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SUPERIOR COURT OF CALIFORNIA

COUNTY OF FRESNO

CULTIVA LA SALUD, a nonprofit community benefit organization; and FRESNO BUILDING HEALTHY COMMUNITIES, a nonprofit community benefit organization, Petitioners and plaintiffs, vs. COMMUNITY HOSPITALS OF CENTRAL CALIFORNIA, a California nonprofit public benefit corporation; FRESNO COMMUNITY HOSPITAL AND MEDICAL CENTER, dba COMMUNITY HEALTH SYSTEM, a California nonprofit public benefit corporation; BOARD OF TRUSTEES for COMMUNITY HOSPITALS OF CENTRAL CALIFORNIA and FRESNO COMMUNITY HOSPITAL AND MEDICAL CENTER; and DOES 1-15, Respondents and defendants.	Case No.: PETITION FOR WRIT OF MANDATE AND COMPLAINT FOR DECLARATORY RELIEF, AND OTHER RELIEF ARISING FROM (1) VIOLATIONS of California Welfare & Institutions Code §§ 14169.50, *et seq*., 14105.98, and 14166.12 (2) VIOLATIONS of California Government Code § 11135, *et seq*. (3) FOR RELIEF pursuant to California Code of Civil Procedure § 1060 and § 1085

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I. INTRODUCTION

Two statutory schemes principally fund California hospitals serving Medi-Cal beneficiaries and other low-income Californians: the Hospital Quality Assurance Fee (HQAF) program, and the Disproportionate Share Hospital (DSH) program. Both of these funding programs require hospitals receiving funds, including Respondents' Fresno CRMC, to expend those funds to "support[] hospital care to Medi-Cal patients and to help pay for health care for low-income children," California Constitution, Art. XVI, § 3.5, § 2, and to make "health care services, including infrequent yet high-cost services. . . available[] to Medi-Cal beneficiaries," Welfare & Institutions Code § 14166.12(s)(1)(D). Respondents have failed to spend Supplemental Medi-Cal funds as required by statute—to improve access to care and the quality of that care for the Black and Latino low-income patients reliant on Fresno CRMC for their medical care—instead spending the funding to enhance Respondents' suburban facility, Clovis CMC, which serves a much wealthier, whiter, and healthier population, and far fewer Medi-Cal beneficiaries.

As they poured resources into their Clovis campus, Respondents were aware their safety net hospital, Fresno CRMC, required critical upgrades due to antiquated facilities, outdated and malfunctioning equipment,[1] insufficient operating rooms, an overwhelmed Emergency Department, and chronic understaffing. Respondents were also well aware of the high numbers of Medi-Cal eligible, migrant farmworker, low income, uninsured, and homeless patients for whom Fresno CRMC was the only health care option, the great

[1] Just one example: the endoscopy scopes at Fresno CRMC are obsolete; some do not function at all. Staff have been told "there is no money" to replace scopes, or to buy the newer technology on which medical school residents should be trained. Many resources that should be available at CRMC—a Level 1 Trauma Center hospital affiliated with world-ranked University of California San Francisco—are not available there. In contrast, this summer Clovis CMC is opening a new Endoscopy Center fully equipped with the latest state-of-the-art equipment. One health care system—Respondent Community Health System (CHS)—owns and operates both hospitals.

majority of whom were Latino and Black. California law required Respondents to use Medi-Cal revenue to improve access to quality care for medically underserved populations, especially given that the zip codes most heavily served by Fresno CRMC comprise an area of acute medical need. Much of the area has a documented 20-year deficit in life expectancy when compared to zip codes most heavily served by Clovis CMC, as well as high pollution levels, high rates of chronic disease, and patients who struggle to navigate the health care system and to access routine preventative and specialty care.

However, rather than invest in Fresno CRMC—expand the Emergency Department in the only Level 1 Trauma Center in the Central Valley, replace patient towers, and adequately staff inpatient floors to ensure sufficient beds to admit the predictably high volume of patients in need—Respondents targeted their limited resources to an extravagant building program on its suburban Clovis campus and, more recently, on Community Health Partners, a new provider network whose sites are located far from downtown Fresno's healthcare desert. Meanwhile, Respondents have yet to address Fresno CRMC's urgent facility and staffing deficiencies, or to improve Emergency Department patient flow to provide timely critical care at the downtown safety net hospital. Respondents' disinvestment in Fresno CRMC—in favor of funding massive investments in Clovis CMC, land acquisition in Madera County, and losses from its new provider network—has exacerbated a growing gap in both access to care and the quality of care for Black and Latino patients within the Community Health System.

Continuing a trend begun in 2009, of the fourteen current members of CHS's Board of Trustees, six are or were land developers or bankers with close ties to prominent developer Granville Homes, and/or with projects or holdings in the vicinity of Clovis CMC. The present Respondent Board continues to operate CHS strategically to further developer

interests, including misdirecting hospital funds into their private, for-profit medical school. Even more problematic, they have misallocated a billion dollars of funding intended to improve care for the indigent into a "luxurious but not opulent"[2] hospital campus in Clovis, which primarily serves Fresno's wealthy mostly-white suburbs. Since 2009, this sprawl-inducing business model has perpetuated segregated housing patterns while boosting the value of current and former CHS Trustee developers' still-to-be-built-out greenfield holdings, at the expense of the patients whom the hospital's historical mission and its tax-exempt status require it to serve—in particular, the low-income Latino and Black populations living in central and south Fresno.

Although Respondents' revenue streams are many and varied, almost three-quarters of those revenues are public monies, intended to ensure health care to vulnerable populations. Government Code § 11135 imposes on entities receiving state funding, such as Respondents, the obligation to provide services equitably. The statute and its implementing regulations apply to the full range of Respondents' operations and medical services, irrespective of how funded, and rendering unlawful Respondents' decisions to invest the significant majority of CHS's strategic capital, from whatever source, in the much newer Clovis CMC campus because they have created a disparate adverse impact on Fresno CRMC Protected Classes: making it more difficult for Fresno CRMC Protected Classes to access health services, and defeating or substantially impairing such patients' access to the Medi-Cal services to which they are entitled.

Petitioners Cultiva La Salud and Fresno Building Healthy Communities bring this action to correct CHS's discriminatory allocation of resources to the Clovis CMC campus

[2] See, https://www.smithgroup.com/projects/community-cancer-institute-at-the-clovis-community-medical-center.

and to redirect them, as the law requires, to Fresno CRMC.

Petitioners seek a judicial declaration that the statutory purpose of Supplemental Medi-Cal payments is to benefit the low-income patients whose care generates those funds, and that those funds, almost all of which the State distributes to Fresno CRMC, must be used exclusively to increase low-income residents' access to medical care, and to enhance the quality of their care. Petitioners also seek injunctive relief requiring Respondents to spend the Supplemental Medi-Cal funding distributed to Fresno CRMC for the benefit of Fresno CRMC's low-income patient populations. Furthermore, Petitioners seek injunctive relief to address Respondents' discriminatory allocation of resources which disproportionately and negatively impact protected classes, and to compel Respondents' prompt compliance with Government Code § 11135.

II. VENUE AND JURISDICTION

1. This court has jurisdiction to hear the subject matter of this verified Petition for Writ of Mandate and Complaint for Declaratory Relief pursuant to Code of Civil Procedure §§ 1060 and 1085, Government Code §11135, and 2 California Code of Regulations § 14050(b). This court also has jurisdiction over each respondent/defendant, as the acts and omissions alleged herein occurred in California. Venue is proper in this court because all of the violations of law alleged herein have occurred, and continue to occur, in Fresno County.

III. EXHAUSTION OF ADMINISTRATIVE REMEDIES

2. Petitioners/plaintiffs are not required to exhaust administrative remedies with respect to their claims under California Government Code § 11135. *Donovan v. Poway Unified School Dist.* (2008) 167 Cal.App.4th 567, 594 [84 Cal.Rptr.3d 285, 304–305]; 2

California Code of Regulations §14051(a). Petitioners have a direct and substantial beneficial interest in insuring that the Respondents/defendants comply with state law mandates requiring expenditure of corporate resources in a non-discriminatory manner, and of public funds consistent with their intended purpose.

IV. PARTIES

3. Petitioner/plaintiff CULTIVA LA SALUD (hereafter, "**Cultiva**") or "Cultivate Health," is a California nonprofit community benefit organization that works to promote healthy communities and to advance health equity among low-income, minority, immigrant, and limited English proficient residents, principally in rural Fresno County, and urban Fresno neighborhoods. The people whom Cultiva la Salud serves are overwhelmingly members of the class of charitable beneficiaries of Respondents—users of the hospital, members of their families, and low-income residents in the communities most reliant on Fresno CRMC. Among other roles, Cultiva connects needy individuals and families to medical services and other resources, and otherwise advocates on their behalf to improve health outcomes for vulnerable Fresno communities. Respondents' actions directly impact Cultiva and the residents whom Cultiva serves.

4. Petitioner/plaintiff FRESNO BUILDING HEATHY COMMUNITIES (hereafter, "**Fresno BHC**") is a California nonprofit community benefit organization. Fresno BHC has led efforts to ensure access to health care services and to advance health equity across Fresno, to protect access to Fresno County's Medically Indigent Services Program for undocumented and indigent residents, and to advance state legislation to expand access to Medi-Cal for all residents regardless of zip code, income, or immigration status. Many staff, born and raised in South Fresno, are directly impacted by the disparities in healthcare access affecting South Fresno residents. Respondents' actions directly impact

Fresno BHC and the communities on whose behalf Fresno BHC advocates.

5. For ease of reference Petitioners/plaintiffs will be referred to as "Petitioners." At all relevant times, Petitioners and their staff, the individuals Cultiva serves, and the coalition of residents and non-profit and faith-based organizations Fresno BHC serves, are aggrieved persons within the meaning of 2 CCR §14020(d), in that they fall within the zone of interest protected by the statutes which authorize supplemental Medi-Cal payments to private hospitals in California, and they believe they have been, are being, and are likely to be injured by Respondents' discriminatory practice of expending public funding so as to deny full and equal access to high quality medical care at Fresno CRMC. Petitioners, and the residents Petitioners serve, have been suffering and continue to suffer economic and non-economic injury from the lack of equitable access to health care due to respondents' unlawful and discriminatory allocation of resources.

6. In addition, as members of "protected classes" within the meaning of 2 CCR § 14020(jj) who apply for, participate in, benefit from or are unlawfully deterred or excluded from benefitting from programs, activities, or services of Respondents, Petitioners' staff members and clients are "ultimate beneficiaries" of state funding within the meaning of 2 CCR § 14020(aaa). As ultimate beneficiaries, Petitioners' staff members and clients are also "aggrieved persons" within the meaning of 2 CCR 14020(d).

7. Respondent/defendant FRESNO COMMUNITY HOSPITAL AND MEDICAL CENTER (hereafter, "**Fresno Community**"), and dba Community Health System ("**CHS**") as of 2021, was incorporated in July 1945 as a California nonprofit public benefit corporation. At all times relevant herein, respondent Fresno Community was a wholly-owned subsidiary of respondent Community Hospitals. Respondent Fresno Community is the

corporate entity that owns and operates the two hospitals of concern[3] in this action: (1) Community Regional Medical Center (hereafter, "**Fresno CRMC**"), in downtown Fresno, and the only Level 1 Trauma Center in the Central Valley; and (2) Clovis Community Medical Center (hereafter, "**Clovis CMC**"), in suburban Clovis. Respondents moreover operate: Community Health Partners (hereafter, "**CHP**"), a health care foundation which contracts with many medical providers practicing at CHS facilities; and Community Care Health Plan, a wholly-owned Health Maintenance Organization (HMO) that provides health insurance coverage to employees of Respondents and other employers. Fresno Community holds, and at all times relevant herein held, all of its assets in trust for charitable purposes. Fresno Community operates under an exemption from taxation pursuant to § 23701 of the California Revenue and Taxation Code, and § 50l(c)(3) of the Internal Revenue Code of the United States.

