually and on behalf of those persons similarly situated,

Plaintiffs,

vs.

LILLIAN B. KOLLER in her official capacity as Director of the State of Hawaii Department of Human Services; and KENNETH FINK in his official capacity as State of Hawai'i, Department of Human Services, Med-QUEST Division Administrator,

Defendants.

CIVIL NO. 10-00483 JMS KSC

DECLARATION OF KENNETH S. FINK, M.D., M.G.A., M.P.H.

DECLARATION OF KENNETH S. FINK, M.D., M.G.A., M.P.H.

I, Kenneth S. Fink, M.D., M.G.A., M.P.H., declare as follows:

1. I make this Declaration to the best of my personal knowledge and if called to testify I could and would do so competently as follows:

2. Since June 30, 2008, I have been the Administrator of the Department of Human Services, Med-QUEST Division, which is the state agency that administers the Medicaid program in the State of Hawaii.

3. I received a Medical Doctor degree from the University of Pennsylvania in 1996, a Master of Governmental Administration degree from the University of Pennsylvania in 1995, and a Master of Public Health degree from the University of North Carolina at Chapel Hill in 2000. I completed a residency in family medicine at the University of Washington from 1996 to 1999 and a residency in preventive medicine at the University of North Carolina at Chapel Hill from 1999 to 2001. I have been board certified in family medicine since 1999 and in preventive medicine since 2002 and was granted the degree of Fellow by the American Academy of Family Physicians in 2004 and by the American College of Preventive Medicine in 2006.

4. I was a Robert Wood Johnson Clinical Scholar completing a health services research fellowship in 2001 and was a Kerr White Visiting Scholar completing a health policy fellowship in 2003.

5. From 2003 to 2004, I directed the U.S. Preventive Services Task Force program and from 2004 to 2006 I directed the Evidence-based Practice Centers program where I helped implement the Comparative Effectiveness Research program, both at the U.S. Department of Health and Human Services (DHHS) Agency for Healthcare Research and Quality. From 2006 to 2008, I served as the Chief Medical Officer for the DHHS, Centers for Medicare & Medicaid Services Region 10.

6. In addition, I have been a physician in the U.S. Air Force Reserve since 2000, am a flight surgeon, currently hold the rank of Lieutenant Colonel, and am a veteran of Operation Enduring Freedom. I currently have academic appointments at the University of Washington and the University of Hawaii, and I am widely published in the peer reviewed literature.

7. The term "New Residents" as applied in the present lawsuit refers to non-pregnant legal immigrants, age nineteen or older, who have been United States residents for less than five years.

8. In response to the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 ("PRWORA"), and recognizing the impact this federal legislation would have on the health care safety-net, the Hawaii legislature appropriated funds for safety-net providers who would otherwise have provided uncompensated care to the affected

population. This was called the Immigrant Health Initiative (IHI), and the State contracted with an entity to disperse the funding to safety-net providers.

9. New Residents who became ineligible for federally funded medical assistance as a result of PRWORA continued to have access to care from safety-net providers even after implementation of the IHI.

10. The IHI contract is a mechanism for the DHS to transfer funds appropriated by the Hawaii State Legislature to safety-net providers who would, regardless of the existence of the IHI, be treating New Residents who became newly uninsured due to PRWORA.

11. As a subsidy to providers to offset uncompensated care, the limited IHI funds are consumed as care is provided to patients.

12. The IHI is not a medical assistance program. Individuals do not receive any benefit package. In fact, no individual related to IHI receives an eligibility determination by the State, is entered into a State information system, or receives an eligibility identification card. The IHI does not exist in statute or administrative rule; it is simply an appropriation that gets dispersed by a contractor to safety-net providers.

13. To the best of my knowledge, the DHS believes that the Hawaii Primary Care Association ("HPCA"), has been awarded the IHI contract since 1997.

