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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FIRST APPELLATE DISTRICT

DIVISION FIVE

WILFREDO COREA et al.,
Plaintiffs and Respondents,
v.
CITY AND COUNTY OF SAN
FRANCISCO et al.,
Defendants and Appellants.

A136950

(San Francisco County
Super. Ct. No. CPF-085-09118)

In 2006, the San Francisco Board of Supervisors created the health care program known as Healthy San Francisco (HSF). HSF is one of the programs San Francisco uses to satisfy its obligations under Welfare and Institutions Code section 17000,¹ which requires counties to “relieve and support all incompetent, poor, indigent persons[.]” Courts have interpreted that section to mandate that counties provide subsistence medical care to indigents who do not receive care through other state, federal, or private programs. To administer delivery of such aid, section 17001 requires counties to “adopt standards of aid and care for the indigent and dependent poor of the county or city and county.”

Petitioners Wilfredo Corea, Robyn Paige, and Lisa Qare (Petitioners) brought an action for writ of mandamus against respondent City and County of San Francisco and

¹ All undesignated statutory references are to the Welfare and Institutions Code.

various county agencies.² Their principal claim was that the County had failed to discharge its mandatory duties under sections 17000 and 17001 because the participant cost-sharing fees for HSF were not based on indigent participants' ability to pay and thus resulted in the denial of medical care to indigent residents. They also alleged the County was unlawfully requiring advance payment of fees before delivering medically necessary care. Petitioners further alleged the County was violating its statutory duties to provide care promptly and humanely and to ensure that residents received the aid to which they were entitled.

The trial court ruled in favor of Petitioners on their claims under sections 17000 and 17001, and issued a writ of mandate compelling the County to adopt new eligibility standards and participant fees based on a survey of the local cost of living. It denied their remaining claims as moot. The County appealed from the resulting judgment, and Petitioners cross-appealed.

After briefing was completed, there were significant changes in the law of health insurance due to federal health care reform. We requested supplemental briefing from the parties on the effect of these changes on Petitioners' standing. As we will explain, Petitioners lack a personal beneficial interest in the issuance of the writ, and we decline to apply the public interest exception to the ordinary beneficial interest requirement. Petitioners' lack of standing renders the controversy nonjusticiable. We will therefore reverse the judgment and remand the matter to the trial court with instructions to dismiss the action.

FACTUAL AND PROCEDURAL BACKGROUND

An understanding of the issues raised by this litigation requires an explanation of the development of HSF. After setting out the history of the program's creation and the establishment of its fee structure, we will turn to the procedural history of the case.

² San Francisco is a consolidated city and county. (*San Francisco v. Collins* (1932) 216 Cal. 187, 191.) In performing its "duty to relieve the indigent, established by state statute . . . the city and county of San Francisco . . . acts as a county—an agent of the state." (*Id.* at pp. 191-192.) We therefore refer to respondents collectively as "the County."

The Creation of HSF

In 2006, San Francisco’s many uninsured residents obtained safety net medical care from two main sources—through the County’s “Sliding Scale” program at facilities operated by the San Francisco Department of Public Health (DPH)³ and from a consortium of community-based, nonprofit health clinics. To address the problem of the San Francisco’s uninsured population, Mayor Gavin Newsom created a Universal Healthcare Council to develop a plan to provide the County’s uninsured residents with access to health care.

The Universal Healthcare Council proposed a health care access program that would later become HSF.⁴ The program would be financed by a combination of employer, individual, and public funding. The council reported that within the context of the County’s section 17000 obligation, “indigent residents and uninsured residents are not synonymous . . . while an indigent resident is very likely to be uninsured, all uninsured residents are not indigent” and therefore not all uninsured residents fall under section 17000.

On July 18, 2006, the Board of Supervisors passed Ordinance No. 218-06, the San Francisco Health Care Security Ordinance (HCSO), creating HSF. (S.F. Admin. Code, §§ 14.1-14.8.) The HCSO delegated administration of HSF to DPH, which developed the program’s components. (S.F. Admin. Code, § 14.2(a).) In addition to consultation with various stakeholders, DPH received guidance from The Lewin Group (Lewin), a consulting firm specializing in health care issues. All HSF policy, program, and financial

³ DPH’s Sliding Scale program was created in 1989 and provides primary, urgent, specialty, and inpatient services through DPH clinics and San Francisco General Hospital. The County agrees with the trial court that the differences between HSF and the Sliding Scale program are immaterial to the issues in this litigation. We will therefore refer to both as HSF save when context requires that they be discussed separately.

⁴ We use the words “health care access program” because HSF is not insurance. Unlike insurance, it provides no coverage for services rendered outside of San Francisco, does not cover services provided by medical professionals outside of the program’s provider network, and is available only to qualifying San Francisco residents.

matters were reviewed by DPH's governing body, the San Francisco Health Commission (the Health Commission).

Participant Cost Sharing and Fees

In preliminary recommendations to the Board of Supervisors in January 2007, DPH proposed making the program available to all uninsured San Francisco residents, regardless of immigration status, between the ages of 19 and 64 with incomes at or below 500 percent of the federal poverty level (FPL).⁵ It also recommended the program incorporate a system of patient cost sharing similar to that of DPH's existing Sliding Scale program. The recommendations proposed two kinds of participant fees—monthly participation fees and point-of-service (POS) fees. Both types of fees would be tied to participants' income in relation to the FPL and were "designed not to discourage participation or accessing services." Thus, participants with incomes below 100 percent of the FPL would pay no participation fees at all, with fees rising up to \$150 per month for residents with incomes between 400 and 499 percent of the FPL. Recommended POS fees ranged from \$0 to \$200 depending on income and type of service.

DPH's draft regulations implementing HSF proposed participation fees and POS fees "based on Participant income which is measured with reference to the [FPL]." POS fees were to be the same for participants with incomes between 101 and 500 percent of the FPL. Participation fees were to be assessed quarterly and were graduated by income. They ranged from \$60 for individuals with incomes from 101 to 200 percent of the FPL to \$450 for participants with incomes between 401 and 500 percent of the FPL.