8. Respondent/defendant COMMUNITY HOSPITALS OF CENTRAL CALIFORNIA (hereafter, "**Community Hospitals**") was incorporated in 1982 as a California nonprofit public benefit corporation. Community Hospitals, with its affiliated corporations, is a multi-facility integrated healthcare organization located in Fresno County, California. Respondent Community Hospitals is the central management, administrative, and planning entity for Respondent Fresno Community Hospital and Medical Center. Community Hospitals holds, and at all times relevant herein held, all of its assets in trust for charitable purposes. Community Hospitals operates under an exemption from taxation pursuant to § 23701 of the California Revenue and Taxation Code, and §

[3] The California Department of Public Health separately licenses Fresno CRMC and Clovis CMC. Three facilities operate under Fresno CRMC's license: two specialty hospitals, Fresno Heart and Surgical Hospital and Community Behavioral Health Center, and a long-term care facility, Community Subacute and Transitional Care Center.

50l(c)(3) of the Internal Revenue Code of the United States.

9. Respondents/defendants Community Hospitals and Fresno Community, hereafter collectively referred to as the "**Respondents**" or "**CHS**," are each governed by separate, but identical, Boards of Trustees[4]. The corporate officers of CHS serve in the same capacity and perform the same management and administrative functions for Fresno Community as they do for CHS.

10. Board of Trustees for Respondent/defendant COMMUNITY HOSPITALS OF CENTRAL CALIFORNIA and Board of Trustees for Respondent/defendant FRESNO COMMUNITY HOSPITAL AND MEDICAL CENTER are collectively referred to herein as "Respondent Board." At all relevant times, Respondent Board are and have been vested with authority to control, manage, and administer the corporate resources of Respondents Community Hospitals and Fresno Community, subject to state and federal law and fiduciary duties of care and loyalty to Respondents and their charitable beneficiaries.

11. Respondents are "covered entities" within the meaning of 2 CCR § 14020(m), subd. (2), (3), and (6), subject to and obligated to comply with the mandates of Government Code §11135 because they receive state financial assistance. Over the last five fiscal years, at least 70% of CHS's earned revenue comes directly from taxpayers.

12. At all times relevant herein, Respondents and each of them have been transacting business in the County of Fresno. The violations of law hereinafter described have been and are now being carried out, in whole or in part, within said county.

[4] Respondent Community Hospital is the sole member of Respondent corporation Fresno Community, with the sole and exclusive right to appoint all members of Fresno Community's Board of Trustees, as well as the right to approve amendments to the Articles of Incorporation and Bylaws.

13. Respondents/defendants DOES 1 through 15 are named as fictitious parties who have participated with or acted in concert with one or more Respondents, or who have acted on behalf of or as agents, servants, or employees of one or more Respondents, but whose true names and capacities, whether individual, corporate, or otherwise, are presently unknown to petitioner. Petitioners are informed and believe and thereon allege that DOES 1 through 15 have directly or indirectly participated in and are responsible for the acts and omissions that are more specifically described herein, and that Petitioners' injuries as alleged herein were proximately caused by such Respondents. Because Petitioners are presently uninformed as to the true names and capacities of DOES 1 through 15, Petitioners sue them herein by fictitious names, but will seek leave to amend this Complaint when their true names and capacities are discovered.

14. At all relevant times, each of the Respondents has been, and is now, the agent or employee of the remaining respondents, and each was acting within the course and scope of such agency or employment.

V. STATUTORY FRAMEWORK

A. Background – Medicaid and Administration of the Medi-Cal Program

15. Medicaid is a federal-state cooperative program for the provision of medical care to certain low-income populations, which is jointly funded by the federal and state governments and administered by the states. Within the confines of federal law, the states determine eligibility, the types of services covered, payment levels for services, and other aspects of administration. California participates in Medicaid through the California Medical Assistance Program, known as 'Medi-Cal,' which is administered by the Department of Health Care Services (hereafter, "**DHCS**"). The objective of Medicaid is to "furnish medical assistance" on *"behalf of individuals whose incomes and resources*

are insufficient to meet the costs of necessary health care." 42 U.S.C. § 1396-1; id. at § 1396d(a); *see also* Cal. Welf. & Inst. Code § 14000 (declaring the goal of Medi-Cal is to enable individuals to secure health care in the same manner as the public generally and without discrimination or segregation based on economic disability).

16. To qualify for federal funds, each state must submit a detailed State Medicaid plan for review and approval to the Centers for Medicare and Medicaid Services (hereafter, "**CMS**", a division of the federal Department of Health and Human Services). The plan must describe the population groups and services that are eligible for Medicaid payments, and must include assurances that the coverage will be provided in conformity with minimum federal requirements. See, 42 U.S.C. § 1396a(a)(4).

B. Statutes governing Supplemental Medi-Cal Payments to private hospitals

1. Hospital Quality Assurance Fee Program

17. The Hospital Quality Assurance Fee ("**HQAF**") Program provides supplemental Medi-Cal payments to private general acute care hospitals, based on each hospital's total Medi-Cal inpatient days and outpatient services. Enacted in 2009, the HQAF statute was extended three times. Finally, in November 2016, voter approval of Proposition 52 amended the California Constitution to extend indefinitely the HQAF Program codified at Welfare & Institutions Code §§ 14169.50, *et seq.*

18. To ensure hospitals' HQAF fees are used as intended, Proposition 52, § 2, Statement of Purpose, declared that "[T]he people hereby amend the Constitution to require voter approval of changes to the hospital fee program to ensure that the state uses these funds *for the intended purpose of supporting hospital care to Medi-Cal patients and to help pay*

for health care for low-income children." California Constitution, Art. XVI, § 3.5, § 2[5] [emphasis added.]

19. More specifically, Welfare and Institutions Code § 14169.53(b)(1) requires that "[A]ll funds from the proceeds of the [Hospital Provider] fee assessed in the Fund, together with any interest and dividends earned on money in the fund, *shall* continue to be used *exclusively to enhance federal financial participation for hospital services under the Medi-Cal program*, to provide additional reimbursement to, and *to support quality improvement efforts of hospitals*, and *to minimize uncompensated care provided by hospitals to uninsured patients*, as well as to pay for the state's administrative costs and to provide funding for children's health coverage." [emphasis added].

20. The Welfare and Institutions Code mandates that 100% of supplemental payments under the HQAF program "shall be made to support the availability of hospital services and ensure access to hospital services for Medi-Cal beneficiaries." Welfare and Institutions Code § 14169.56(e)(1). Also see, § 14169.57.

21. In specifying that HQAF funding must *supplement*, not *supplant*, hospital spending for Medi-Cal patients, the legislature further clarified that hospitals must use HQAF funding to increase and improve access to and quality of care for the neediest Californians—and must be able to prove that those expenditures were in addition to monies already slated to serve low-income patients. California Welfare & Institutions Code § 14169.68.

22. Federal regulations[6] impose, as a condition for participation in the Medi-Cal program, the requirement that Respondent CHS enter into a Medi-Cal Provider Agreement with

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[5] See also, Sec. 1, Statement of Findings, subsec. B, affirming funding under the program is intended to "pay for health care for low-income children" and "meet the needs of Medi-Cal patients."

[6] 42 USC § 1396a(a)(27), 42 Code of Federal Regulations § 431.107, Welfare & Institutions Code § 14043.2, and 22 California Code of Regulations § 51000.30(a)(2).

DHCS, committing to comply with "all applicable provisions of Chapters 7 and 8 of the Welfare and Institutions Code" (including §§ 14169.50, *et seq*., 14105.98, and 14166.12)." [7] As a recipient of these public funds, CHS additionally commits to "comply with all federal laws and regulations governing and regulating Medicaid providers"[8] and to "comply with all applicable federal and State laws and regulations pursuant to Provider Agreements with Medi-Cal Managed Care Plans."[9]

23. Until 2020, CMS had routinely approved several California State Plan Amendments (hereafter, "**SPA**"), as well as the State's proposed methodology for setting HQAF fees and calculating HQAF Supplemental Medi-Cal payments for hospital inpatient and outpatient services.

24. In 2020, the CMS approval process was far more detailed. In its SPA review that year, CMS asked the State of California, through DHCS, to provide a detailed explanation of the policy goals of the HQAF program, and its compliance with the Medicaid statute. CMS's approval was predicated on the additional information and guarantees DHCS provided.[10]

25. DHCS's responses assured CMS that the purpose of the HQAF program was to "*improve access to health care for some of California's most vulnerable residents, improve*

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[7] Medi-Cal Provider Agreement, DHCS Form 6210, Compliance with Laws and Regulations, ¶ 2.

[8] *Ibid*.

[9] Each subcontract with a health care provider shall commit that provider [in this case, CHS] to "comply with all applicable requirements specified in: … federal and State laws and regulations…." Geographic Managed Care Agreement, Exhibit A, Scope of Work, Attachment 6. Provider Network, Section B. Subcontract Requirements, subsection 21, p. 7 (PDF p. 39). https://www.dhcs.ca.gov/provgovpart/Documents/GMCBoilerplate032014.pdf.

[10] CMS's approval was conveyed in a letter dated February 25, 2020, approving the State Plan Amendments 19-0018 and 19-0019 for inpatient and outpatient hospital services, respectively, for the service period July 1, 2019 through December 31, 2021.

reimbursement and secure additional federal funds for those hospitals essential to maintaining the Medi-Cal safety net, and to provide funding for healthcare coverage for low-income children in California." [emphasis added] DHCS also acknowledged the *"legislative intent to target…those private hospitals in California that are most likely to service a significant volume of Medi-Cal beneficiaries and thus are integral to maintaining Medi-Cal access."* [emphasis added.] Because the Legislature intended to target a specific class of hospitals, "it therefore taxes certain California [private] hospitals and redistributes the money to those hospitals *most likely to serve a significant volume of Medi-Cal beneficiaries*." (CMS February 25, 2020, State Plan Amendment Approval letter [emphasis added].) CRMC—with its DSH designation—is clearly one of those hospitals; Clovis, which has never qualified for the annual DSH Eligibility List, is clearly not.

26. CMS analyzed and approved California's stated policy goal for its HQAF Program, finding it to be "both reasonable and legitimate." CMS opined that targeting the fee to in-state hospitals is "rationally related to the *legitimate state interest of maintaining sufficient access to care and improving reimbursement to those in-state private hospitals that serve the critical role of caring for a disproportionate share of the Medi-Cal population*." CMS February 25, 2020, State Plan Amendment Approval letter [emphasis added].

27. The California DHCS awards supplemental Medi-Cal funding to individual hospitals, not to their parent corporations or systems. DHCS calculates each hospital's HQAF award using a complicated formula that calculates supplemental Medi-Cal payments based on the total number of Medi-Cal inpatient days as well as Medi-Cal outpatient services at that hospital. Welfare & Institutions Code §§ 14169.54, 14169.55(b).

28. Legislative language authorizing the HQAF program variously describes those for whom public dollars under these statutes will ensure access to high-quality medical care as "Medi-Cal patients,"[11] "low-income children," "uninsured patients," "Medi-Cal beneficiaries," "the Medi-Cal population," and "California's most vulnerable residents." For ease of reference, this Petition will use the term "Fresno CRMC Low-Income Patients," or "Low-Income Patients," for these individuals.

2. Disproportionate Share Hospital Program

29. California's Disproportionate Share Hospital Program (hereafter, "**DSH**") is a Supplemental Medi-Cal Payment program established to direct additional funding to hospitals that serve disproportionately high volumes of Medicaid and low-income patients, and provide high levels of uncompensated care to Medi-Cal and uninsured individuals. DSH eligibility is hospital-specific and determined by DHCS each year.

30. Private DSH supplemental payments to eligible private hospitals are authorized pursuant to CMS approval of State Plan Amendments that extend DSH payments to private hospitals. Welfare & Institutions Code § 14166.11.