14. DHS has recently received State Procurement Office approval to sole source the IHI contract to the HPCA using Rainy Day funds appropriated through Act 191, SLH 2010 at section 20, for the state fiscal year 2010.

15. My understanding is that FQHCs must provide services to all, regardless of ability to pay.

16. Neither IHI nor BHH had any impact on a New Resident's ability to receive services from a FQHC.

17. Unlike IHI, BHH does provide medical assistance to legal aliens ineligible for Medicaid. Upon implementation of BHH, certain legal aliens, including New Residents, receiving a State human services benefit were deemed into BHH and not subject to the enrollment limit. HAR §17-1722.3-32, et seq. BHH is a new and additional benefit, and it is voluntary. Deemed individuals can disenroll. HAR §17-1722.3-12(4).

18. BHH provides services that are not available through FQHCs, such as inpatient care and access to specialists outside of the FQHCs' available providers, and New Residents who use up their allotted BHH benefits still have access to all of the services that are available through the FQHCs.

I declare the foregoing to be true and correct under penalty of perjury.

DATED: Honolulu, Hawaii, May 9, 2011.

KENNETH S. FINK M.D., M.G.A., M.P.H.

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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF HAWAI'I

TONY KORAB, TOJIO CLANTON, KEBEN ENOCH, CASMIRA AGUSTIN, ANTONIO IBANA, AGAPITA MATEO, and RENATO MATEO, each individually and on behalf of those persons similarly situated, Plaintiffs, vs. PATRICIA MCMANAMAN in her official capacity as Director of the State of Hawaii Department of Human Services; and KENNETH FINK in his official capacity as State of Hawai'i, Department of Human Services, Med-	CIVIL NO. 10-00483 JMS KSC DECLARATION OF JOHN F. MOLAY

DECLARATION OF JOHN F. MOLAY

I, JOHN F. MOLAY, declare as follows:

1. I am an attorney at law, duly licensed to practice before all courts in the State of Hawaii.

2. I am a Deputy Attorney General and am attorney of record for Defendants.

3. Attached hereto as Exhibit A is a copy of the company information for the Hawaii Primary Care Association posted by the State of Hawaii, Department of Commerce and Consumer Affairs, Business Registration Division, on its website, available at http://hbe.ehawaii.gov/documents/business.html?fileNumber=73741D2 (printed on May 5, 2011).

4. Attached hereto as Exhibit B is a copy of the Hawaii Primary Care Association's description of Community Health Centers, available at http://www.hawaiipca.net/9/what-are-chcs (printed on May 6, 2011).

5. Attached hereto as Exhibit C is a copy of a description of a federally qualified health center, posted by the United States Department of Health and Human Services, Health Resources Services Administration, and available at http://bphc.hrsa.gov/about/index.html (printed on May 5, 2011).

6. Attached hereto as Exhibit D is a copy of the Hawaii Primary Care Association's Mission, available at http://www.hawaiipca.net/22/mission (printed on May 9, 2011).

7. Attached hereto as Exhibit E is a copy of the Kaiser Family Foundation's individual state profile for the state of Hawaii titled "Hawaii: Distribution of Revenue by Source for Federally-Funded Federally Qualified Health Centers, 2009," available at http://www.statehealthfacts.org/profileind.jsp?ind=428&cat=8&rgn=13 (printed on May 5, 2011).

I declare the foregoing to be true and correct under penalty of perjury.

DATED: Honolulu, Hawaii, May 9, 2011.