Participants who were homeless, receiving general assistance (GA) benefits, or who had

⁵ The FPL is usually referred to in the record as the "federal poverty level." Elsewhere in the Welfare and Institutions Code, it is referred to as the "federal official poverty line" and defined by reference to subsection (2) of section 9902 of Title 42 of the United States Code. (See § 17000.5, subd. (c).) The FPL is defined annually by the federal Office of Management and Budget and income levels are revised each year by the Secretary of Health and Human Services. (42 U.S.C. § 9902(2).)

incomes up to 100 percent of the FPL would pay neither participation nor POS fees.⁶ DPH estimated that 66.7 percent of the uninsured population had incomes at or below 100 percent of the FPL. Responding to public comments that the fee structure must take into account residents' financial ability to obtain subsistence medical care, DPH stated the fee structure took household income into account.

In July 2007, DPH provided the Board of Supervisors with a status report on the implementation of the HCSO. That same month, DPH presented its proposed regulations and its response to public comments to the Health Commission.⁷ The Health Commission then approved HSF's fee structure. It found that on average, HSF participants would pay 2.2 percent of their income on participation and POS fees.

DPH's 2011 Fee Collection Policies and Procedures

Over the next four years, DPH submitted status reports on HSF to the Board of Supervisors and the Health Commission. In September 2011, DPH issued its policies and procedures for collection of POS fees.⁸ Consistent with its earlier proposal, the policy imposed no fees on the homeless, GA recipients, or individuals earning no more than 100 percent of the FPL. In addition, a number of services are provided without POS fees.⁹ The policy imposed a monthly cap on the number of POS fees a participant would pay. Patients who did not have the fee at the time of service would be medically screened to

⁶ The sole exception was the assessment of a \$25 POS fee for emergency room visits that did not result in admission.

⁷ The response to comments explained that DPH had chosen not to incorporate the fee schedule into the regulations themselves so that the Health Commission could review and update the fees without the need to modify the regulations each time changes to the fee structure were made.

⁸ The policies and procedures applied to the collection of "co-payments" for the Sliding Scale program and POS fees for HSF.

⁹ Emergency and urgent care are provided at no fee. Other no-fee services include chemotherapy treatment, basic diagnostic services (such as laboratory services, x-ray, and mammography), specialty services like renal dialysis and tuberculosis services, methadone maintenance, and pharmaceuticals like anti-psychotics, antibiotics for acute infections, and insulin or glucose strips.

determine whether the need was urgent, and if it was, they would be seen without payment of the fee. If it was not, their visits would be rescheduled.

The Petition for Writ of Mandate

On December 30, 2008, Petitioners filed a petition for ordinary and administrative mandamus. (See Code Civ. Proc., §§ 1085, 1094.5.) They alleged that the County failed to provide “necessary medical services in conformity with the requirements of law.” As relevant here, the petition claimed the County was violating sections 17000 and 17001¹⁰ by failing to ensure that Petitioners and other persons “eligible for medical services pursuant to [section] 17000 are provided with all necessary medical services – including necessary prescription medications – based upon their ability to pay.” According to the petition, the fees and charges for necessary medical services had the effect of illegally denying persons eligible for section 17000 care access to such services. In addition, Petitioners alleged the County’s policy and practice of assessing fees and charges violated sections 17000 and 17001 because “those fees and charges are not based upon the ability of persons eligible for services pursuant to [section] 17000 to pay the fees and charges.”

In a related claim, Petitioners alleged that the County’s failure to ensure that all San Francisco residents eligible for section 17000 medical services are able to obtain those services violated the County’s duty under section 10500.¹¹ The petition further alleged a violation of section 10000, based on the County’s claimed failure to ensure that indigent San Francisco residents eligible for section 17000 medical services promptly

¹⁰ Section 17000 provides: “Every county and every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions.”

Section 17001 provides: “The board of supervisors of each county, or the agency authorized by county charter, shall adopt standards of aid and care for the indigent and dependent poor of the county or city and county.”

¹¹ Section 10500 provides in relevant part: “Every person administering aid under any public assistance program . . . shall endeavor at all times to perform his duties in such manner as to secure for every person the amount of aid to which he is entitled[.]”

received such services “promptly and humanely” (§ 10000) regardless of ability to pay and without incurring illegal charges.

In addition to the violations described above, Petitioners claimed the County violated section 16804.1, subdivision (a), which provides that “[n]o fee or charge shall be required of any person before a county renders medically necessary services to persons entitled to services pursuant to Section 17000.” Petitioners claimed the County had implemented policies and procedures that required payment of fees before it would render necessary medical services to those eligible for section 17000 care.

After the County filed its answer to the petition, the parties conducted extensive discovery. In June 2011, Petitioners moved for a writ of ordinary mandate on their causes of action alleging violations of section 17000 and 17001. They argued the County failed to consider indigent residents’ ability to pay in setting income eligibility standards and fees for HSF. Petitioners requested a writ of mandate directing the County to “conduct a study and determine the costs of housing, utilities, food and the other necessities of life in San Francisco” and to “establish new and uniform eligibility standards and fees for HSF . . . based upon residents’ actual ability to pay for all or part of their health care.”

In its opposition, the County explained the data upon which DPH had relied in setting the fees. The County did not claim DPH had conducted a study to determine the local cost of subsistence in San Francisco. Rather, it acknowledged HSF fees were set in relation to the FPL and argued HSF participation and POS fees were affordable based on Lewin’s finding that all HSF participants would spend on average 2.2 percent of their total annual income on health care. It noted that HSF’s fees were comparable to and typically lower than those charged by other state or federal programs. The County explained that DPH periodically reviewed data to determine whether HSF fees were affecting access to care, and based on disenrollment data and participant complaints, the agency concluded affordability was not a significant factor in participant disenrollment. Finally, the County argued that indigent residents were not denied subsistence medical care for inability to pay because medical providers had discretion to waive the fees.

The County also pointed to the lack of evidence that any person eligible for section 17000 medical services had ever been denied care because of program fees. It noted it never charged POS fees to patients who had emergent or urgent medical conditions, and it contended it had created procedures allowing medical professionals to screen patients who could not pay fees to ensure that patients receive subsistence medical care even if they are unable to pay the assessed fees. It submitted declarations from medical staff who stated the procedures were adequate to assure the provision of subsistence medical services without payment of assessed fees. HSF director Tangerine Brigham stated she was unaware of any instance in which an HSF participant had been denied section 17000 care due to inability to pay either participation or POS fees. Similarly, DPH's chief pharmacy officer declared he had not received any information indicating that the fees charged for medications had resulted in patients not obtaining their drugs.