31. The Medi-Cal / Uninsured Hospital Care Demonstration Project Act created the Private Hospital Supplemental Fund (Welfare and Institutions Code § 14166.12), pursuant to which DHCS distributes supplemental Medi-Cal payments to private hospitals, such as Fresno CRMC, that qualify as DSH Medi-Cal providers pursuant to Welfare and Institutions Code §§14105.98 and 14163. To be eligible for Private Hospital Supplemental Fund distributions, a hospital must satisfy the Medicaid State Plan criteria

[11] Medi-Cal eligibility is granted to individuals and families with incomes up to 138% of the Federal Poverty Level (**FPL**)—in 2024, $20,783 for an individual, and $43,056 for a family of four. See Covered California's Program Eligibility by Federal Poverty Level for 2024 https://www.coveredca.com/pdfs/FPL-chart.pdf.

for DSH hospital status and "*demonstrate a purpose for additional funding including proposals relating to emergency services and other health care services, including infrequent yet high-cost services, that are made available, or will be made available, to Medi-Cal beneficiaries*." Welfare & Institutions Code § 14166.12(s)(1)(D).

32. Annually, DHCS composes a DHS Eligibility List. For years, it has determined that Fresno CRMC is eligible for Private DSH funding. However, DHCS has never found Clovis CMC eligible, as Clovis has never treated enough low-income or Medi-Cal eligible patients to qualify.

33. As with HQAF payments, DHCS awards Private DSH payments to an individual hospital, not to the parent corporation or umbrella health care system. See Welfare & Institutions Code § 14105.98(b), mandating that DSH "payments are intended to support health care services *rendered by disproportionate share hospitals*." [emphasis added].

33. Legislation authorizing the DSH programs describe its target population as "Medi-Cal beneficiaries and uninsured individuals." For ease of reference, this Petition will use the term "Fresno CRMC Low-Income Patients," or "Low-Income Patients," for these individuals.

C. Pertinent civil rights statutes and regulations

34. California Government Code, § 11135(a), provides "[n]o person in the State of California shall, on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, or sexual orientation, *be unlawfully denied full and equal access to* the benefits of, or be unlawfully subjected to discrimination under, any program or activity that is conducted, operated, or administered by the state or by any state agency, *is funded directly by the state, or receives any financial assistance from the*

state." (Emphasis added.)

35. In addition, programs and activities of the state must "meet the protections and prohibitions contained in § 202 of the federal Americans with Disabilities Act of 1990 (42 U.S.C. § 12132), and the federal rules and regulations adopted in implementation thereof, "except that if the laws of this state prescribe stronger protections and prohibitions, the programs and activities subject to subdivision (a) shall be subject to the stronger protections and prohibitions." (Govt Code § 11135(b).)

36. The California Civil Rights Council recently amended and adopted additional implementing regulations for § 11135, including regulations recognizing claims based on a showing of disparate impact, which went into effect on July 1, 2024, and are codified at subchapter 9 of chapter 5 of division 4.1 of title 2 of the California Code of Regulations, §§ 14000 et seq, (All further references to "Regulation" or "Regulations" are to Title 2 of the California Code of Regulations).

37. Respondents are subject to the mandates of Government Code § 11135 pursuant to 2 CCR § 14020:

    a. As a "contractor" within the meaning of §14020(*l*) [a recipient that receives any state support under contract or subcontract].

    b. As a "covered entity" within the meaning of §14020(m), subsections (2) [an entity involved in carrying out any program or activity that is conducted, operated, or administered by the state or by any state agency], (3) [an entity, including local agencies, recipients, contractors, and grantees, that is funded directly by the state or receives any state support], and (6) [(A) state support is extended to or received by such entity; (B) the entity is principally engaged in the business of health care; and (C) the entire facility, plant, or other comparable, geographically separate facility, if any part of it receives state

support or to which state support is extended, in the case of any corporation, partnership, private organization, or sole proprietorship].

c. As a "recipient" within the meaning of §14020(pp) [a covered entity that receives state support].

38. Respondents' provision of medical care is subject to the mandates of Government Code § 11135 as a "program or activity" within the meaning of § 14020(ii). The regulation brings within the statute's ambit "all of the operations and facilities of, or services, benefits, or aid provided by, a covered entity, directly or indirectly through others by grants, contracts, arrangements, or agreements." The statute specifically governs "the provision of…health…services," as well as "permitting, site and facility selection decisions; or the provision of facilities for furnishing services…or other benefits." *Id*.

39. At subdivision (1), the regulation explicitly extends the statute's coverage to "… all the operations of the covered entity. This is true even if only one part of the covered entity receives state support." Moreover, the statute governs any "program or activity provided by the covered entity … in, at or through a facility that is or was provided…with the aid or benefit of state support…." *Id*. at subdivision (2). Thus, the statute and regulations apply to Respondents' full range of medical services—what care is provided, to whom, with what equipment, and where—irrespective of how funded.

40. An aggrieved person "includes any person who believes that they have been injured by a discriminatory practice or denial of full and equal access, or believes that the person will be injured by a discriminatory practice or denial of full and equal access that is about to occur. 'Aggrieved person' shall include unpaid interns, volunteers, and persons providing services pursuant to a contract." 2 CCR § 14020(d). An aggrieved person may bring an action for equitable or declaratory relief, including an action for cessation or

suspension of state support. 2 CCR §14050(b).

41. An "ultimate beneficiary" is "a person identified in Government Code § 11135 in a protected class who receives, applies for, participates in or benefits from, or is unlawfully deterred or excluded from benefiting from, full and equal access to the benefits of, or employment with, or is subjected to discrimination under a program, activity, or service that is conducted, operated, or administered by any covered entity." 2 CCR § 14020(aaa).

42. California Government Code § 11135 defines classes protected under the statute to include race, color, national origin, and ethnic group identification. Petitioners allege that Respondents' conduct has created and continues to create disparate adverse impacts on Petitioners, on their clients, and on Black and Latino patients and potential patients who are heavily reliant on Fresno CRMC. For ease of reference, this Petition will use the term "Fresno CRMC Protected Classes," or "Protected Classes," for these residents.

VI. STATEMENT OF FACTS

A. Respondents' misuse of Supplemental Medi-Cal payments, including HQAF and DSH payments, violated statutory mandates.

43. Fresno CRMC has for decades served as the safety-net hospital to one of the poorest regions in California; it is the CHS hospital where the bulk of Medi-Cal care, indigent care, and charity care are provided. Fresno CRMC is the second largest Medi-Cal provider in California, and one of the top ten largest Medicaid providers in the nation. Fresno CRMC also operates the second busiest emergency department in California and among the top 15 busiest in the nation; its Level 1 Trauma Center is the busiest in California.

44. In 1996, Respondent CHS entered into a Master Agreement with the County of Fresno,

agreeing to assume the County's obligation to provide medical services to the County's indigent residents and inmates for thirty years for a set annual fee. The County agreed to lease its County hospital, Valley Medical Center, to CRMC until the capital projects[12] needed to relocate its patients and medical services downtown were completed. These projects included $30 million from University of California San Francisco medical school (hereafter, "**UCSF**") to build a 3-story Fresno Medical Education and Research Center in support of Fresno CRMC's role as a teaching hospital. The capital improvements were a precondition to transferring the County hospital's Level 1 Trauma designation to CRMC, as well as to its continued partnership[13] with UCSF, one of the most highly regarded medical schools in the country and recognized internationally for the quality of its training, research, residents and fellows. Even before these construction projects were completed in 2010, and continuing to the present, Respondents' attention and the vast majority of their investments have shifted to CHS's Clovis campus.

45. Fresno CRMC's downtown Fresno location is at the heart of critical public infrastructure, while Clovis CMC's physical remoteness has ramifications for patient safety, as well as patient access. Before CHS's developer-heavy Board took control, CHS's partnership with local government had amplified transportation and emergency access to Fresno CRMC and its Trauma Center. The City's general plan and traffic plan were built around ensuring the most efficient access to Fresno CRMC: the regional freeway system was

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[12] 6th Comprehensive Annual Financial Report, Redevelopment Agency of the City of Fresno, for Fiscal Year ended 6-30-10, pp. xxi-xxii, http://test.addoctane.com/srda/wp-content/uploads/2016/10/09-10-Comprehensive-Annual-Financial-Report.pdf

[13] Each year, UCSF helps train 300 physicians at CRMC in nine Residency Specialties, 21 Fellowship Sub-specialties and two Physician Assistant Residencies, as well as 300 rotating medical students annually, and attracts funding for clinical research. This UCSF partnership helps address our region's chronic physician shortage, particularly specialists, as the majority remain in the Valley to practice.

purposely built around Fresno CRMC, providing hospital access to the most Valley residents in the shortest time, including train and public transit service for those not arriving by car. The airspace above Fresno CRMC is protected by the Federal Aviation Administration to protect CRMC's access to its helipad for emergency helicopter traffic. As a PG&E-designated Essential Use area, Fresno downtown utilities have the highest level of protection from power loss, including protection from rolling blackouts during energy shortages. These public investments were intended to facilitate access to care at Fresno CRMC, which serves the region's most vulnerable patient populations. Respondents' recent focus on its Clovis facility effectively frustrates these concentrated public infrastructure investments.

46. In 2007, after the Level 1 trauma designation was transferred from the County hospital to Fresno CRMC, all inpatient acute-care services, including burn and Level 1 trauma services, were also relocated to Fresno CRMC. The County hospital, University Medical Center (UMC), closed soon after. Closing UMC triggered the loss of its 300-plus inpatient beds in southeast Fresno.

47. Respondents had built Clovis CMC in 1988, a brand new hospital with 106 beds on 125 acres of farmland that, at that time, was well outside Clovis' city limits. Since 2009, Clovis CMC has benefited from the lion's share of CHS capital projects[14]—$815 million dollars' worth[15]—almost four times the $224 million spent at CHS's "flagship" hospital,

[14] See, CHS website, accessed June 11, 2024. See also, Clovis Community Opens New Tower - Nov 29, 2012 YouTube video.

[15] Source: HCAI Detailed Annual Financial Disclosure Reports for Fiscal Years ending 8/31/2009 and 8/31/2023, p. 5.

Fresno CRMC, a far larger hospital with far more patients, with far greater needs.[16]

48. Clovis CMC building projects included the following:

- total remodel of the existing hospital; renovating the original patient tower with all private rooms to promote Clovis' labor and delivery services; construction of two additional five-story bed towers, which opened in 2012 and 2022, and adding 288 all-private beds, including 41 new ICU beds.
    - While the vast majority of Fresno CRMC's inpatients occupy traditional two-bed rooms, Clovis advertises that "Every room at Clovis a private room." Studies show that single-patient private rooms enhance recovery and healing, help reduce infection transmission and provide better privacy, dignity and confidentiality.
- expansion of the Emergency Department (ED), almost tripling Emergency Medical Treatment (EMT) beds to a total of 59, and a new ambulance dock.
    - Until very recently, Fresno CRMC treated double the number of emergency patients seen at Clovis CMC. Yet, since 2006 not a single new EMT station has been added to Fresno CRMC's original 73 EMT beds, and hallways continue to overflow with patients on gurneys in its chaotic ED.
- expansion and renovation of the surgery department with 12 new operating rooms, construction of a new Outpatient Care Center, state-of-the-art Community Cancer Institute (which has consolidated system-wide cancer services at the Clovis campus); a new Heart and Lung Institute (a multidisciplinary cardiothoracic and pulmonary program, consolidating system-wide cardiac care at the Clovis campus); and construction of a new Endoscopy Center;
    - A Center of Excellence for Total Joint Replacement Surgery accreditation is highly coveted. CRMC obtained this distinction after much effort and providing nurses special training. After Clovis opened its new outpatient center and added operating rooms, Clovis CMC now boasts this distinction, which CRMC no longer has. On information and belief, orthopedic surgeons previously serving patients at Fresno CRMC are now practicing in Clovis' new, well-equipped operating rooms, making their services difficult to access for Fresno CRMC Protected Classes.

[16] This $224 million total capital spending since 2009 includes any projects over $1 million at the other three facilities operating under Fresno CRMC's license, Fresno Heart Hospital, Community Behavioral Health Center and Community Subacute & Transitional Care Center.