/s/ John F. Molay .
JOHN F. MOLAY
Deputy Attorney General
Attorney for Defendants
PATRICIA MCMANAMAN and
KENNETH FINK

EXHIBIT "A"

HAWAII PRIMARY CARE ASSOCIATION

DOMESTIC NONPROFIT CORPORATION

GENERAL INFO | ANNUAL FILINGS | OFFICERS | OTHER FILINGS | BUY AVAILABLE DOCS

General Info

VIEW AND PRINT COMPANY INFO

Purchase a Certificate of Good Standing for this business:

☐ ELECTRONIC **$7.50**

☐ PRINTED **$7.50**

[redacted]

MASTER NAME	HAWAII PRIMARY CARE ASSOCIATION
BUSINESS TYPE	Domestic Nonprofit Corporation
FILE NUMBER	73741 D2
STATUS	Active
PURPOSE	TO IMPROVE THE HEALTH OF COMMUNITIES IN NEED BY ADVOCATING FOR, EXPANDING ACCESS TO, AND SUSTAINING HIGH QUALITY CARE THROUGH THE STATEWIDE NETWORK OF COMMUNITY HEALTH CENTERS.
PLACE INCORPORATED	Hawaii UNITED STATES
REGISTRATION DATE	Nov 17, 1988

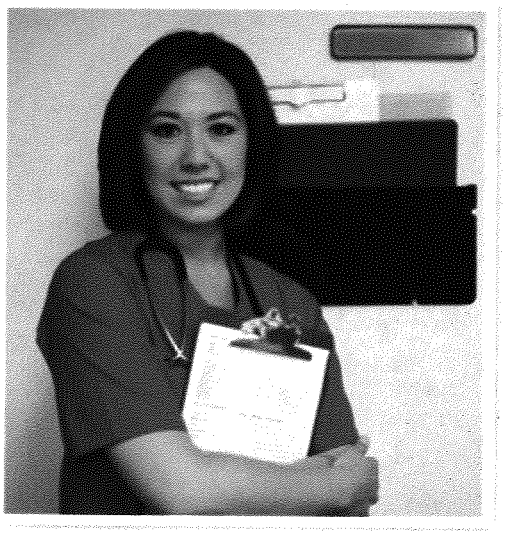
MAILING ADDRESS	345 QUEEN ST STE 601 HONOLULU, Hawaii 96813 UNITED STATES
TERM	PER
AGENT NAME	ELIZABETH C. GIESTING
AGENT ADDRESS	345 QUEEN STREET SUITE 601 HONOLULU, Hawaii 96813 UNITED STATES

Bookmark

Hawaii Primary Care Association

What are CHCs?

Community Health Centers (CHCs), also known as Federally Qualified Health Centers (FQHCs), are the cornerstone of the health care system and a vital part of our social safety net. They are non-profit organizations, and exist in federally-recognized areas where residents have barriers to getting health care.



Each CHC is governed by a board of directors, the majority of which are patients who use its services. In this way, members of the community have direct input into the development of their health center.

How CHCs Are Different

CHCs specialize in helping people overcome barriers to care by providing a comprehensive array of enabling services that a typical private practice physician would not. This includes language interpretation, transportation assistance, and care that is culturally-competent.

Also, unlike most private physicians, community health centers see patients regardless of their ability to pay. While this doesn't mean that health care is provided for free, patients who do not have insurance or who are homeless are not turned away simply because they will have difficulty paying for their care.

What CHCs Do

Community health centers provide comprehensive, high quality, cost-effective care and are leaders in the effective treatment and management of chronic diseases like diabetes, depression, and hypertension. CHCs are the medical home for over 127,000 patients, providing a comprehensive array of services that include*:

- Primary medical care
- Behavioral / mental health care
- Dental services
- Diagnostic services
- Prescription drugs
- Case management
- Language assistance
- Culturally-competent and sensitive care
- Health education, including nutrition counseling
- Assistance with program applications, including housing and cash assistance

EXHIBIT "B"

For more information on how community health centers are transforming the health care system by creating patient-centered medical homes throughout Hawai'i, see Why CHCs Are The Future.

*Note: not all services listed are provided at each health center; please contact your nearest CHC directly to determine which services they currently provide.