Because the County had been unable to depose petitioners Corea and Qare, the parties stipulated that the only factual allegations the trial court should consider regarding these petitioners were those admitted in the County's answer to the petition. The County's answer denied Corea and Qare's allegations that they had not received all of the care they needed, were charged more than they could afford, and had been forced to forgo critical prescription medications.¹²

At argument on Petitioners' motion, counsel for the County pointed out that although Petitioners had litigated the case for three years, they had yet to produce a single person who had been denied subsistence medical care. Petitioners' counsel agreed there was no evidence of any particular individual who could not afford HSF's fees. In his

¹² Regarding petitioner Paige, the County submitted excerpts of her deposition. She testified she had received care from San Francisco General Hospital and Laguna Honda Hospital for which no co-payment was required. Paige testified that her sole claim was that when she sought to refill a prescription, she had been told a \$25 co-payment would apply. The County pointed out Paige had not told anyone at the treating facility she could not afford the co-payment and had not asked whether she could receive the medication without paying. Petitioners' reply to the County's opposition made no direct response to these arguments.

view, however, this was largely irrelevant; what mattered was that the County had not conducted a local cost-of-living survey before setting the fees for HSF.

The Trial Court Grants Petitioners' Motion

On December 13, 2011, the trial court granted Petitioners' motion in part. It concluded the County had violated its duties under section 17000 by adopting a fee structure having the FPL as its sole touchstone rather than tailoring the fees to the cost of living in San Francisco. The court found the fee structure invalid because it did not measure the actual burden on San Francisco's indigent residents.

The trial court directed the parties to draft an order entering judgment for Petitioners and requiring the County "to create eligibility criteria based on residents' ability to pay which are based on 'statistics, surveys and calculations' or equivalents." The court declined to impose any interim relief pending the County's compliance with its usual administrative procedures, because Petitioners had "no evidence of wide-spread denial of services to those in need[.]" The parties later stipulated that Petitioners' remaining claims could be resolved without trial.

DPH Revises the Fee Collection Policies and Procedures

In May 2012, DPH revised its written fee collection policy and procedures for all medical services provided by HSF. The revised policy provides that patients unable to pay a POS fee for any medical service will receive a medical screening. If a medical provider "determine[s] that delaying care to a later date Carrie[s] the risk of worsening of the [patient's] medical condition or unnecessary suffering. The patient [will be] seen without paying the required patient fee." According to DPH staff, this standard is broadly interpreted, taking into consideration a patient's individual circumstances and such factors as the patient's physical and emotional condition, degree of engagement with health care over time, and any hardships associated with returning for a rescheduled appointment.

Patients who cannot pay the fee are given a notice stating that the fee was not paid and that they should receive any prescribed medication at no cost. According to Brigham, DPH staff are expected to accept a patient's statement that he or she does not

have the funds necessary to pay the fee, and staff are instructed not to request information or documentation from patients about why they cannot pay the fee. “The patient’s representation about his or her inability to pay the fee is taken at face value.” A similar procedure for medical screening and fee waiver also applies to the provision of other particular medical services covered under HSF, including dental care and prescription medications.

Both Brigham and Dr. Todd May, Chief Medical Officer at San Francisco General Hospital, explained that the May 2012 fee collection policies and procedures vest absolute discretion in the hands of medical personnel responsible for a patient’s care because those personnel are most qualified to assess whether a patient should receive medical care on a particular day notwithstanding payment of the patient fee.

Petitioners’ Second Motion for Writ of Mandate and the County’s Request for Reconsideration

On June 1, 2012, Petitioners filed a second writ motion on their causes of action under sections 16804.1, 10000, and 10500. The County opposed this second motion and requested reconsideration of the December 13, 2011 order granting Petitioners’ original motion. The County relied on DPH’s May 2012 revision of its fee collection policies and procedures, and it submitted declarations from medical, nursing, social work, and administrative staff explaining how the policies are applied. The declarants explained that the revised fee collection policies were consistent with existing practices within DPH. They also stated they were unaware of any instances in which HSF participants had been denied services because of inability to pay patient fees, and the County again pointed out Petitioners’ failure—after almost four years of litigation—to identify a single individual who had been denied subsistence medical care because he or she could not afford a fee. The County contended its voluntary change in its written policies constituted compliance with its duties under sections 17000 and 17001, and thus the writ was unnecessary.

The trial court held a hearing on July 11, 2012. In response to the court’s question about Petitioners’ claim under section 16804.1, Petitioners’ counsel conceded there was

no evidence in the record of people who had paid fees in advance because they were unaware of their right to receive medical services without such payment. Counsel for the County argued Petitioners' failure to identify a single person who had been denied subsistence medical care meant that "we're all having these conversations in a vacuum[.]"

The trial court denied both Petitioners' request for further writ relief and the County's request for reconsideration. The court entered judgment, and issued a writ of mandate on August 27, 2012.¹³ The writ required the County to implement new income eligibility standards and fees for HSF and the Sliding Scale program based "on San Francisco residents' ability to pay for such health care and . . . on statistics, surveys, calculations, studies or the equivalents thereof regarding the costs to low income residents of housing, utilities, food, transportation, clothing, items of personal care and other necessities of life in San Francisco[.]" The County appealed from the writ and judgment, and Petitioners filed a cross-appeal.

Subsequent Developments

This case became fully briefed in December 2013. On January 1, 2014, the health insurance coverage provisions of the Patient Protection and Affordable Care Act (ACA) (Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010)), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010)) took effect. (See 26 U.S.C. § 5000A(a) [requiring applicable individuals to ensure they acquire "minimum essential coverage" "for each month beginning after 2013"].) As part of federal health care reform, the Legislature created a state health care exchange, known as Covered California, through which Californians can purchase health insurance coverage pursuant to the ACA. (See Gov. Code, § 100500, subd. (a).) Many of those purchasing coverage through the exchange are eligible for federal tax subsidies to offset the cost of health insurance premiums. (26 U.S.C. § 36B(b); Cal. Code Regs., tit. 10, § 6474(c).) In addition, the Legislature acted to expand eligibility for Medi-Cal.

¹³ Petitioners voluntarily dismissed their other causes of action on August 21, 2012.

(§§ 14005.60, 14005.64.) The parties agree that U.S. citizens and lawfully present immigrants with incomes up to 138 percent of the FPL may now enroll in that program. (See Department of Health Care Services, *Medi-Cal Expansion: Covering More Californians*, <http://www.dhcs.ca.gov/Pages/Medi-CalExpansionInformation.aspx> [as of July 22, 2014] [“To be eligible, your annual income must be lower than 138 percent of the federal poverty level.”].) The Legislature anticipates that with these changes, county costs and responsibilities for indigent health care will decrease. (Sen. Rules Com., Off. of Sen. Floor Analyses, 3d reading analysis of Assem. Bill No. 85 (2013-2014 Reg. Sess.) as amended June 13, 2013, p. 1.)