- new imaging and radiology suites with new equipment, an expanded laboratory and pharmacy, high-tech Conference Center, three new medical office buildings, and a newly upgraded main lobby in 2022, with one-stop admitting and registration to facilitate smooth patient flow, and a chandelier valued at over $1 million dollars.

These Clovis CMC renovations and additions were top-tier: as the Cancer Institute project architect proudly asserted, "The client wanted a sense of luxury but not opulence": furniture and fixtures were inspired by upscale hotels like the Four Seasons[17]—consistent with CEO Craig Castro's vision, expressed in a 2012 video on Clovis' Master Plan, "to convert this little hospital into a medical complex like no other and to make the patients' experience like no other."

49. These improvements resulted in an eleven-fold increase in the value of Clovis CMC's total Property, Plant and Equipment (PPE)[18], from $103 million in 2009 to almost $1.1 billion in 2023, an increase of $1 billion dollars. During the years between 2009 and 2023, the added value of Clovis CMC's net PPE increased by $735.4 million, almost *twenty times* CRMC's increase at $39.6 million. On information and belief, a significant portion of the investment in the Clovis campus was funded by operating income generated at Fresno CRMC, including supplemental Medi-Cal funding.

50. In stark contrast, Fresno CRMC's two patient towers—built in 1957 and 1968 and housing approximately 90 percent of the hospital's 685 beds—do not currently meet 2030 seismic requirements. Regardless of the state's seismic upgrade requirements, CRMC's two bed towers, operating rooms, equipment, and technology are outdated and in need of

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[17] Community Cancer Institute at the Clovis Community Medical Center, https://www.smithgroup.com/projects/community-cancer-institute-at-the-clovis-community-medical-center (last viewed December 27, 2023).

[18] PPE is a category of data maintained by HCAI, a repository for the data hospitals are regularly required to report under penalty of perjury. See, https://hcai.ca.gov/about/programs/#data PPE data is reported in Audited Detailed Annual Financial Disclosure Reports, pages 5, 5.1, and 5.2, and in each hospital's Annual Pivot Table.

major renovations and modernization—at a minimum, to ensure Fresno CRMC patients have full, equal, and equitable access to the same level of medical care available at Clovis CMC.

51. Supplemental Medi-Cal funding is explicitly granted for the purpose of improving access to and the quality of care for *Medi-Cal and indigent patients.* Yet, CHS has continued to spend these funds at Clovis CMC, which serves far fewer Medi-Cal beneficiaries, contravening this purpose. CHS Chief Executive Officer Craig Castro has explicitly claimed that all revenues coming into Fresno CRMC are property of the Respondent corporation as a whole: "The money is viewed as a system asset, and we're looking to serve the region. The money that came from the government was in order to support the patients we care for as a system, and we used it in the best way, as a system, to get the most capacity."[19] However, rather than spend the funds to improve access to quality care for Medi-Cal and indigent patients, Respondents treated Private DSH and HQAF payments as a slush fund for glamorizing Clovis CMC, and funding its new medical foundation and provider network, rather than "*to target…those private hospitals in California that are most likely to service a significant volume of Medi-Cal beneficiaries and thus are integral to maintaining Medi-Cal access."*[20]

52. Petitioners allege that Respondents' past and ongoing violation of these statutes has harmed and continues to harm Petitioners, and Low-Income Patients residing in the zip codes most heavily reliant on Fresno CRMC. In those zip codes, almost 40% of

[19] *Fresno Bee*, "Care & Conflict: CMC's Money Moves" series, August 2022.

[20] CMS February 25, 2020, State Plan Amendment Approval letter [emphasis added].

families[21] are eligible for Medi-Cal[22]—while half as many have incomes above 400% of the FPL.[23] In comparison, in the zip codes most heavily dependent on Clovis CMC, fewer than 15% of families are eligible for Medi-Cal, while 50%—more than three times as many—have incomes at or above 400% of the FPL.

53. Despite the fact that Respondents chose to site the vast majority of their capital projects in Clovis, in fiscal year 2023 Fresno CRMC generated 98% of all net income, 70% of all net patient revenue, 75% of all patient census days, and 66% of all discharges for Fresno CRMC and Clovis CMC, taken together. Year over year, at least 70% of Respondents' revenue comes from public sources, including Medi-Cal, Medicare, and DSH grants.

54. California Department of Healthcare Access and Information ("**HCAI**") data, submitted by CHS under penalty of perjury, establish that Fresno CRMC is (and over many years has been) the financial engine of Respondent CHS, consistently accounting for over two-thirds of both hospitals' net income and 75% of all net patient revenue[24]—in significant part because CRMC's high Medi-Cal volumes annually generate hundreds of millions in supplemental Medi-Cal payments, and its active Trauma Center generates substantial revenues.

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[21] Source: Table S2701, American Community Survey 2022 5-year Estimates, Selected Characteristics of Health. https://data.census.gov/table/ACSST5Y2022.S2701?q=S2701:%20Selected%20Characteristics%20of%20Health%20Insurance%20Coverage%20in%20the%20United%20States, Downloaded data July 22, 2024.

[22] Medi-Cal eligibility requires an income of 138% of the Federal Poverty Level (FPL) or below. In 2024, maximum incomes qualifying for Medi-Cal are $20,783 for an individual, and $43,056 for a family of four. While 400% of the FPL is $58,320 for an individual or $120,000 for a family of four. See Covered California, Program Eligibility by Federal Poverty Level for 2024, https://www.coveredca.com/pdfs/FPL-chart.pdf.

[23] Source: S2701 ACS 5-year estimates for Fresno County: https://data.census.gov/table/ACSST5Y2022.S2701?g=050XX00US06019.

[24] Source: HCAI Pivot Table Hospital Annual Selected File, Selected Years.

55. Over the decade from 2012 through 2021, Fresno CRMC had average annual cash on hand of $70 million dollars, compared to less than $5,000 for Clovis CMC. In addition, Fresno CRMC's limited use investments have risen steadily to $750 million in 2022, eclipsing Clovis CMC which has been at $0 since 2018.

56. Fresno CRMC has been Respondent's principal source of HQAF and DSH funding, projected to generate between July of 2017 and December 2024 more than $1.1 billion in net HQAF funds, which amounts to over 85% of the $1.3 billion in net HQAF funds DHCS will have distributed to Fresno CRMC or Clovis CMC over that period.[25] Fresno CRMC also received $420 million in Private DSH funding from 2014 through 2021 (topping $73 million in 2021), while Clovis CMC received none because it has never met the required threshold for serving Medi-Cal and low-income patients.

57. Respondents funded much of the $1 billion dollars in capital expenditures at Clovis CMC from operating cash flow, including, on information and belief, HQAF and DSH funding, the vast majority of which DHCS had distributed directly to Fresno CRMC.

58. Fresno CRMC's strong cash reserves made it possible for Respondent CHS to issue $850 million in long-term debt between 2017 and 2022. By far the largest portion of that debt—$653 million—was incurred to rebuild, expand, and equip Clovis CMC, and to reimburse Respondents for expenditures made in connection with the Clovis project. The November 2021 bond rating by Moody's Investors Service reflected an "expectation that [Respondents] will continue to benefit significantly from the HQAF program, which is currently netting on average $150 million per year, representing the majority of the

[25] See HQAF VI (SFY 2019-2022, HQAF VII (CY 2022), and HQAF VIII (CYs 2023, 2024), Fee & Payment Models available online at DHCS website, https://www.dhcs.ca.gov/provgovpart/Pages/hqaf.aspx, and HQAF V Fee & Payment Model provided by DHCS in response to Petitioners' Public Records Act request.

[Respondent]s' cashflow." Other factors Moody identified as supporting the A3 bond rating were a large revenue base, a leading market position in the greater Fresno region, strong clinical services, and its relationship with UCSF Medical Center—most of which can be attributed to Fresno CRMC.

59. With issuance of the 2021 Series Bonds in December 2021, the aggregate principal of Respondents' outstanding long-term debt is now $802 million dollars, with an annual debt service of $47.2 million for the next 30 years. The 2021 Master Indenture includes a Limitation on Additional Indebtedness clause that appears to limit Respondents' ability to incur additional long-term debt (affecting its ability to fund multiple essential capital improvement projects at Fresno CRMC), as well as a requirement that Respondents effectively freeze Fresno CRMC's large cash reserves to satisfy bondholders that bond payments (primarily arising from Clovis building projects) will be repaid. Of even greater concern, the $653 million dollars in bond debt incurred to finance the Clovis expansion is secured by a pledge of the Gross Receivables of *both* CRMC and Clovis CMC, including but not limited to operating cash, which unlawfully includes Supplemental Medi-Cal and DSH payments[26].

60. As a result, the Respondents now find their exhausted borrowing capacity is insufficient to update or upgrade Fresno CRMC's antiquated facilities, equipment and technology, and enhance patient flow. Having used all their strategic capital to invest in the much newer Clovis CMC campus and CHP's new provider network, Respondents now find

[26] It appears Respondents and bondholders may have anticipated this problem: the CMFA 2021 Revenue Bonds (Community Health System), Series 2021A and 2021B Official Statement, provides at page 21: "In addition, there are Gross Receivables, *possibly including Gross Receivables owing from federal, state, or other governmental entities*, in which the Members of the Obligated Group cannot validly grant a security interest, and the Master Trustee (and thus the Bond Trustee and the holders of the Bonds) will have not have a security interest in such Gross Receivables." [emphasis added.]

their very large, overcrowded safety net hospital in danger of noncompliance with the State of California's mandatory 2030 seismic standards. In addition, aging hospitals like Fresno CRMC *must* invest in facilities and innovation to stay competitive, attract privately insured patients, and recruit and retain staff, UCSF residents, and fellows.

61. Unfortunately, long-anticipated projects at the Fresno CRMC campus, such as new patient towers to house additional inpatient and ICU beds, an Emergency Department with additional EMT beds and efficient patient flow, additional operating rooms, and new imaging equipment, are now, according to CHS executives, no longer feasible due to the large increase in long-term debt incurred for the Clovis expansion.

62. In July 2020, Respondents launched Community Health Partners (CHP), a nonprofit that operates a hospital foundation and provider network. Dollars funneled to this new venture mean continued delay of necessary infrastructure investments in Fresno CRMC, as limited resources are siphoned away to cover CHP's substantial losses. Moreover, a review of the more than 40 current CHP primary care and specialty provider offices reveals that almost all are located near the upscale new housing developments in north Fresno and Clovis, miles from the healthcare deserts in Central and South Fresno, where most indigent residents reside. Few serve Medi-Cal patients. As CHP has offered lucrative incentives—on information and belief, these include above-market salaries, signing bonuses, and deluxe office facilities—to recruit local providers to build up its provider network, CHP losses have piled up, totaling over $83 million dollars during its first two years of operation, and projected to approach $100 million this year.

63. Respondents' purchases of medical practices and provider locations for CHP follow a pattern of land acquisitions that have included speculation and sprawl-inducing investment on the outskirts of Clovis and in rural Madera County, where, in 2017, CHS

purchased 200 acres from developer (now Respondent Board member) Karen McCaffrey. Then-CEO Tim Joslin explained, "In future years, when families start moving into the 30,000 planned homes, Community [Health System] will be there" to meet their healthcare needs.[27] CHS's land purchase in a prime development corridor is a strategic coup for the many land developers on Respondent Board, increasing the appeal of their resort-style high income new town in Madera County.

64. Respondents' disinvestment in Fresno CRMC—in favor of funding land acquisition in Madera County, massive investments in Clovis CMC, and losses at its new medical foundation CHP—has exacerbated a growing gap in both access to care and the quality of care for Fresno CRMC Protected Classes and Low-Income Patients within the Community Health System.

65. Respondents are under a legal obligation to treat HQAF and DSH funding, the vast majority of which is generated at Fresno CRMC, as restricted resources for improving access to and quality of care available to Medi-Cal patients and the indigent. Petitioners have an interest in ensuring that such funds are expended to address Fresno CRMC's critical need for expanding and modernizing its facilities, purchasing state-of-the-art equipment, and improving patient flow at the hospital that serves a disproportionate share of those patients.