Why CHCs Need Your Help

As non-profit organizations, Community Health Centers must depend on the limited revenue they receive from health plans, government reimbursements, and private grants, in order to function. Because they operate in communities that have significant needs – with higher rates of chronic diseases and greater barriers to care – CHCs invest more time and resources into caring for their vulnerable populations.

Given that they also provide services to anyone, regardless of their ability to pay, health centers are performing heroic work under extraordinary circumstances.

You can help health centers receive the resources and commitment needed from policymakers and funders by becoming an informed advocate for CHCs. Visit our advocacy section to learn more about how your kokua can help thousands of your friends, family, and neighbors receive the highest quality care possible.

U.S. Department of Health and Human Services www.hhs

HRSA Primary Care

About Health Centers

What is a Health Center?

How to Apply (How to Apply for Funding of Look-Alike Designation)

Program Requirements

Program Benefits

Special Populations

What is a Health Center?

For more than 40 years, HRSA-supported health centers have provided comprehensive, culturally competent, quality primary health care services to medically underserved communities and vulnerable populations.

Health centers are community-based and patient-directed organizations that serve populations with limited access to health care. These include low income populations, the uninsured, those with limited English proficiency, migrant and seasonal farmworkers, individuals and families experiencing homelessness, and those living in public housing.

Our Stories

Technical Assistance

Health Center Program Fundamentals

- **Located in or serve a high need community** (designated Medically Underserved Area or Population). Find MUAs and MUPs
- **Governed by a community board** composed of a majority (51% or more) of health center patients who represent the population served. More about health center governance
- **Provide comprehensive primary health care** services as well as supportive services (education, translation and transportation, etc.) that promote access to health care.
- **Provide services available to all** with fees adjusted based on ability to pay.
- **Meet other performance and accountability requirements** regarding administrative, clinical, and financial operations.

Who Health Centers Serve

- **People of all ages.** Approximately 33 percent of patients in 2009 were children (age 18 and younger); about 7 percent were 65 or older.
- **People without and with health insurance.** The proportion of uninsured patients of all ages was approximately 38% in 2009, while the number of uninsured patients increased from 4 million in 2001 to over 7.2 million in 2009.
- **People of all races and ethnicities**. In 2009, 27 percent of health center patients were African-American and 35 percent were Hispanic/Latino--more than twice the proportion of African-Americans and over two times the proportion of Hispanics/Latinos reported in the overall U.S. population.
- **Special populations**. In 2009, health centers served nearly 865,000 migrant and seasonal farm workers and their families; more than 1 million individuals experiencing homelessness; and more than 165,000 residents of public housing.

Types of Health Centers

- **Grant-Supported Federally Qualified Health Centers** are public and private non-profit health care organizations that meet certain criteria under the Medicare and Medicaid Programs (respectively, Sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act and receive funds under the Health Center Program (Section 330 of the Public Health Service Act).
  - **Community Health Centers** serve a variety of underserved populations and areas.
  - **Migrant Health Centers** serve migrant and seasonal agricultural workers
  - **Healthcare for the Homeless Programs** reach out to homeless individuals and families and provide primary care and substance abuse services.
  - **Public Housing Primary Care Programs** serve residents of public housing and are located in or adjacent to the communities they serve.
- **Federally Qualified Health Center Look-Alikes** are health centers that have been identified by HRSA and certified by the Centers for Medicare and Medicaid Services as meeting the definition of "health center" under Section 330 of the PHS Act, although they do not receive grant funding under Section 330.
- **Outpatient health programs/facilities operated by tribal organizations** (under the Indian Self-Determination Act, P.L. 96-638) or urban Indian organizations (under the Indian Health Care Improvement Act, P.L. 94-437).

Data & Statistics

Uniform Data System (UDS) Reports, Data Highlights and Reporting Technical Assistance.

More Health Center Data >

Bookmark

Hawaii Primary Care Association

Mission

The Hawai'i Primary Care Association improves the health of communities in need by advocating for, expanding access to, and sustaining high quality health care through our statewide network of Community Health Centers.