In light of these statutory developments, we ordered the parties to file supplemental briefs addressing whether the statutory changes had rendered any of the issues in this case moot and whether Petitioners possessed a present beneficial interest in the issuance of the writ. In addition, if Petitioners claimed only public interest standing to bring this action, we asked who was aggrieved by the County’s alleged violations of its statutory duties. The parties filed their supplemental briefs on May 14, 2014.

DISCUSSION

The parties raise numerous arguments in these cross-appeals. As we explain below, we will not reach the merits of these arguments because Petitioners lack a beneficial interest in this litigation. Furthermore, in view of the very significant changes the ACA has made in the law governing health insurance, we conclude that the balance of interests weighs against granting Petitioners an exception to the general rule requiring that they have a beneficial interest in the issuance of the writ. We therefore decline to accord them public interest standing.

I. *The Statutory Scheme*

“Section 17000 imposes upon counties a mandatory duty to ‘relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident,’ when those persons are not relieved and supported by some other means.” (*Hunt v. Superior Court* (1999) 21 Cal.4th 984, 991, fn. omitted (*Hunt*).) Among a county’s duties under the statute is the provision of medical care, a duty which is

“independent of other obligations imposed by that section[.]”¹⁴ (*Id.* at p. 1002.) In delivering medical care under section 17000, a county acts “as the provider of last resort[.]” (*Id.* at p. 1014; accord, *Alford v. County of San Diego* (2007) 151 Cal.App.4th 16, 27 (*Alford*) [§ 17000 establishes “a program of ‘ ‘last resort’ ’ ”].) The statute “creates ‘the *residual* fund’ to sustain indigents ‘who cannot qualify . . . under any specialized aid programs.’ ” (*County of San Diego v. State of California* (1997) 15 Cal.4th 68, 92 (*County of San Diego*)). This means that to the extent indigent residents are relieved and supported by other federal or state programs, a county’s section 17000 obligations are reduced. (*Ibid.*)

The scope of the County’s health care obligation to its indigent residents is defined by section 17000, which has been construed to require the provision of “subsistence medical care.” (*Hunt, supra*, 21 Cal.4th at pp. 1005, 1013.) The California Supreme Court has not defined what “specific medical services a county must offer to provide residents with subsistence medical care pursuant to section 17000[.]” (*Id.* at p. 1014; see *County of San Diego, supra*, 15 Cal.4th at p. 106 [“we need not here define the precise contours of [the county’s] statutory health care obligation”].) Nevertheless, our high court has observed that “[c]ourts construing section 17000 have held that it ‘imposes a mandatory duty upon all counties to provide “medically necessary care,” not just emergency care.’ [Citation.]” (*Id.* at pp. 104-105.) A service is “ ‘ ‘medically necessary’ . . . when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain[.]’ ” (*Id.* at p. 105, quoting § 14059.5.) The statute creates a mandatory duty to provide subsistence medical care, and counties have “no discretion concerning whether to provide such care[.]” (*Tailfeather v. Board of Supervisors* (1996) 48 Cal.App.4th 1223, 1245 (*Tailfeather*)). Counties must therefore

¹⁴ Pursuant to section 17000, counties also provide separate systems of cash and/or in-kind benefits to indigents through their GA programs. (See *Gardner v. County of Los Angeles* (1995) 34 Cal.App.4th 200, 204; *Boehm v. Superior Court* (1986) 178 Cal.App.3d 494, 499.)

provide “medical services to the poor at a level which does not lead to unnecessary suffering or endanger life and health” (*Id.* at p. 1240.)

Under section 17001, counties have an affirmative duty “to adopt standards of eligibility for aid and care for the indigent and dependent poor.” (*Tailfeather, supra*, 48 Cal.App.4th at p. 1237.) These standards are in the nature of administrative regulations, and their adoption is a legislative function. (*Scates v. Rydingsword* (1991) 229 Cal.App.3d 1085, 1101 (*Scates*); *Poverty Resistance Center v. Hart* (1989) 213 Cal.App.3d 295, 304 (*Poverty Resistance Center*)). The County’s standards are presumptively valid, and Petitioners bear the burden of pleading and proving their invalidity. (*Poverty Resistance Center, supra*, at p. 311.)

“Although [section 17001] confers upon a county broad discretion to determine eligibility for—and the types of—indigent relief, this discretion must be exercised in a manner that is consistent with—and that furthers the objectives of—state statutes.” (*Hunt, supra*, 21 Cal.4th at p. 991.) Those objectives, as set forth in section 10000, are “to provide for protection, care, and assistance to the people of the state in need thereof, and to promote the welfare and happiness of all of the people of the state by providing appropriate aid and services to all of its needy and distressed.” Counties are to administer aid and provide services “promptly and humanely[.]” (§ 10000.) “County standards that fail to carry out section 17000’s objectives ‘are void and no protestations that they are merely an exercise of administrative discretion can sanctify them.’ [Citation.] Courts, which have ‘final responsibility for the interpretation of the law,’ must strike them down. [Citation.] Indeed, despite the counties’ statutory discretion, ‘courts have consistently invalidated . . . county welfare regulations that fail to meet statutory requirements. [Citations.]’ [Citation.]” (*County of San Diego, supra*, 15 Cal.4th at p. 100.)

Section 10000 imposes only a “minimum standard of care” on counties. (*Hunt, supra*, 21 Cal.4th at p. 1014.) They thus have wide discretion in determining how to meet that minimum standard, but “they may not deny subsistence medical care to residents based upon criteria unrelated to individual residents’ financial ability to pay all

or part of the actual cost of such care.” (*Id.* at p. 1015.) A standard that “results in a denial of subsistence medical care to [indigent] individuals . . . is void.” (*Alford, supra*, 151 Cal.App.4th at p. 35.)

II. *HSF Is Not Immune from Judicial Review Under Section 17000.*

We first address the County’s argument that HSF is not governed by section 17000 and thus the County “may decide what services it will offer under HSF, whether to charge fees for those services, and, if so, how much.” The County contends that since HSF voluntarily provides a broad array of services with components that exceed the minimum standards imposed by section 17000, it may manage HSF as it sees fit. We disagree.