B. The populations served by Respondents' two hospitals are starkly different, one marked by poverty, medical vulnerability, and high concentrations of Black and Latino residents, and the other by affluence, opportunity, and high concentrations of white residents.

66. **CHS Patient Populations.** The patient populations of each hospital reflect deep

[27] 2-10-17 CMC Newsroom *Growth on the horizon in Madera County,* https://www.communitymedical.org/about-us/nws/growth-on-the-horizon-in-madera-county

disparities. Within Respondents' hospital system, Fresno CRMC serves far more Black and Latino residents than Clovis CMC. For example, for all patient visits in 2022:[28] Fresno CRMC served 16,300 Black patients, almost 12,000 more than Clovis CMC, and 78% of all Black patients treated at CHS hospitals. CRMC served 78,300 Latino patients, 40,000 more than Clovis, and more than two-thirds of all Latino patients treated at CHS.

67. Between 2017 and 2022, while Respondents expended hundreds of millions more on CHS's Clovis campus than on Fresno CRMC, the racial and ethnic disparities between the two hospitals' patient populations widened significantly. Downtown Fresno CRMC saw a dramatic shift: in 2017, patients at CRMC were 49% Latino and 43% white. By 2022, the proportion of white patients had dropped by more than a third, to 28%. During those same five years, the percentage of white patients at Clovis CMC increased 25%: from 36.3% to 45.6%.

68. In contrast, between 2017 and 2022, the percentage of Black patients rose from 2.8% to 10.9% of all Fresno CRMC patients, while the percentage of Latino patients at Clovis CMC dropped by more than 16%, and the Latino patient population at Fresno CRMC increased from 49% to 52.4%.

69. The disparities in the patient populations of Fresno CRMC and Clovis CMC also show up as differences in health insurance coverage. Across the board in 2022,[29] whether in the Emergency Department, inpatient, or ambulatory surgery, Clovis CMC had fewer

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[28] HCAI Patient Characteristics by County & Facility, 2022. See https://hcai.ca.gov/visualizations/patient-characteristics-by-county-and-facility/ (accessed on May 12, 2024).

[29] HCAI Patient Characteristics by County and Facility, 2022. Data Visualizations present a calendar year overview of patients. https://hcai.ca.gov/visualizations/patient-characteristics-by-county-and-facility/ (accessed May 12, 2024).

uninsured patients, fewer Medi-Cal patients, and a much higher percentage of privately insured patients than Fresno CRMC–higher than Fresno County and the State. That year, Fresno CRMC treated 85,000 Medi-Cal patients, 2.5 times the number of Medi-Cal patients treated at Clovis CMC, and 71% of all CHS Medi-Cal patients. Fresno CRMC also treated 11,700 uninsured patients, 2.6 times the number of uninsured patients treating at Clovis CMC, and 72% of all CHS uninsured patients. Meantime, Clovis CMC treated almost twice the number of privately insured patients as Fresno CRMC, comprising almost two-thirds of all CHS patients with private coverage.

70. A significantly higher volume of patients arrives at the Fresno CRMC Emergency Department more gravely ill, requiring more inpatient surgeries and longer hospital stays (which generate higher revenues per discharge). For example, Fresno CRMC performed 8,500 inpatient surgeries, almost 5,600 more than Clovis CMC, with those surgeries requiring over 1 million more operating room minutes than those in Clovis.[30] The higher volume of gravely ill patients Fresno CRMC treats is reflected in hospital stays—on average 3 days longer, and for Medi-Cal patients almost 4 days longer, than Clovis.

71. Fresno CRMC treated 9,200 homeless patients in 2022, more than seven times as many as Clovis CMC: 88% of all CHS patients, and 70% of Fresno County patients, who cannot provide a residential address are seen at Fresno CRMC.[31] Of patients coming to CHS's hospitals with a principal diagnosis of mental illness, 96% were seen at CRMC, while only 4% were seen at Clovis CMC.[32] On information and belief, the vast majority

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[30] Source: HCAI Annual Utilization Report, 2022

[31] See, HCAI Patient Discharge Data, 2022 Patient Origin/Market Share (Pivot Profile).

[32] See, HCAI 2021 Hospital Discharge Summary Report, Principal Diagnosis Code. Effective January 2023, an involuntarily detained person has the right to a judicial hearing within seven days of the initial 5150 detention—an AB 2275 hearing—to contest probable cause exists to continue the hold.

of patients involuntarily detained on a 72-hour 5150 hold are taken to Fresno CRMC for mental health treatment: during 2023, approximately 600 AB 2275 hearings were held at CRMC, while Clovis held fewer than 10.

72. Fresno CRMC patients, compared to Clovis CMC patients, are more likely to have lower incomes and low health literacy,[33] and lack adequate health insurance, paid medical leave, and reliable access to routine preventive care, including regular checkups and patient counseling, which are essential to better health outcomes. As a result, they are also more likely to be diagnosed with, and die from, late-stage cancer, as well as other diseases and chronic conditions, that might have been treated more effectively if diagnosed at an earlier stage.[34]

73. Fresno CRMC primarily serves zip codes[35] in the older established neighborhoods of urban Fresno and rural communities in west Fresno County—which are home to the

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[33] See, e.g., https://health.gov/healthypeople/priority-areas/health-literacy-healthy-people-2030

[34] See https://www.cancer.gov/about-cancer/understanding/disparities, National Cancer Institute, *Cancer Disparities.* Also see, e.g., https://www.cancer.gov/news-events/cancer-currents-blog/2020/persistent-poverty-increased-cancer-death-risk (last viewed December 29, 2023).

[35] The sets of zip codes that primarily rely on Fresno CRMC or Clovis CMC are based on HCAI patient discharge data for all patients—emergency department, ambulatory surgery, and admitted patients—and include breakdowns by: **Market Share** –percent of all 2022 patients from a zip code that receive treatment at each hospital; **2022 patient admits** – Number of all inpatient and Emergency Department admits at each hospital; and **Patient Origin** – the percentage of each hospital's 2022 patients that come from each zip code. Source: *HCAI Patient Discharge Data, 2022 Patient Origin/Market Share (Pivot Profile.*

Over 90% of all CHS patients originate from Fresno County. Fresno County zip codes where the market share of residents who treated at CRMC and Clovis CMC in 2022 was insignificant, when compared to other Fresno County hospitals (Adventist Health Selma (which operates under Adventist Health Hanford's CDPH license), Adventist Health Reedley, Saint Agnes Medical Center or Coalinga Regional Medical Center), or sparsely populated rural zip codes with not many residents seeking care at either CHS hospital are not included. For example, rural communities in southern and southeastern Fresno County, which also have high concentrations of Latino and low-income residents, are primarily served by one of three nearby Adventist Health hospitals or Coalinga Regional Medical Center, although it is worth noting that Fresno CRMC treats over 60% of all CHS patients in all but two of these communities, Sanger and unincorporated Del Rey.

largest concentrations of Black, Latino and low-income residents served by any CHS hospital.

74. Clovis CMC primarily serves zip codes centered in the City of Clovis, and take in the upscale new housing developments in northeastern and eastern Fresno County, the less-dense communities of the foothills to the east, and the rural City of Sanger. These zip codes are home to a markedly greater concentration of white and more affluent residents than Fresno County as a whole, and particularly than zip codes heavily reliant on Fresno CRMC.

75. **Fresno CRMC Protected Classes.** Respondents' spending decisions have a disparate adverse impact on Fresno CRMC Protected Classes and Low-Income Patients, based on hospital data[36] reported to HCAI, as well as California Department of Finance, U.S. Census, and American Community Survey data. These data reveal which Fresno County zip codes have high concentrations of Black, Latino and white residents, and which zip codes most heavily rely on either Fresno CRMC or Clovis CMC.

76. Fresno County zip codes where residents rely more heavily on Fresno CRMC for their medical care have very high concentrations of Latino and Black residents (averaging over 70% Latino and Black, and under 20% white). In comparison, zip codes with high concentrations of white residents send far more patients to Clovis CMC than Fresno CRMC. While three out of four CHS patients from zip codes with high concentrations of Latino and Black residents sought treatment at CRMC during calendar year 2022, more

[36] Sources: HCAI Patient Discharge Data, 2022 Patient Origin/Market Share (Pivot Profile), *HCAI Patient Characteristics by County & Facility, 2022 (*patient race, ethnicity, and payor source data, by hospital), and the California Hard-to-Count Index Interactive Map, created by the California Department of Finance Demographic Unit, with data updated in February 2023 to incorporate the 2017-2021 American Community Survey 5-year estimates, and selected data from the Census 2020 PL94-171 file and 2020 census tract geography (for race and ethnicity demographics, poverty status, Limited English proficiency, and educational attainment, by zip code and countywide), as well as Census Table S2701.

than two thirds of CHS patients from zip codes[37] with high proportions of white residents were treated at Clovis CMC.

77. The California Healthy Places Index (HPI 3.0[38]) evaluates the many factors affecting population health at the community level, and is designed to identify opportunities to improve neighborhood health and help guide investments, programs, and policy changes to produce the strongest positive impact on health, well-being, and life expectancy. Lower scores indicate more unhealthy conditions. The pooled HPI score for neighborhoods heavily reliant on Fresno CRMC is in the lowest decile: these zip codes have less healthy community conditions than over 90% of other California communities. This compares to a pooled HPI score for zip codes heavily reliant on Clovis CMC of over 60, signifying healthier community conditions than over 60% of other California communities. Respondents' spending decisions clearly favored the privileged neighborhoods with objectively far healthier community conditions that feed Clovis CMC, at the expense of the neighborhoods with very low HPI scores that face significant health inequities and are heavily reliant on Fresno CRMC. Thus, the patient populations that treat at each hospital reflect material disparities in race, ethnicity, wealth, and most importantly, health and well-being.

78. Respondents understood or should have understood the concentrated poverty, community disinvestment, and health challenges that have long characterized the neighborhoods with high concentrations of Black and Latino residents that primarily feed Fresno CRMC. Nevertheless, when making the crucial decisions about where to prioritize investment of

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[37] St. Agnes Medical Center has a significant market share—over 40%—for several North Fresno zip codes, but each of these zip codes also feeds more than 5,000 patients to CHS hospitals.

[38] https://www.healthyplacesindex.org/

limited resources, Respondents have consistently chosen to invest in Clovis CMC, rather than to protect and build up Fresno's safety net hospital—to the detriment of Low Income and Fresno CRMC Protected Classes patients and to the benefit of Clovis patients.

C. Respondents' policy of excessive investment in Clovis CMC has unlawfully inflicted disparate adverse impacts on Fresno CRMC Protected Classes, including both patients and potential patients.

79. Respondents' disinvestment in Fresno CRMC in order to fund massive investments in Clovis CMC has made it more difficult for the much larger number of Black and Latino patients that treat at Fresno CRMC to access quality care, and continues to defeat or substantially impair their access to the Medi-Cal services to which they are entitled.

80. On information and belief, CHS's Board began to pivot away from its "flagship" hospital downtown, and toward its Clovis campus, in order to exploit the disparity in wealth and income between the areas served by Clovis CMC and Fresno CRMC. Specifically, in approximately 2009 CHS administrators proposed, and Respondent Board adopted, policies and practices to maximize their investment in the Clovis facility with new construction, new state-of-the-art equipment, major renovations, and other improvements, for the express purpose of attracting the considerably wealthier (also whiter) patient population living in the city of Clovis, in north Fresno, and in the new upscale planned housing developments for Clovis, northeastern Fresno County, and southeast Madera County. These policies and practices have generated a 25% increase in white patients at Clovis CMC since 2017.

81. The Respondents, on information and belief, have used and are continuing to use CRMC income, operating cash, and other resources to finance improvements at Clovis CMC and a new provider network, both of which cater to more white as well as higher-income patients who have private insurance and Medicare.

82. Although resource allocation decisions taken by Respondent Board are facially neutral, they have created an egregious disparate adverse impact on the Latino and Black patients and potential patients in the older established neighborhoods primarily served by the downtown Fresno hospital. Given the close correlation in the region between wealth and race/ethnicity, Respondents' Clovis expansion has directed and continues to direct investment away from downtown facilities serving majority low-income patients, and Black and Latino residents in the urban core and rural communities in western Fresno County, and toward a suburban facility already serving—and built to serve—a higher proportion of wealthier and white patients.