For over twenty years, the Hawai'i Primary Care Association has been working on behalf of vulnerable populations throughout our state, and helping to establish access to primary health care services for everyone. HPCA has developed strong, productive partnerships with providers, health care organizations, lawmakers, policy officials, and public advocates to improve quality and access for over 125,000 people.

We believe in nurturing vibrant and healthy communities that work together, and are committed to the partnerships, innovation, and teamwork that will transform our health care system and improve the lives of all Hawai'i's people.

EXHIBIT D

Choose a different State:
Hawaii

Choose a category
Change Category

Providers & Service Use
- Hospitals
  - Total Hospitals
  - Hospitals by Ownership
  - Beds
  - Beds by Ownership
  - Admissions
  - Admissions by Ownership
  - Emergency Room Visits
  - Emergency Room Visits by Ownership
  - Inpatient Days
  - Inpatient Days by Ownership
  - Outpatient Visits
  - Outpatient Visits by Ownership
- Nursing Facilities
  - Number of Nursing Facility Residents
  - Residents by Primary Payer Source
  - Number of Nursing Facilities
  - Nursing Facilities by Ownership Type
  - Number of Nursing Facility Beds
  - Beds by Certification Category
  - Number of Special Care Beds
  - Nursing Facility Occupancy Rates

Hawaii: Providers & Service Use

Compare Hawaii to: United States

Hospitals

Total Hospitals, 2008 — Compare

	HI #	HI % of US Total	US #	US % of US Total
	25	0.5%	5,010	100.0%

(show/hide notes)

Hospitals by Ownership Type, 2008 — Compare

	HI #	HI %	US #	US %
State/Local Government	8	32.0%	1,105	22.1%
Non-Profit	17	68.0%	2,923	58.3%
For-Profit	NA	NA	982	19.6%
Total	25	100.0%	5,010	100.0%

(show/hide notes)

Hospital Beds per 1,000 Population, 2008 — Compare

	HI #	US #

Nurse Hours per Resident Day
Avg # of Nursing Facility Deficiencies
% Nursing Facilites with Deficiencies
% of Facilities w/ Serious Deficiencies
Top Ten Nursing Facility Deficiencies
Resident and Family Groups
⊟Rural Health Clinics
Total Rural Health Clinics
⊟Federally Qualified Health Centers
Total FQHCs
Total FQHCs Service Delivery Sites
Total Patients Served by FQHCs
Total FQHC Encounters or Visits
FQHC Revenue by Source
⊟Health Professional Shortage Areas
Primary Care HPSAs
Mental Health HPSAs
Dental HPSAs
⊟Access to Care
Could Not See Doctor Because of Cost
Children with a Medical Home
⊟Medical School Graduates
Total Medical School Graduates
Medical School Graduates by Gender
⊟Medical Malpractice
Paid Medical Malpractice Claims
Medical Malpractice Payments
⊟Non-Physician Providers
Total Registered Nurses
Registered Nurses per 100,000 Population
Total Physician Assistants
Physician Assistants per 100,000 Pop.
Total Nurse Practitioners
Nurse Practitioners per 100,000 Pop.
⊟Dentists
Total Dentists
Dentists per 1,000 Population

	2.4	2.7

(show/hide notes)

Hospital Beds per 1,000 Population by Ownership Type, 2008 Compare

	HI #	US #
State/Local Government	0.7	0.4
Non-Profit	1.7	1.8
For-Profit	NA	0.4
Total	2.4	2.7

(show/hide notes)

Hospital Admissions per 1,000 Population, 2008 Compare

	HI #	US #
	86	117

(show/hide notes)

Hospital Admissions per 1,000 Population by Ownership Type, 2008 Compare

	HI #	US #
State/Local Government	19	17
Non-Profit	68	85
For-Profit	NA	16
Total	86	117

(show/hide notes)