It is undisputed that HSF provides health care to individuals, such as undocumented aliens, to whom the County is not statutorily obligated to offer care. (*Khasminskaya v. Lum* (1996) 47 Cal.App.4th 537, 540 [benefits under section 17000 are limited to persons ‘lawfully resident’ in each county, which “does not include citizens of other countries who are present here on a temporary, undocumented, or illegal basis . . .”].) In addition, HSF offers a wide range of health care services that would appear to exceed section 17000’s obligation for the provision of “subsistence medical care.” (*Hunt, supra*, 21 Cal.4th at p. 1014.) Thus, the County has “in [its] discretion . . . go[ne] beyond the section 17000 minimum subsistence needs of the indigent[.]” (*Scates, supra*, 229 Cal.App.3d at p. 1103, fn. 11.)

Nevertheless, the County admits it uses HSF as one means of providing subsistence medical care. Because the County is using HSF to satisfy its obligations under section 17000, it may not insulate itself from judicial enforcement of its duties under that statute merely by choosing to cover additional individuals or by offering medical services that exceed the statutory requirements. Thus, insofar as HSF is being used to provide subsistence medical care to the County’s indigent residents in response to

the mandate of section 17000, the courts are empowered to enforce the County's duties under the statute.¹⁵

III. *Beneficial Interest and Public Interest Standing*

As noted earlier, we asked the parties to provide supplemental briefs on the issue of Petitioners' beneficial interest in the issuance of the writ. In their supplemental brief, Petitioners concede that based on the record before us they are not adversely affected by governmental action and have no special interest or particular right above those held by the public at large. Furthermore, Petitioners cannot name other individuals harmed by the County's alleged violations of its mandatory duties. They therefore claim they have "citizen standing" to seek writ relief.¹⁶ To determine whether Petitioners should be accorded such standing, we first review the applicable legal principles.

A. *Governing Law*

Petitioners sought a writ of mandate under Code of Civil Procedure section 1085. Code of Civil Procedure section 1086 provides that such writs "must be issued upon the verified petition of the party beneficially interested." As the California Supreme Court recently explained, "[t]he requirement that a petitioner be "beneficially interested" has been generally interpreted to mean that one may obtain the writ only if the person has some special interest to be served or some particular right to be preserved or protected over and above the interest held in common with the public at large. [Citations.] As Professor Davis states the rule: "One who is in fact adversely affected by governmental

¹⁵ The County is correct only in the limited sense that it is under no statutory duty to serve residents who do not fall within the class of persons covered by section 17000 (indigent, lawful residents) or to offer services that exceed the subsistence medical care that section requires. Mandamus is not available to compel the County to go above and beyond its statutory obligations. Petitioners do not appear to disagree on this point, and we understand their arguments as addressing *only* the County's duty to provide subsistence medical care to indigents who are lawful residents.

¹⁶ Petitioners correctly note that the County did not challenge their public interest standing in the court below. However, because "contentions based on a lack of standing involve jurisdictional challenges [they] may be raised at any time in the proceeding." (*Common Cause v. Board of Supervisors* (1989) 49 Cal.3d 432, 438 [standing first raised before California Supreme Court].)

action should have standing to challenge that action if it is judicially reviewable.” (Davis, 3 Administrative Law Treatise (1958) p. 291.)’ [Citation.] The beneficial interest must be direct and substantial.” (*Save the Plastic Bag Coalition v. City of Manhattan Beach* (2011) 52 Cal.4th 155, 165 (*Save the Plastic Bag Coalition*)).) The beneficial interest standard “is equivalent to the federal ‘injury in fact’ test, which requires a party to prove by a preponderance of the evidence that it has suffered ‘an invasion of a legally protected interest that is “(a) concrete and particularized, and (b) actual or imminent, not conjectural or hypothetical.” ’ ” (*Associated Builders & Contractors, Inc. v. San Francisco Airports Com.* (1999) 21 Cal.4th 352, 362.) A petitioner has no beneficial interest within the meaning of the statute if he or she “will gain no direct benefit from [the writ’s] issuance and suffer no direct detriment if it is denied.” (*Waste Management of Alameda County, Inc. v. County of Alameda* (2000) 79 Cal.App.4th 1223, 1232 (*Waste Management*), disapproved in part on other grounds in *Save the Plastic Bag Coalition, supra*, 52 Cal.4th at pp. 160, 166-171; see, e.g., *Brown v. Crandall* (2011) 198 Cal.App.4th 1, 13 (*Brown*) [petitioner had no beneficial interest in requiring a county “to provide coverage to other residents described in section 17000”].)

Code of Civil Procedure section 1086 has been construed to “establish[.] a standing requirement for writs of mandate[.]” (*Brown, supra*, 198 Cal.App.4th at p. 8.) Standing “ ‘focuses on the party seeking to get his complaint before a . . . court, and not in the issues he wishes to have adjudicated.’ ” (*Harman v. City and County of San Francisco* (1972) 7 Cal.3d 150, 159.) The purpose of the standing requirement “ ‘is to ensure that the courts will decide only actual controversies between parties with a sufficient interest in the subject matter of the dispute to press their case with vigor.’ ” (*Brown, supra*, at p. 14.) Ordinarily, standing in actions for traditional mandamus is limited to parties who have “a direct interest in the outcome of the writ proceeding.” (1 Cal. Civil Writ Practice (Cont.Ed.Bar 4th ed. 2014) § 2.12, p. 17.)

An exception to the general beneficial interest requirement exists “ ‘ “where the question is one of public right and the object of the mandamus is to procure the enforcement of a public duty[.] [In such cases,] the [petitioner] need not show that he has

any legal or special interest in the result, since it is sufficient that he is interested as a citizen in having the laws executed and the duty in question enforced.” ’ ’ (*Save the Plastic Bag Coalition, supra*, 52 Cal.4th at p. 166.) This public right/public duty exception “promotes the policy of guaranteeing citizens the opportunity to ensure that no governmental body impairs or defeats the purpose of legislation establishing a public right.” (*Green v. Obledo* (1981) 29 Cal.3d 126, 144.) Thus, parties who lack a direct, personal interest in issuance of the writ may still be granted what the California Supreme Court calls “ ‘public interest standing.’ ” (*Save the Plastic Bag Coalition, supra*, 52 Cal.4th at p. 166.)