83. As a result of Respondents' disinvestment in Fresno CRMC, the disproportionately higher number of Black and Latino patients and residents in neighborhoods dependent on Fresno CRMC have more limited access to emergency care, hospital services, and specialty services when compared to higher-proportion white patients and potential patients in Clovis CMC's patient zip codes.

84. Besides absorbing most of CHS's strategic capital, the newer facilities, equipment, and technology at Clovis CMC were designed to attract the region's medical specialists and services to the Clovis CMC campus. This shift has resulted in changes in physician referral patterns: consolidating crucial specialty services in Clovis and the northern fringe of Fresno creates significant access challenges for the large population in Fresno's urban core and rural residents who rely on Fresno CRMC for care.

85. Latino and Black residents dependent on Fresno CRMC already experience barriers to health care such as lack of preventive care, primary and specialty care providers, transportation, or paid leave from work for illness or medical appointments. If they cannot obtain care at CRMC, they must now travel many more miles and hours to obtain

medical care no longer readily available at Fresno CRMC. The additional travel time to Clovis CMC disproportionately burdens access to care for residents of neighborhoods that primarily rely on Fresno CRMC, who are significantly less likely to have reliable access to a vehicle. A bus ride from Fresno CRMC to Clovis CMC takes almost two hours from downtown Fresno, requiring transfers on three separate bus routes and from a Fresno City bus to a Clovis City bus, followed by a long walk from the nearest bus stop to the Clovis hospital.[39]

1. Respondents' policy of excessive investment in Clovis CMC has disparately adversely affected Fresno CRMC Protected Classes' access to emergency care at Fresno CRMC, negatively impacting patient safety and patient outcomes.

86. Construction in the early 2000s of a new Trauma and Critical Care Building at Fresno CRMC was a precondition to the transfer of Fresno County hospital's Level 1 Trauma designation to Fresno CRMC. The capital projects required to relocate the County Hospital's patients and medical services downtown were completed in 2010.

87. For decades, Fresno CRMC treated almost twice as many emergency patients as Clovis CMC. By 2022, Clovis was still treating only 38% of all system Emergency Department visits, almost the same percentage (33%) as in 2012, notwithstanding major additions to capacity at the Clovis Emergency Department.

88. Long wait times at both hospitals' Emergency Departments are directly related to the lack of available staffed beds on patient floors. On average, 100 licensed beds at Fresno CRMC have *not* been staffed over the past 10 years (2013 to 2022). On Monday, March 13, 2023, Fresno CRMC was officially out of gurneys, with 197 patients waiting in the lobby and hallways of the Emergency Department, most of whom had been admitted and

[39] Google Maps, https://maps.app.goo.gl/H9v5FUhjgjmUtakU8, accessed June 11, 2024.

were awaiting transfer to floor beds—a not uncommon problem. In contrast, Clovis CMC has experienced far fewer unstaffed beds–an average of 22 during that same period.

89. Many more Low-Income Patients and Fresno CRMC Protected Classes arrive at CRMC's Emergency Department with higher-acuity medical problems that urgently require intensive treatment and longer care. Many will have delayed seeking medical care due to long waits and difficulties accessing primary or preventative care, and to CRMC's infamously long ED wait times. They struggle with untreated chronic conditions and with low health literacy (which increases the difficulty of navigating provider networks, required referrals, and prior authorizations). Many are on Medi-Cal or uninsured, while others have inadequate insurance coverage and fear incurring medical debt[40] for high deductibles and copays. All these factors create significant barriers to accessing timely care, especially specialty care. Medi-Cal patients are the highest users of Emergency Rooms, in part because there are not enough primary care physicians who accept Medi-Cal, and appointments on short notice are hard to get.

90. Lacking such timely primary and preventative care, many Fresno CRMC Emergency Department patients require emergency surgery for urgent medical conditions: 60% of the surgeries performed at CRMC in 2022 required a hospital stay. (In contrast, 78% of surgeries at Clovis CMC were conducted as outpatient procedures.)

91. For patients with more acute conditions, the lengthy waits in Fresno CRMC's overwhelmed and chaotic Emergency Department further delay needed care and are far

[40] High health care costs and medical debt are particularly acute issues in the Central Valley, especially for low income and Latino residents. **Delaying Care:** 63% of Central Valley residents report skipping or delaying care due to cost; and nearly half said skipping care made their condition worse. 49% of low-income residents and 44% of Latino residents reported they had difficulty paying medical bills in the last year; compared to 30% of White residents. **Medical Debt:** 56% of Latinos and 56% of low-income residents report having medical debt compared to 36% for White residents. 19% of residents who report medical debt owe more than $5,000. (2024 Central Valley CHCF California Health Policy, pp. 28-32.)

more likely to produce the well-documented adverse health consequences of Emergency Department "boarding."[41] Delays in medical care are associated with worse health outcomes and higher costs for patients with underlying medical conditions and poorer overall health, as well as for patients with preventable and treatable medical conditions—factors more likely to be found among the Black and Latino residents who comprise Fresno CRMC's patient population.

2. Respondents' policy of excessive investment in Clovis CMC has disparately adversely affected Fresno CRMC Protected Classes' access to specialty care at Fresno CRMC, negatively impacting patient outcomes.

92. The exodus of CHS medical specialists from downtown has been steady and continues, with no apparent effort by Respondents to reverse the trend.

93. In 2018, at the opening of the Community Cancer Institute on the Clovis CMC campus, CHS touted "access to world-class cancer care in the Valley," including new 3D enhanced mammography equipment and "the only fully-digital PET/CT scanner in the Central Valley." In comparison, the Respondents' website highlights at the downtown Fresno campus only a Lung Cancer Screening Program and Lung Nodule Program, where services are limited to infusion and screening. Patients must go to the Clovis campus for diagnostic mammograms, ultrasound-guided breast biopsies, high-resolution breast imaging Faxitron machines, and state of the art equipment to place wires preoperatively to help surgeons target tissue for excision. Clovis CMC is the only facility in Fresno that does MRI-guided biopsies in its outpatient center.

[41] Laam, et al., "Quantifying the impact of patient boarding on emergency department length of stay: All admitted patients are negatively affected by boarding," *Journal of the American College of Emergency Physicians*, 2-12-2021, https://doi.org/10.1002/emp2.12401 (accessed June 11, 2024).

94. The neighborhoods heavily reliant on Fresno CRMC include the census tract[42] that has consistently ranked as most burdened by pollution in the state. Poverty, endemic to these neighborhoods, is also associated with worse cancer outcomes, including a higher risk of dying from cancer[43]. Nevertheless, once Respondents consolidated CHS's cancer services at the Clovis Cancer Institute, the cancer patients living in the neighborhoods that primarily feed Fresno CRMC have reduced access to necessary imaging, surgical follow-up, chemotherapy, radiation, and other cancer care, as compared to wealthier and majority-white residents who primarily rely on Clovis CMC. For a significant number of Fresno CRMC Protected Classes and low-income cancer patients who rely on hospital-based cancer care, these advanced services and facilities are inaccessible or more difficult to access when not available at the downtown hospital.

95. In late 2022, Respondents opened a new Heart and Lung Institute at Clovis CMC, the region's only multidisciplinary cardiothoracic and pulmonary program with centralized patient registration, with five rooms equipped to perform cardiac catheterizations, and three operating rooms licensed to perform cardiovascular surgery. These new facilities incorporate the latest technology and equipment. Although Fresno CRMC hosts the region's Trauma Center, the number of cardiovascular operating rooms (two) and catheterization labs (four) at the Fresno hospital has not changed in the past ten years and is now surpassed by Clovis. On information and belief, Respondents have made no

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[42] Census tract 6019001100 scores high for air pollution, lead in housing, contaminated drinking water and hazardous waste sites. Residents have high rates of asthma, cardiovascular disease, and low birth weight; many residents live with incomes below the poverty level, are unemployed and paying more than 50% of their incomes for housing. https://fresnoland.org/2021/10/20/article255135437-html/ (last viewed December 27, 2023).

[43] See *Persistent Poverty Linked to Increased Risk of Dying from Cancer,* November 19, 2020, by National Cancer Institute Staff, https://www.cancer.gov/news-events/cancer-currents-blog/2020/persistent-poverty-increased-cancer-death-risk; accessed September 29, 2023.

recent investments to update or significantly upgrade Fresno CRMC's operating rooms or cardiac care facilities or equipment.

96. In 2024, Respondents are opening a new Endoscopy Center at Clovis CMC, fully equipped with the latest state of the art equipment. In comparison, Fresno CRMC is equipped with obsolete endoscopy scopes that malfunction, limit views, and cannot connect to irrigation, requiring an endoscopy technician to manually introduce water. Nor are these outdated scopes compatible with improved imaging software. CRMC staff have been told there is "no money" to replace scopes or to buy the newer technology on which medical residents should be trained.

97. In 2022 Respondent CHS consolidated its pulmonary care specialty practice at the new Heart and Lung Institute on the Clovis CMC campus. As a result, Black, Latino, and low-income asthma, COPD, and other patients in neighborhoods that primarily feed Fresno CRMC experience reduced access to pulmonary care as compared to wealthier and higher-proportion white patients who treat at Clovis CMC.

98. In July 2020 Respondents began to invest substantial sums to establish CHP, a new medical foundation that is drawing both primary care and specialty physicians away from downtown's healthcare shortage area and into north Fresno and Clovis. Respondents continue to invest tens of millions of dollars in CHP, which provides negligible benefit to the patient populations reliant on Fresno CRMC, who are disproportionately Latino, Black, and low-income. Specifically, these residents find it much more difficult, and often impossible, to secure consults and care from specialty practitioners, including surgical follow up and ongoing treatment for chronic conditions, even after their conditions worsen and they present to the CRMC Emergency Department. Making matters worse, Fresno CRMC (as Respondents acknowledge) is the only provider for

many medical specialties willing to take referrals for Medi-Cal patients from health clinics and outlying hospitals.[44]

99. Taken together—and these are a few examples rather than an exhaustive catalogue—the Respondents' investments in Clovis CMC have deprived Fresno CRMC Protected Classes, as well as communities with high concentrations of Black and Latino residents who rely on Fresno CRMC, of full and equal access to the standard of care provided to patients at Respondents' suburban Clovis hospital, and to residents of the majority-white zip codes reliant on Clovis CMC for care. These disparities in available care include, among others, reasonable access to emergency medical attention, and timely, reasonable access to necessary specialty care providers, modern facilities set up to facilitate patient flow, and reasonably up-to-date equipment.

D. Respondents have no legitimate non-discriminatory justification for their decisions to expend public and corporate assets to the detriment of Fresno CRMC Protected Classes, and for the benefit of Clovis CMC's patient population.

100. As far as Petitioners can determine, there appear to be three possible bases—none of them legitimate or non-discriminatory—for Respondents' decisions to prioritize investments in Clovis CMC and to neglect and disinvest in its Fresno CRMC safety-net hospital:

1) cash infusions into new and upgraded facilities at Clovis CMC would create an amenity, and a marketing tool, for attracting the upper middle class and largely white families to whom Respondent Board member land developers and their bankers promote their upscale new housing developments; and/or,

[44] CMC Newsroom, *The One-in-a-Million ER,* 1-10-16, https://www.communitymedical.org/about-us/news/the-one-in-a-million-er

2) an objectively false theory that Fresno CRMC was losing money, that CRMC's Medi-Cal-heavy patient population would ultimately bankrupt Respondent CHS, and that only massive investments in the Clovis facility to attract privately insured, largely white patient populations to Clovis, could "save" the hospital system; and/or

3) a new, modern Clovis CMC facility would attract students to the private for-profit medical school founded by three then-members of Respondent Board within a mile of Clovis CMC's location, as well as provide opportunities for profitable business dealings for Respondent Board members playing dual, conflicting, roles at CHS and the medical school.