Hospital Emergency Room Visits per 1,000 Population, 2008 Compare

	HI #	US #
	280	404

(show/hide notes)

Total Dentists by Gender

Dentists by Specialty Field

⊟Health Care Employment

Total Health Care Employment

Health Care Employment as % Total

Hospital Emergency Room Visits per 1,000 Population by Ownership Type, 2008	Compare	
	HI #	US #
State/Local Government	57	67
Non-Profit	223	284
For-Profit	NA	53
Total	280	404

(show/hide notes)

Hospital Inpatient Days per 1,000 Population, 2008	Compare	
	HI #	US #
	658	644

(show/hide notes)

Hospital Inpatient Days per 1,000 Population by Ownership Type, 2008	Compare	
	HI #	US #
State/Local Government	193	104
Non-Profit	465	457
For-Profit	NA	84
Total	658	644

(show/hide notes)

Hospital Outpatient Visits per 1,000 Population, 2008	Compare	
	HI #	US #
	1,568	2,050

(show/hide notes)

Hospital Outpatient Visits per 1,000 Population by Ownership Type, 2008		Compare
	HI #	US #
State/Local Government	128	359
Non-Profit	1,440	1,544
For-Profit	NA	148
Total	1,568	2,050

(show/hide notes)

Medical Errors

Nursing Facilities

Total Number of Residents in Certified Nursing Facilities, 2009				Compare
	HI #	HI % of US Total	US #	US % of US Total
	3,871	0.3%	1,393,127	100.0%

(show/hide notes)

Distribution of Certified Nursing Facility Residents by Primary Payer Source, 2009		Compare
	HI %	US %
Medicaid	70%	64%
Medicare	9%	14%
Private/Other	21%	22%
Total	100%	100%

(show/hide notes)

Total Number of Certified Nursing Facilities, 2009				Compare
	HI #	HI % of US Total	US #	US % of US Total

	48	0.3%	15,658	100.0%

(show/hide notes)

Distribution of Certified Nursing Facilities by Ownership Type, 2009		Compare
	HI %	US %
For Profit	50%	67%
Non-Profit	29%	26%
Government-Owned	21%	6%
Total	100%	100%

(show/hide notes)

Certified Nursing Facility Beds, 2009		Compare
	HI #	US #
Total Number of Certified Nursing Facility Beds	4,163	1,663,959

(show/hide notes)

Distribution of Nursing Facility Beds by Certification Category, 2009		Compare
	HI %	US %
Medicaid	4.3%	2.8%
Medicare	0.3%	2.3%
Dually Certified	95.5%	95.0%

(show/hide notes)

Total Number of Special Care Beds in Certified Nursing Facilities, 2009		Compare
	HI #	US #
	179	109,590

(show/hide notes)

Certified Nursing Facility Occupancy Rate, 2009		Compare
	HI %	US %
	93.0%	83.7%

(show/hide notes)

Average Nurse Hours per Resident Day in All Certified Nursing Facilities, 2009		Compare
	HI #	US #
Licensed Nurse Hours	1.3	1.5
Total Nursing Staff Hours	3.9	3.9

(show/hide notes)

Average Number of Deficiencies per Certified Nursing Facility, 2009		Compare
	HI #	US #
	10.7	10.0

(show/hide notes)

Percent of Nursing Facilities with Deficiencies, 2009		Compare
	HI %	US %
% with Deficiencies	97.9%	93.4%
% with no Deficiencies	2.1%	6.6%

(show/hide notes)

Percent of Certified Nursing Facilities Receiving a Deficiency for Actual Harm or Jeopardy, 2009		Compare
	HI %	US %
	10.4%	24.7%

(show/hide notes)