Even though courts will relax ordinary standing requirements in appropriate cases, “[n]o party . . . may proceed with a mandamus petition as a matter of right under the public interest exception.” (*Save the Plastic Bag Coalition, supra*, 52 Cal.4th at p. 170, fn. 5.) “ ‘Judicial recognition of citizen standing is an exception to, rather than repudiation of, the usual requirement of a beneficial interest. The policy underlying the exception may be outweighed by competing considerations of a more urgent nature.’ ” (*Ibid.*, quoting *Waste Management, supra*, 79 Cal.App.4th at p. 1237.) Determining whether public interest standing is appropriate “requires a judicial balancing of interests, and the interest of a citizen may be considered sufficient when the public duty is sharp and the public need weighty.” (*Ibid.*) Where these factors are present, and there are no countervailing concerns, courts are not reluctant to recognize a citizen’s standing to enforce a public duty. (*Brown, supra*, 198 Cal.App.4th at p. 14.)

That said, the public interest exception to ordinary standing requirements remains just that—an *exception*. The *rule* remains that a party seeking a writ of mandate under Code of Civil Procedure section 1085 must demonstrate that he or she has a special interest or particular right beyond that possessed by the general public. (See *Save the Plastic Bag Coalition, supra*, 52 Cal.4th at pp. 165, 170, fn. 5.) For the reasons that follow, in this case we apply the rule rather than the exception.

B. *Application of the Public Interest Standing Doctrine Is Discretionary.*

At the outset, we agree with Petitioners that the provision of subsistence medical care to indigent San Franciscans is a matter of significant public interest. As our colleagues in Division One explained in *Brown*, “[t]he ability to obtain necessary medical care is a basic human need, and the public has a strong interest in the provision of such care to indigent persons to facilitate their continuing independence and prevent them from becoming dependents of the state.” (*Brown, supra*, 198 Cal.App.4th at p. 14.)

This does not end our inquiry, however, because “application of the [public interest standing] doctrine is still discretionary.” (*Reynolds v. City of Calistoga* (2014) 223 Cal.App.4th 865, 874 (*Reynolds*)). Consequently, “even if a plaintiff otherwise meets the requirements of the public right/public duty exception in a mandamus proceeding, he is not entitled to proceed ‘as a matter of right.’ ” (*Ibid.*) In this case, unlike *Brown*, the County has identified competing considerations that may outweigh the policies underlying the doctrine.¹⁷ (Cf. *Brown, supra*, 198 Cal.App.4th at p. 14 [county identified no such considerations].) We therefore look to the balance of interests to determine whether it is appropriate to allow Petitioners to proceed despite their lack of a beneficial interest in issuance of the writ. (See *Waste Management, supra*, 79 Cal.App.4th at p. 1237.) “[T]he interest of a citizen may be considered sufficient when the public duty is sharp and the public need weighty.” (*Ibid.*) “ ‘When the public need is less pointed, the courts hold the petitioner to a sharper showing of personal need.’ ” (*Reynolds, supra*, 223 Cal.App.4th at p. 875.) Petitioners bear the burden of pleading and proving the facts on which their claim for relief is based, and this includes facts showing their standing. (*American Coatings Assn. v. South Coast Air Quality Management Dist.*

¹⁷ *Brown* is also distinguishable from this case because *Brown*’s standing was challenged on demurrer, and the court held that issues of fact concerning the weight of the public need could not be resolved at the pleading stage. (*Brown, supra*, 198 Cal.App.4th at p. 15.) Moreover, the court concluded *Brown* had alleged facts sufficient to establish an individual beneficial interest with respect to *some* of her claims, although she lacked such an interest as to others. (*Id.* at pp. 9-10, 13.)

(2012) 54 Cal.4th 446, 460; *Tahoe Vista Concerned Citizens v. County of Placer* (2000) 81 Cal.App.4th 577, 590-591.)

C. *The Balance of Interests Weighs Against Granting Public Interest Standing in this Case.*

The County attacks Petitioners' standing on two fronts. It first questions whether the public need is as weighty as Petitioners claim, because there is no evidence that any member of the public has been harmed by the alleged violations of its statutory duties. It then argues that this is a case in which the policies underlying the public interest exception are "outweighed . . . by 'competing considerations of a more urgent nature.'" (*Green v. Obledo, supra*, 29 Cal.3d at p. 145.) It contends that implementation of the ACA and the expansion of Medi-Cal have greatly reduced the scope of its obligations under section 17000.¹⁸

1. *Public Duty and Public Need*

Petitioners assert that there are large numbers of individuals harmed by the County's alleged violation of its statutory duties. They refer us to a 2009 Kaiser Family Foundation study of HSF participants in which 33 percent of participants with incomes between 100 percent and 300 percent of the FPL (who made up one quarter of HSF enrollees) reported "they are paying more for health care now than before they were enrolled in the program." But the study did not say that cost was a barrier to these enrollees' participation in HSF, and it recommended only that they be tracked in the future to determine "whether they are able to access care through [HSF] in a way that is financially affordable." Moreover, DPH examined this data and determined it could not conclude that these participants delayed or did not receive medical care because of cost. Responses to DPH's health access questionnaire showed that over the years, a declining

¹⁸ The County does not contend these legislative enactments have eliminated its obligations under section 17000. Thus, it makes no argument that implementation of the ACA's coverage provisions and the expansion of Medi-Cal have rendered this action entirely moot. (See *Consolidated Fire Protection Dist. v. Howard Jarvis Taxpayers' Assn.* (1998) 63 Cal.App.4th 211, 218 [appeal not moot where intervening change in legislation did not completely eliminate claimed harm to plaintiff].)

number of HSF participants said they had delayed getting care or prescription medications due to cost. (See *California Assn. for Health Services at Home v. State Dept. of Health Care Services* (2012) 204 Cal.App.4th 676, 687-688 [agency could rely on complaint data from Medi-Cal recipients in assessing whether quality of care was sufficient].)

Petitioners also point to the number of HSF participants who have been disenrolled for insufficient payment of quarterly participation fees. They contend these numbers have only increased over time.¹⁹ In looking at this data, however, DPH concluded that disenrollments that are recorded as related to participation fees do not always indicate inability to pay, but rather may mask other disenrollment reasons. For example, such disenrollments may reflect participants who disregarded participation fee invoices because they had obtained health insurance elsewhere. Based on a review of participation fee related disenrollment data from 2007 to 2011, DPH concluded, “it does not appear that the participation fee was a deterrent to continued program enrollment.” Petitioners also point out that failure to pay participation fees results in disenrollment from HSF, but it appears there is no penalty for disenrollment, and participants may re-enroll at any time without having to pay previously unpaid participation fees.