101. At least six current and recent members of Respondent Board and their families have business interests, projects, or inventory—as landowners, housing developers, business owners, or building contractors—in the Clovis CMC patient zip codes and/or the vicinity of the site Respondents purchased in Madera to locate a new hospital facility. At least three current and former bankers with close ties to the developer members are currently serving or have recently left Respondent Board.

102. On information and belief, Respondents and Does 1-15 promoted the false narrative to Respondent Board that CHS would never survive unless it massively expanded its suburban Clovis facility to provide more remunerative services, in a location they predicted would attract a higher-income patient population—which in the Fresno region translates to a higher-proportion white population with more lucrative private insurance coverage. On information and belief, those misrepresentations were a material factor in driving Respondents' massive investments in Clovis CMC—both capital improvements, and the creation of an expensive, new medical foundation to lure specialty practices and patient referrals to the Clovis facility.

103. In 2012, two members[45] of Respondent Board incorporated a co-owned private for-profit California Health Sciences University, comprising a pharmacy college[46] and a school of osteopathic medicine (hereafter "medical school"). Two current, long-term members[47] of Respondent Board joined them as trustees of the medical school. Placement of current and former members of Respondent Board in positions as trustees and administrators of the medical school provided multiple possibilities for contracts benefiting family members, for potential cash infusions from the hospital system into the private medical school, and for the clinical rotations benefiting both the medical school students and the medical school, which was essential to accreditation and thus profitability of the medical school.

104. Respondents' resource allocation decisions described herein, taken with the intent of attracting white, upper income homebuyers, violated the statutory intent that Supplemental Medi-Cal funding be used to improve access to care and enhance the quality of care for Medi-Cal beneficiaries and the indigent. The target populations who benefited from this strategy are largely white and upper-income, while the populations whose access to quality medical care has suffered are largely Black, Latino, and/or indigent, thereby violating Medi-Cal requirements that health care be provided without discrimination or segregation based on economic disability, as well as Government Code § 11135's statutory proscription against using public funding in a manner that creates a disparate impact on protected classes.

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[45] Developer Farid Assemi and his banker, Florence Dunn.

[46] The pharmacy college was not accredited and is closing after graduation of the 2024 class.

[47] Another former Assemi banker, Susan Abundis, and an attorney who provided legal services for the Assemi family's wide-ranging business interests, John MacGregor.

VII. CAUSES OF ACTION

A. FIRST CAUSE OF ACTION

Unlawful expenditure of federal and state funds intended to serve low-income patients

(Against All Respondents, and Does 1 through 15)

105. Petitioners reallege and incorporate by reference as though fully set forth herein each of the allegations of the Introduction and paragraphs 1 through 104 of this complaint.

106. Beginning on about 2009, Respondents began implementing policies and practices that used supplemental Medi-Cal funding in a manner and for purposes that violate California Welfare and Institutions Code §§ 14169.50, *et seq*., 14105.98, and 14166.12, by applying HQAF and DSH funding to expand, equip, and improve their Clovis facility, to pay debt service on bonds for Clovis building projects, to create (and fund losses) for an unnecessary, expensive medical foundation, and to acquire land for further outward expansion—all to the detriment of the patient populations for whose care that public funding is provided.

107. Respondents failed to adequately establish policies for the use of HQAF and DSH funding, and/or to monitor their use to ensure these funds were expended for their intended purpose—and in particular to ensure their reinvestment to support quality improvement and access to quality medical care at Fresno CRMC, the facility where these funds were generated and where there is objectively the greatest need among the Medi-Cal and uninsured residents reliant on that hospital for care.

108. On information and belief, as a direct and proximate result of Respondents' policy and practice, the Respondents directed hundreds of millions of that funding to construct and equip lavish new buildings and to relocate specialty services to the hospital system's Clovis campus, which serves far fewer low-income and Medi-Cal patients and does not

meet the requirements to qualify as a DSH hospital. Such expenditures violated the provisions of Welfare & Institutions Code §§ 14105.98(b) and 14166.12, mandating that Private DSH funding and Private Hospital Supplemental Fund payments be expended only to support health care services rendered by DSH-qualified hospitals. Such expenditures also created a two-tier health care system, segregated geographically and in significant degree by income, race, and ethnicity, in violation of the clear intent of the HQAF statutes to exclusively benefit Medi-Cal patients, and to provide health care without discrimination or segregation based on economic disability. (See, Welfare & Institutions Code §§14169.50, 14169.53(b)(1), 14169.56(e), and 14169.57). Finally, Respondents' policies and practices flew in the face of the representations DHCS made to CMS as to the State's policy goals for the HQAF program, during CMS' extensive 2020 review and approval of California's State Plan Amendment.

109. There now exists an actual controversy between the parties relating to Respondents' interpretation of the statutes authorizing payment to private hospitals of supplemental Medi-Cal funds in the form of HQAF and DSH payments, in that CHS has, and without a declarative judgment of this Court will continue, to violate the statutory intent of such laws, by expending such funding for other purposes and in other facilities than intended by state law. Disputed rights and obligations arising by statute are the proper subject of an action for declaratory relief, and the Petitioners have a strong beneficial interest in the proper expenditure of limited federal and state health care dollars, and in ensuring those public funds benefit the Fresno CRMC Low-Income Residents whom Petitioners serve and for whose benefit those public funds have been granted to Fresno CRMC—to protect and improve access to quality care among Fresno County's most vulnerable populations. Petitioners therefore request a judicial declaration that the pertinent statutes require CHS

to expend HQAF funding for the benefit of low-income and uninsured patients, and to expend DSH funding at the facility where services to low-income patients generated Fresno CRMC's right to receive such funds.

110. Unless restrained or enjoined by this court, Respondents will continue to use supplemental Medi-Cal funding in a manner and for purposes that violate California law. Petitioners have no plain, speedy, or adequate remedy at law, and for that reason seek declaratory and injunctive relief as more fully set forth in the Prayer below.

B. SECOND CAUSE OF ACTION

Discrimination in state-funded programs, Gov't Code § 11135
(Against All Respondents, and Does 1 through 15)

111. Petitioners reallege and incorporate by reference as though fully set forth herein each of the allegations of the Introduction and paragraphs 1 through 110 of this complaint.

112. Respondents in or about 2009 conceived and implemented facially neutral policies and practices that called for massive investment in Clovis CMC, and minimal expenditures at Fresno CRMC. On information and belief, Respondents knew at the time that Fresno CRMC serves very high proportions of low-income patients, and patients who are members of protected classes, and that Clovis CMC serves high proportions of white and higher-income patients. Also on information and belief, Respondents' explicit purpose in implementing this expenditure policy was to attract to Clovis CMC higher-income patients more likely to be privately insured—who, in Fresno County, are more likely also to be white. On information and belief, these facially neutral expenditure policies and practices continue to the present day, and continue to affect all of the patient populations served by Respondents.

113. Respondent hospital system's provision of medical care is subject to the mandates of Government Code § 11135 as a "program or activity" within the meaning of 2 California

Code of Regulations § 14020(ii), subjecting "all of the operations and facilities of, or services, benefits, or aid provided by, a covered entity, directly or indirectly through others by grants, contracts, arrangements, or agreements."

114. Statistical disparities between Community Health System patients as a whole on one hand, and the populations heavily reliant on Fresno CRMC on the other, have created such significant adverse effects on protected groups, as described herein above, that they are functionally equivalent to intentional discrimination. These policies and practices materially benefit the non-protected classes comprising much of Clovis CMC's patient population: comparing the two hospitals' patient populations highlights the disparate impacts on Fresno CRMC Protected Classes.

115. Petitioners here assert that Respondents' unlawful practices have included siting more facilities and more modern facilities, which are better-equipped, and served by more care providers including specialists, in locations more difficult to access for Fresno CRMC Protected Classes. Respondents' permitting, site, and facility selection decisions have resulted not only in superior facilities at Clovis CMC, but have also relocated specialty services, clinics, and medical offices away from Fresno CRMC and to the Clovis campus itself, or to locations more easily accessible to the white populations Respondents serve and less accessible to Fresno CRMC Protected Classes.

116. Respondents' outsize spending of CHS resources at their Clovis hospital has further resulted in seriously reduced access to critical medical services at Fresno CRMC, including neglect of the physical plant, failure and refusal to maintain and replace medical equipment, and to adequately staff at every level from janitors to physicians, which disproportionately adversely affect Fresno CRMC Protected Classes.

117. These decisions violate Government Code § 11135, in that they have

disproportionately and adversely impacted protected classes of CHS patients, especially Black and Latino patients/potential patients, and are otherwise unjustified by a legitimate non-discriminatory rationale. Specifically, Respondents have created two tiers of medical care within Community Health System, in which white Fresno residents and CHS patients receive better or more effective medical care than Fresno CRMC Protected Classes, because it is burdensome or impossible to obtain the same level and quality of care for members of those protected classes. Respondents' policies and practices effectively reduce the benefits of medical care provided to Fresno CRMC Protected Classes, in that Protected Classes disproportionately rely on a resource-starved safety net hospital, where withholding of funding has resulted and predictably continues to result in delays or deprivation of access to care, making care less effective, and more difficult to obtain. Moreover, Respondents' policies and practices increase, reinforce, or perpetuate segregation on the basis of membership in a protected class, in that they create a magnet for development of upper-middle-income housing in the area surrounding the Clovis hospital, and contribute to the de facto racial segregation that exists in that area[48].

118. Respondents' decisions to expend the vast majority of its strategic capital to invest in the much newer Clovis CMC campus and CHP's new provider network for the benefit of residents in zip codes that primarily feed Clovis CMC rather than Fresno CRMC, are facially neutral practices that cause a disparate adverse impact on protected classes, having the purpose and effect of advantaging white and wealthier patients, while denying

[48] In 2023, the Fifth District Court of Appeal in *Martinez v. City of Clovis, et al* (2023) 90 Cal.App.5th 193, held that Clovis' land use and planning policies since at least 2008 have favored housing for higher-income families in violation both of California Housing Element requirements and the City's duty to affirmatively further fair housing. "A practice has a discriminatory effect where it actually or predictably results in a disparate impact on a group of individuals, or creates, increases, reinforces, or perpetuates segregated housing patterns, based on membership in a protected class." (Title. 2 CCR § 12060, subd. (b).)

and/or making it more difficult for Fresno CRMC Protected Classes to access health services, and to defeat or substantially impair their access to services to which they are entitled under the Medi-Cal program.

119. Respondents cannot justify their decisions to misallocate hundreds of millions of dollars to their Clovis site, while neglecting Fresno CRMC, as necessary to achieve any substantial, legitimate, and non-discriminatory purpose sufficiently compelling to override their disparate impact. Respondents' permitting, site, facility selection, maintenance, equipment replacement, staffing, and financing decisions violated Government Code § 11135 by creating an adverse disparate and discriminatory impact on Fresno CRMC Protected Classes. Respondents' failure to use less-discriminatory alternatives defeats or substantially impairs protected classes' access to health care services. 2 CCR §14027(b)(3).

120. Respondents have a clear duty to expend all its resources—both public and corporate—in a non-discriminatory manner. Respondents have violated, and on information and belief continue to violate, that duty as described herein. Respondents' statutory violations have inflicted irreparable economic and non-economic injury on Petitioners, on their staff members and clients, and on the members of the public on whose behalf Petitioners work. Petitioners therefore have a beneficial interest in the Respondents' performance of their duty to avoid discriminatory impacts in Respondents' provision of health care services. Respondents are capable of performing this duty but have failed and/or refused to do so to date; Petitioners assert on information and belief that unless enjoined by this Court, Respondents will continue to fail in this mandatory duty. Petitioners have no other plain, speedy, or adequate remedy at law, and therefore petition this Court for relief.

121. Petitioners seek declaratory and injunctive relief to prevent the Respondents from continuing to discriminate against Fresno CRMC Protected Classes, and to order Respondents' prompt compliance with Government Code § 11135.