Percent of Certified Nursing Facilities with Top Ten Deficiencies, 2009		Compare
	HI %	US %
Comprehensive Care Plans	29%	29%
Unnecessary Drugs	8%	24%
Clinical Records	13%	22%
Pressure Sores	19%	21%
Housekeeping	8%	21%
Accident Environment	35%	45%
Food Sanitation	48%	40%
Quality of Care	42%	36%
Professional Standards	13%	34%
Infection Control	58%	30%

(show/hide notes)

Percent Certified Nursing Facilities with Resident Groups and Family Groups, 2009		Compare
	HI %	US %
Resident Groups	91.7%	95.8%
Family Groups	52.1%	34.0%

(show/hide notes)

Rural Health Clinics

Number of Medicare Certified Rural Health Clinics, 2011				Compare
	HI #	HI % of US Total	US #	US % of US Total
	2	0.1%	3,846	100.0%

(show/hide notes)

Federally Qualified Health Centers

Number of Federally-Funded Federally Qualified Health Centers, 2009		Compare
	HI #	US #
	13	1,048

(show/hide notes)

Service Delivery Sites Operated by Federally-Funded Federally Qualified Health Centers, 2009		Compare
	HI #	US #
	69	7,240

(show/hide notes)

Patients Served by Federally-Funded Federally Qualified Health Centers, 2009		Compare
	HI #	US #
	126,952	18,681,012

(show/hide notes)

Federally-Funded Federally Qualified Health Centers Patient Encounters or Visits, 2009		Compare
	HI #	US #
	582,224	73,643,891

(show/hide notes)

Distribution of Revenue by Source for Federally-Funded Federally Qualified Health Centers, 2009		Compare
	HI %	US %
Federal Grants	16.9%	21.9%
State & Local Grants/ Contracts	13.0%	12.1%
Foundation/Private Grants/ Contracts	4.2%	3.9%
Medicaid	43.2%	37.1%

Medicare	6.8%	5.9%
Other Public Insurance	0.4%	2.9%
Private Insurance	10.5%	7.3%
Patient Self-Pay	2.8%	6.0%
Other Revenue	2.4%	2.9%
Total	100.0%	100.0%

(show/hide notes)

Physicians

Health Professional Shortage Areas

Estimated Underserved Population Living in Primary Care Health Professional Shortage Areas (HPSAs), as of September, 2008				Compare
	HI #	HI %	US #	US %
Estimated Underserved Population	33,495	2.6%	35,817,861	11.8%

(show/hide notes)

Estimated Underserved Population Living in Mental Health Health Professional Shortage Areas (HPSAs), as of September, 2008				Compare
	HI #	HI %	US #	US %
Estimated Underserved Population	61,111	4.7%	56,793,556	18.7%

(show/hide notes)

Estimated Underserved Population Living in Dental Health Professional Shortage Areas (HPSAs), as of September, 2008				Compare
	HI #	HI %	US #	US %
Estimated Underserved Population	72,213	5.6%	31,531,717	10.4%

(show/hide notes)

Access to Care

Percentage Reporting Not Seeing a Doctor in the Past 12 Months Because of Cost, 2009				Compare
	HI #	HI %	US #	US %
Could Not See Doctor Because of Cost	74,000	7.3%	34,993,000	14.9%
Lower Bound 90% Confidence Interval	66,000	6.5%	34,449,000	14.7%
Upper Bound 90% Confidence Interval	82,000	8.1%	35,537,000	15.1%

(show/hide notes)

Percent of Children with a Medical Home, 2007			Compare
	HI %	US %	
No Medical Home	39.9%	42.5%	
Medical Home	60.1%	57.5%	
Total	100.0%	100.0%	

(show/hide notes)

Medical School Graduates

Total Number of Medical School Graduates, 2010		Compare
	HI #	US #
	58	16,838

(show/hide notes)

Distribution of Medical School Graduates by Gender, 2010		Compare
	HI #	US #
Female	28	8,133
Male	30	8,705
Total	58	16,838

(show/hide notes)