Petitioners note that in fiscal year 2010-2011, there were 219 HSF participants who have expressly stated they cannot afford to pay the quarterly participation fees.²⁰ But in that period, a total of 54,348 uninsured adult residents were enrolled in HSF. These numbers support the trial court’s finding that Petitioners “have no evidence of wide-spread denial of services to those in need[.]” We also note that after years of

¹⁹ As the County notes, however, while the absolute number of disenrollments for nonpayment or insufficient payment of fees has increased, the total number of HSF enrollees has also increased, and thus the percentage of all disenrollments related to insufficient payment of participation fees has declined.

²⁰ Petitioners also allude to individuals who allegedly are deterred from joining HSF because of the various program fees. They refer to portions of the record discussing rates of HSF participation versus the total target population. The cited material does not indicate that lack of participation is due to cost, although it does suggest a number of other explanations.

litigation, none of these individuals has come forward to participate in Petitioners' action. Thus, citizens whose interests are more immediate than Petitioners' have not pressed these claims, a fact which suggests "that the public duty is not as sharp and the public need not as weighty as [Petitioners] perceive[] them to be." (*Reynolds, supra*, 223 Cal.App.4th at p. 875; cf. *Madera Community Hospital v. County of Madera* (1984) 155 Cal.App.3d 136, 142 [county's medically indigent population had no incentive to assert claims under § 17000 because they were receiving free services from nonprofit hospital].)

Moreover, while the availability of coverage under the ACA and the expansion of the Medi-Cal program have not eliminated the County's obligations under section 17000, the parties do not dispute that those obligations have been reduced. As explained earlier, individuals earning up to 138 percent of the FPL are now eligible for Medi-Cal coverage. Although it is not entirely clear what percentage of HSF participants will now be eligible for Medi-Cal, DPH's 2009 annual report on HSF found that 81 percent of HSF participants had incomes at or below 133 percent of the FPL and would potentially be covered under Medi-Cal if its income eligibility were expanded to that level. Presumably, a somewhat greater percentage of HSF participants will be eligible for Medi-Cal now that its income limits have been raised to 138 percent of the FPL. The increase in participants eligible for Medi-Cal means there has been a corresponding decrease in indigents whose medical care is the County's responsibility. (See *County of San Diego, supra*, 15 Cal.4th at p. 92 [to the extent that state and federal governments provide medical care for indigents, counties' § 17000 obligation is reduced].)

In sum, all of this suggests the number of people who may have been adversely affected by the County's alleged failure to comply with its statutory duties is relatively small. Furthermore, the recent changes in federal and state health insurance coverage have very likely decreased the number of those who might be adversely affected in the future. Thus, the public need, while perhaps not absent, is less weighty than it would be if Petitioners had produced evidence of significant numbers of indigents who were unable to access subsistence medical care. (See *Brown, supra*, 198 Cal.App.4th at p. 15

[evidence that very small number of indigents required § 17000 services may bear on weight of public need].)

2. *Competing Considerations*

The County contends issues related to the ongoing implementation of health care reform in California present “ ‘competing considerations’ ” outweighing the policy underlying public interest standing in this case. (See *Green v. Obledo*, *supra*, 29 Cal.3d at p. 145.) There is little published case law explaining the sort of considerations that will outweigh public interest standing, but at least one case has held such considerations may be embodied in other legislation. (See *Nowlin v. Department of Motor Vehicles* (1997) 53 Cal.App.4th 1529, 1538-1539.) The County argues the statutory and regulatory changes brought about by the ACA may render prior policies for providing safety net medical care irrelevant or ill suited to delivering such care under the new structure. It maintains counties must have discretion to craft locally appropriate policies in the wake of health care reform.

The ACA is undeniably one of the most significant changes in decades to the laws governing health insurance coverage. (See, e.g., *Nat. Fedn. of Indep. Business v. Sebelius* (2012) 132 S.Ct. 2566, 2581-2582 [noting that ACA expands scope of Medicaid program and increases number of individuals states must cover]; *Geneva College v. Sebelius* (W.D. Pa. 2013) 929 F.Supp.2d 402, 413 [ACA “became law and an overhaul of the nation’s healthcare system began”].) In the wake of the ACA, the Legislature has recognized that “many low-income individuals will be eligible for Medi-Cal coverage pursuant to federal law, as part of health care reform.” (§ 14199.1, subd. (a); 4 West’s Cal. Legis. Service 2013, Legis. Counsel’s Dig., Assem. Bill No. 85, Stats. 2013, ch. 24, p. 976 [“eligibility for the Medi-Cal program is expanding”].) Because “[t]he ACA increases access to both private and public health care coverage[,] . . . county costs and responsibilities for indigent health care are expected to decrease as more individuals gain access to insurance.” (Sen. Rules Com., Off. of Sen. Floor Analyses, 3d reading analysis of Assem. Bill No. 85 (2013-2014 Reg. Sess.) as amended June 13, 2013, p. 1.)

Given the breadth of the changes and their unquestioned effect on the County's responsibilities to provide subsistence medical care, we agree that the County has shown competing considerations militating against granting public interest standing to Petitioners. As the trial court recognized, there are "highly nuanced policy issues presented by the nature and extent of co-payment structures[.]" To proceed to the merits of this case despite the intervening changes in the law seems to us imprudent.

In addition, this is not a case in which the issues Petitioners seek to raise "will be removed from judicial review if standing is denied." (*Sacramento County Fire Protection Dist. v. Sacramento County Assessment Appeals Bd.* (1999) 75 Cal.App.4th 327, 334.) If, as Petitioners vigorously contend, the County is indeed violating its statutory duties to its indigent population, then individuals who have actually been injured by those violations can seek to compel the County to comply with its ministerial duties. (See *Alford, supra*, 151 Cal.App.4th at pp. 21-22 [describing individual plaintiffs and their injuries in class action against county under § 17000].) Such an action would have the further advantage of permitting the courts to adjudicate the matter in a concrete factual setting, for "judicial decisionmaking is best conducted in the context of an actual set of facts so that the issues will be framed with sufficient definiteness to enable the court to make a decree finally disposing of the controversy." (*Pacific Legal Foundation v. California Coastal Com.* (1982) 33 Cal.3d 158, 170; see *Carsten v. Psychology Examining Com.* (1980) 27 Cal.3d 793, 798 [noting reluctance of courts to give advisory opinions].) Petitioners suggest that because this " 'case has been litigated intensely, and there is no danger here that the court will be misled by the failure of the parties to adequately explore and argue the issues.' " (*Connerly v. State Personnel Bd.* (2001) 92 Cal.App.4th 16, 30.) Even assuming this case has been litigated as intensely as Petitioners claim, the case law does "not hold a person willing to litigate a claim intensely acquires standing that is otherwise absent, and we are not aware of any case law suggesting that a willingness to fervently pursue a cause is the sine qua non of standing to litigate that cause." (*County of San Diego v. San Diego NORML* (2008) 165 Cal.App.4th 798, 817, fn. 6.)