VIII. PRAYER FOR RELIEF

WHEREFORE, petitioners pray for judgment as follows:

For the First Cause of Action:

1. A declaration that the pertinent statutes prohibit CHS from expending HQAF funding generated by the treatment of patients at Fresno CRMC for any purpose other than direct service to Fresno CRMC Low-Income Patients, and for such property, plant, and equipment as is directly required for such direct service.
2. A declaration that the pertinent statutes require CHS to expend HQAF supplemental Medi-Cal funding exclusively for direct services to Low-Income Patients, and such property, plant, and equipment as is directly required for such direct service, at the facility where services to Low-Income Patients generated each hospital's right to receive such funds and in proportion to each hospital's Medi-Cal and indigent adjusted patient days.[49]
3. An order enjoining respondent CHS to:
    a. Expend HQAF Supplemental Medi-Cal funding exclusively for direct services to Low-Income Patients, and for such property, plant, equipment, and staffing as is directly required to provide such direct services, at the facility where services to low-income patients generated each hospital's right to receive such Supplemental

[49] Adjusted patient days = Total gross patient revenue divided by gross inpatient revenue, times the total number of patient days. The purpose of adjusting the patient days is to recognize outpatient utilization. See HCAI Glossary, Documentation for Hospital Quarterly Financial...PDF, p. 6; *also see*, https://www.chcf.org/wp-content/uploads/2022/07/CAHospitalsAlmanac2022QRG.pdf.

Medi-Cal funding and in proportion to each hospital's Medi-Cal and indigent adjusted patient days, supplementing rather than supplanting Fresno CRMC's proportional share, based on adjusted patient days, of CHS's annual operating budget; and

b. Protect the cash reserves at Fresno CRMC, received as or deriving from HQAF payments, from any expenditure inconsistent with HQAF mandates to improve access to care and the quality of care for Low-Income Patients.

4. A declaration that the pertinent statutes prohibit CHS from expending at Clovis CMC any Private DSH funds and Private Hospital Supplemental Fund distributions generated by treatment of patients at Fresno CRMC, unless and until such time as DHCS were to determine that Clovis CMC serves a sufficient number of low-income and Medi-Cal patients to be included on DHCS's DSH Hospital Eligibility List, at which point any such funding must be spent at each hospital in proportion to its Medi-Cal and indigent adjusted patient days.

5. A declaration that the pertinent statutes require CHS to expend Private DSH and Private Hospital Supplemental Fund distributions exclusively for the benefit of Fresno CRMC Low-Income Patients, *at* Fresno CRMC, unless and until such time as DHCS determines Clovis CMC serves a sufficient number of low income and Medi-Cal patients to be included on its DSH Hospital Eligibility List, at which point any such funding must be spent at each hospital in proportion to its Medi-Cal and indigent adjusted patient days;

6. A declaration that the pertinent statutes require that Supplemental Medi-Cal Funding (including both HQAF and DSH funds): 1) not be used to replace other public funding, or other operating revenue required to be used to provide medical care to

Fresno CRMC Low-Income Patients (non-supplantation), or (2) be used to expand the capacity and provision of services to Fresno CRMC Low-Income Patients, beyond that being provided at the time of this Court's order.

7. A declaration that a security interest in CHS Gross Receivables cannot be granted under applicable federal and state laws providing restricted funding intended to ensure medical care to low-income and uninsured individuals, to the extent such Gross Receivables secure debt incurred for the purpose of building, improving, or equipping Clovis CMC facilities, unless each such expenditure can be justified by relative volumes of low-income and uninsured patients, with the exception of DSH funding, which cannot be used for any purpose related to Clovis CMC. Specifically, Petitioners seek a declaration that the Respondents as Members of the Obligated Group cannot validly grant, and the Master Trustee (and thus the Bond Trustee and the holders of the Bonds) cannot validly have, a security interest in Gross Receivables owing from federal or state governmental entities, including but not limited to Medi-Cal, Supplemental Medi-Cal, DSH funding, or other public funding specifically targeted to provide medical care to low-income and uninsured patients, to the extent such Gross Receivables, or the proceeds thereof, secure debt incurred for the purpose of building, expanding, or equipping Clovis CMC.

8. An order enjoining respondent CHS to:

   a. Expend Private DSH and Private Hospital Supplemental Fund payments generated and received by Fresno CRMC at and for the direct benefit of the Fresno CRMC campus and patients, and for such property, plant, equipment, and staffing, as is directly required to provide such direct services, supplementing

rather than supplanting Fresno CRMC's proportional share, based on adjusted patient days, of CHS's annual operating budget; and

b. Protect the cash reserves at Fresno CRMC, received as or deriving from Private DSH and Private Hospital Supplemental Fund payments, from any expenditure inconsistent with mandates that such funds be spent exclusively at DSH-eligible hospitals, for the purpose of reimbursing hospitals for some of the uncompensated care costs associated with furnishing inpatient hospital services to Low-Income Patients.

9. Petitioners further request an order enjoining respondent CHS to:

a. Create accounting mechanisms to ensure all Supplemental Medi-Cal Funding—including HQAF, Private DSH, and Private Hospital Supplemental Fund distributions—is treated as restricted funding and is spent as required by law:

i. to track receipt of all Supplemental Medi-Cal Funding, by funding category, by hospital;

ii. to separately track and report expenditures of all Supplemental Medi-Cal funding, by hospital, by Cost Center Group or Natural Classification, which categories are routinely reported to HCAI on each hospital's Annual Pivot Table;

iii. to document the non-supplantation of general operating funds by restricted Supplemental Medi-Cal funding, and/or the expansion of services that were already being provided at the time of this Court's order; and

iv. to justify, by reference to specific statutory provisions, any expenditures benefiting any patients other than Low-Income Patients.

b. Report annually to the California Department of Health Care Access and Information (HCAI) the amounts of *all* Supplemental Medi-Cal payments, including DSH payments (SB 855), Private Hospital Supplemental Fund payments, HQAF fees, Fee-for-Service HQAF Payments, and Managed Care HQAF Payments, received by each of its hospitals and how they were spent, including all of the information required by 9.a.i – iv of this Prayer

For the Second Cause of Action:

1. A judicial declaration that Respondents' decisions to disproportionately invest its strategic capital in Clovis CMC facilities, equipment, and technology, and for the benefit of Clovis CMC patient populations, have created a disparate adverse impact on Fresno CRMC Protected Classes' access to health care and the quality of that care, in violation of Government Code § 11135.
2. An order requiring that the Respondents, and those acting in concert with them, cease the following unlawful practices:
   a. Expending public and corporate funds in a manner that creates a disparate adverse impact on Fresno CRMC Protected Classes and substantially impairs accomplishment of the objectives of the State Medi-Cal and federal Medicaid programs for the Low-Income Patients these programs were created to serve;
   b. Failing to ensure that the hospital facilities, operating rooms, and outpatient facilities that serve Fresno CRMC Protected Classes are as safe, as modern, and as fully- and well-equipped and staffed as Clovis CMC;
   c. Locating and concentrating clinics, provider offices, and specialty practices in highly-resourced neighborhoods, leaving relatively low-income neighborhoods with inferior access and services;

d. Failing to provide equal access to emergency services, hospital services, specialty and post-operative care, and provider networks, for residents in those zip codes heavily dependent on Fresno CRMC;

e. Failing to fill gaps to ensure the provision of services and supports for Fresno CRMC Protected Classes are equivalent to or better than those provided to Clovis CMC patient populations, including allocating community benefit and other funding to address unmet patient needs in the zip codes from which patients in Fresno CRMC Protected Classes are most likely to come.

3. For an order requiring that Respondents take affirmative steps to meet their legal obligation to provide full and equal access to healthcare services in a non-discriminatory manner, and to develop necessary measures to regularly monitor and publicly report outcomes. Specifically, require Respondents to:

a. Provide a detailed plan and timeline, enforceable by Petitioners, to upgrade the facilities, equipment, technology, and staffing at Fresno CRMC to a quality equivalent to Clovis CMC, and at a proportional capacity based on patient acuity and patient volumes,

b. Make capital improvements at Fresno CRMC, adequate to modernize its aging physical plant, to alleviate access, quality, and patient flow concerns, and to bring the hospital into compliance with 2030 seismic safety requirements.

c. Maintain Fresno CRMC's existing services at current licensure and designation, and keep the number of licensed beds at or above current levels.

d. Maintain adequate staffing, including on-site and on-call specialists, at Fresno CRMC to efficiently handle its higher-acuity patient load, and to ensure at least equal, or better, access to timely care and quality care as at Clovis CMC

e. Post Emergency Department median wait times for each hospital on Respondents' opening web page at https://www.communitymedical.org/, on an hourly basis, and make a quarterly summary available to the public. Emergency Department wait times are defined as: (1) Time to Triage; (2) Time to Admit Decision; (3) Time to Discharge from the Emergency Department; and (4) Emergency Department Length of Stay for Admitted Patients.

i. Implement best practices at Fresno CRMC to ensure that each of the wait times identified in e., *supra*, are equal to or less than the same wait time measure at Clovis CMC.

ii. Provide in the Emergency Department at Fresno CRMC space adequate (in equal measure to Clovis CMC Emergency Department) to make sure at least one family member or friend can provide support for any patient who is severely ill, elderly, disabled, or who struggles with language or cultural barriers, or mental health or cognitive impairments.

iii. Provide treatment in an environment equally private and free from safety concerns as Clovis CMC; and

f. Publish on the CHS website on an annual basis:

i. A Language Access Plan compliant with federal CMS and Department of Justice requirements, to ensure adequate services at Fresno CRMC that allow staff to communicate with patients in their own language to the same extent as at Clovis CMC, including properly assessing Limited English Proficient patients, developing a proper treatment plan, and obtaining informed consent to treatment, and

ii. Annual (or more frequent) evaluation of Language Access services utilization rates to make sure in-person communication in the patient's own language is equally available at Fresno CRMC and Clovis CMC.

g. Provide full and equal access to Clovis CMC and CHP provider offices on the outer edge of the Fresno-Clovis metropolitan area for Fresno CRMC Protected Classes, including subsidized ride-hailing transportation so access to care is not de facto conditioned on having access to private automobile transportation.

For all causes of action

1. An award to Petitioners of reasonable attorney's fees and costs incurred herein, including but not limited to fees awardable pursuant to Cal. Code Civ. P. § 1021.5 and other pertinent law; and
2. Such other and further relief as the Court deems just and proper.

DATED: August 7, 2024

Respectfully submitted,

Law Office of Patience Milrod

By Patience Milrod
Patience Milrod
Attorney for Petitioners

VERIFICATION

I, Genoveva Islas, state that:

1. I have read the foregoing PETITION FOR WRIT OF MANDATE AND COMPLAINT FOR DECLARATORY RELIEF, AND OTHER RELIEF and know its contents.

2. I, Genoveva Islas, am Executive Director of Cultiva la Salud, a California nonprofit community benefit organization, one of the Petitioners in the above-entitled action and am authorized to make this verification on behalf of Cultiva la Salud. I have read the foregoing Complaint for Declaratory, Injunctive and Other Relief and know the contents thereof. The same is true of my own knowledge, except as to those matters which are therein alleged on information and belief, and as to those matters, I believe them to be true.

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

This verification was executed in Fresno, California, on 6 August, 2024.

Genoveva Islas
Executive Director

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VERIFICATION

I, Sandra Celedón-Castro, state that:

1. I have read the foregoing PETITION FOR WRIT OF MANDATE AND COMPLAINT FOR DECLARATORY RELIEF, AND OTHER RELIEF and know its contents.

2. I, Sandra Celedón-Castro, am President and Chief Executive Officer of Fresno Building Healthy Communities, a California nonprofit community benefit organization, one of the Petitioners in the above-entitled action, and authorized to make this verification on behalf of Fresno Building Healthy Communities. I have read the foregoing Complaint for Declaratory, Injunctive and Other Relief and know the contents thereof. The same is true of my own knowledge, except as to those matters which are therein alleged on information and belief, and as to those matters, I believe them to be true.

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

This verification was executed in Fresno, California, on 6 August, 2024.

Sandra Celedón-Castro
President and CEO

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