Medical Malpractice

Number of Paid Medical Malpractice Claims, 2009		Compare
	HI #	US #
Total Number of Paid Claims	31	10,739[1]

(show/hide notes)

Payments on Medical Malpractice Claims, 2009		Compare
	HI $	US $
Total Dollars in Paid Claims	$13,119,000	$3,471,631,100[1]
Average Claims Payments	$423,194	$323,273[2]

(show/hide notes)

Non-Physician Providers

Total Employed Registered Nurses, 2009				Compare
HI #	HI % of US Total	US #	US % of US Total	
8,930	0.3%	2,583,770	100.0%	

(show/hide notes)

Registered Nurses per 100,000 Population, 2009		Compare
	HI #	US #
	689	842

(show/hide notes)

Projected Number of Physician Assistants in Clinical Practice, 2010				Compare
	HI	HI	US	US

	#	% of US Total	#	% of US Total
	188	0.3%	74,755	100.0%

(show/hide notes)

Projected Number of Physician Assistants per 100,000 Population in Clinical Practice, 2010	Compare
	HI # US # 15 24

(show/hide notes)

Total Nurse Practitioners, 2009				Compare
	HI # HI % of US Total		US # US % of US Total	
Number of Nurse Practitioners	930	0.6%	157,782	100.0%

(show/hide notes)

Total Nurse Practitioners per 100,000 Population, 2009	Compare
	HI # US # 72 51

(show/hide notes)

Dentists

Number of Dentists, 2009				Compare
	HI # HI % of US Total		US # US % of US Total	
	1,318	0.5%	247,767	100.0%

(show/hide notes)

Dentists per 1,000 Population, 2009	Compare
	HI US

	#	#
Dentists per 1,000	1.0	0.8

(show/hide notes)

Number of Dentists by Gender, 2009		Compare
	HI #	US #
Female	206	50,611
Male	1,106	184,164
Total	1,318	247,767

(show/hide notes)

Number of Dentists by Specialty Field, 2009		Compare
	HI #	US #
Dental Public Health	6	1,289
Endodontics	36	5,597
General Practice	1,057	201,510
Oral and Maxilliofacial Surgery	1	123
Oral Pathology	2	566
Oral Surgeon	36	8,614
Orthodontics	58	12,685
Pedodontics	49	6,683
Periodontics	41	6,425
Prosthodontics	32	4,275

(show/hide notes)

Health Care Employment

Total Health Care Employment, 2009		Compare

	HI #	US #
	39,600	11,414,440

(show/hide notes)

Health Care Employment as a Percent of Total Employment, 2009		Compare
	HI %	US %
Health Care Employment as % Total Employment	6.7%	8.7%

(show/hide notes)

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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF HAWAI'I

TONY KORAB, TOJIO CLANTON, KEBEN ENOCH, CASMIRA AGUSTIN, ANTONIO IBANA, AGAPITA MATEO, and RENATO MATEO, each individually and on behalf of those persons similarly situated,

Plaintiffs,

vs.

PATRICIA MCMANAMAN in her official capacity as Director of the State of Hawaii Department of Human Services; and KENNETH FINK in his official capacity as State of Hawai'i, Department of Human Services, Med-

CIVIL NO. 10-00483 JMS KSC

CERTIFICATE OF SERVICE OF DEFENDANTS' MEMORANDUM IN OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION RE: NEW RESIDENTS [DKT. NO. 63]

QUEST Division Administrator,

Defendants.

CERTIFICATE OF SERVICE OF DEFENDANTS' MEMORANDUM IN OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION RE: NEW RESIDENTS [DKT. NO. 63]

I hereby certify that on May 9, 2011 I electronically filed the foregoing document with the Clerk of Court for the United States District Court for the District of Hawaii by using the CM/ECF system.

The following participants in the case who are registered CM/ECF users will be served by the CM/ECF system:

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/s/ John F. Molay .
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PATRICIA MCMANAMAN and
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