Furthermore, we are not persuaded that the issues in this case can be properly determined in the absence of a petitioner with a present beneficial interest. To illustrate, in the court below, the parties disagreed on what services fall within the County’s section 17000 obligation to provide “subsistence medical care.” (See *Hunt, supra*, 21 Cal.4th at p. 1014 [leaving undefined “the specific medical services a county must offer to provide residents with subsistence medical care”]; *County of San Diego, supra*, 15 Cal.4th at pp. 104-105, 106 [citing various interpretations of § 17000 standard of care, but declining to define precise contours of county’s statutory health care obligation].) Petitioners argue that this term includes all “ ‘medically necessary services.’ ”²¹ The County, on the other hand, contends section 17000 requires it to provide care “at a level which does not lead to unnecessary suffering or endanger life and health” (*Tailfeather, supra*, 48 Cal.App.4th at p. 1240), and thus subsistence medical care embraces “only necessary treatment for serious illness and injury[.]” (*Alford, supra*, 151 Cal.App.4th at p. 33; cf. § 14059.5 [“A service is ‘medically necessary’ or a ‘medical necessity’ when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.”].) It argues there is no evidence any indigent resident has been denied such care, and absent such evidence, courts cannot invalidate HSF’s eligibility criteria or fee structure. (See *Hunt, supra*, 21 Cal.4th at p. 1015 [counties “may not *deny subsistence medical care* to residents based upon criteria unrelated to individual residents’ financial ability to pay”] (italics added); *Alford, supra*, 151 Cal.App.4th at p. 35 [“Because the current income cap *results in a denial of subsistence medical care* to [indigent] individuals, *it is void.*”] (italics added).)²²

²¹ Petitioners rely on statements by Dr. Todd May that a number of particular services are “medically necessary.” Whether a specific service falls within the definition of “subsistence medical care” is, however, a *legal* question that a physician’s *medical* opinion cannot answer. (*Watkins v. County of Alameda* (2009) 177 Cal.App.4th 320, 340, fn. 18 [scope of term “ ‘employable’ ” as used in section 17001.5, subd. (a) is for court to determine and opinions of experts as to meaning are not relevant].)

²² Both *Hunt* and *Alford* involved county standards that imposed inflexible income caps on the provision of medical care. (*Hunt, supra*, 21 Cal.4th at p. 994 [county limited medical care to GA recipients who could earn no more than 62 percent of the FPL];

The specific level of care required by section 17000 remains unclear. (See Jones, *Regulatory Takings and Emergency Medical Treatment* (2010) 47 San Diego L.Rev. 145, 158-163 (*Regulatory Takings*) [discussing indeterminacy in level of care counties must provide under § 17000].) The California Supreme Court has held the statute does not require counties to satisfy all unmet needs, offer universal health care, or provide the same quality of health care as that available to nonindigents receiving services in private facilities. (*Hunt, supra*, 21 Cal.4th at p. 1014.) Section 17000 also does not mandate that counties provide a Medi-Cal standard of care. (*Cooke v. Superior Court* (1989) 213 Cal.App.3d 401, 411-413.) And the Legislature has made clear that sections 10000, 17000, and 17001 do not compel counties to provide services that are reduced or eliminated from the Medi-Cal program to persons eligible for care under those sections.²³ (§§ 17030, 17030.1.)

The end result is that “the proper care pursuant to section 17000 will, in the case of each treatment or category of treatment, . . . only be established as a result of litigation.” (*Regulatory Takings, supra*, 47 San Diego L.Rev. at p. 160.) We think that any decision on whether HSF’s fee structure results in the denial of services or treatments falling within the County’s section 17000 obligation is best made “in the context of an actual set of facts[.]” (*Pacific Legal Foundation, supra*, 33 Cal.3d at p. 170.) We conclude that after balancing the interests, Petitioners have failed to demonstrate their interests as citizens outweighs the competing considerations identified by the County. (See *Waste Management, supra*, 79 Cal.App.4th at p. 1237.) We therefore decline to

Alford, supra, 151 Cal.App.4th at pp. 23-26 [county adopted inflexible income cap denying all care to residents exceeding cap].)

²³ Although the section 17000 obligation clearly extends at least as far as the provision of “medical services necessary for the treatment of acute life-and-limb-threatening conditions and emergency medical services” (*Hunt, supra*, 21 Cal.4th at p. 1014), the trial court found the record established that the County provided emergency and urgent care without imposing any financial eligibility standards. There is also no dispute that HSF provides a number of other services without payment of POS fees.

make an exception to the ordinary beneficial interest requirement.²⁴ (*Save the Plastic Bag Coalition, supra*, 52 Cal.4th at p. 170, fn. 5.)

Because we conclude Petitioners lack standing, there is no actual or justiciable controversy. (*Clifford S. v. Superior Court* (1995) 38 Cal.App.4th 747, 751.) Since the controversy is nonjusticiable, “the appropriate course is to reverse [the] judgment and to remand the matter to the trial court with directions to dismiss the action. [Citations.] We follow that course here.”²⁵ (*Wilson & Wilson v. City Council of Redwood City* (2011) 191 Cal.App.4th 1559, 1585.)

DISPOSITION

The judgment is reversed, and the matter is remanded to the trial court with instructions to dismiss the action.

²⁴ Since Petitioners have not made a showing of public need with respect to their claims under section 17000 and 17001, we also make no exception to the beneficial interest requirement with respect to their claims under sections 10000, 10500, and 16804.1. Section 10000 requires that care be delivered “promptly and humanely,” and section 10500 mandates that persons administering public assistance programs “endeavor . . . to secure for every person the amount of aid to which he is entitled[.]” Regarding the claim under section 16804.1, subdivision (a), even if we accept Petitioners’ interpretation of the statute, they have not established that DPH in fact requires the advance payment of any fee to indigent persons entitled to receive subsistence medical care under section 17000.

²⁵ In light of our disposition, we deny as moot the parties’ requests for judicial notice.

Jones, P.J.

We concur:

Simons, J.

Bruiniers, J.