

No. 13-_____

In The
Supreme Court of the United States

CALIFORNIA MEDICAL ASSOCIATION, ET AL.,
PETITIONERS,

v.

KATHLEEN SEBELIUS, SECRETARY OF
THE UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES, ET AL.

*ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT*

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

California's Department of Health Care Services formulated new rates at which health-care providers are reimbursed for providing services to Medicaid beneficiaries. It did so without considering studies of the affected health-care providers' service costs, despite Ninth Circuit precedent requiring such cost studies. The federal Centers for Medicare & Medicaid Services ("CMS"), relying on authority delegated to it by the Secretary of the United States Department of Health and Human Services, approved amendments to California's Medicaid program. The Ninth Circuit concluded that CMS's perfunctory approval letter was an implicit interpretation that the federal Medicaid Act did not require States to consider cost studies. The Ninth Circuit gave that implicit interpretation deference under *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), and thus did not follow its own, contrary circuit precedent. Such an implicit and informal agency interpretation would not have been given *Chevron* deference in the First, Second, or Eighth Circuits.

The question presented is:

Whether the Ninth Circuit erred when, in conflict with the First, Second, and Eighth Circuits, it accorded *Chevron* deference to an implicit and informal agency interpretation.

PARTIES TO THE PROCEEDING

Petitioners are California Medical Association, California Hospital Association, California Pharmacists Association, National Association of Chain Drug Stores, California Association of Medical Product Suppliers, California Dental Association, and American Medical Response West. California Hospital Association was the plaintiff-appellee below in case numbers 12-55068 and 12-55331 and a plaintiff-appellant in 12-55535. All other petitioners were plaintiffs-appellees below in case numbers 12-55315 and 12-55335 and plaintiffs-appellants in 12-55550.

AIDS Healthcare Foundation and Jennifer Arnold also were plaintiffs-appellees in case numbers 12-55315 and 12-55335 and plaintiffs-appellants in 12-55550. Individuals identified with the initials G.G., I.F., R.E., A.W., and A.G. also were plaintiffs-appellants below in case number 12-55535. These parties are not petitioners here.

Managed Pharmacy Care; Independent Living Center of Southern California, Inc.; California Foundation for Independent Living Centers; Gerald Shapiro, Pharm D, dba Upton Pharmacy and Gift Shoppe; Sharon Steen, dba Central Pharmacy; Tran Pharmacy, Inc.; Odette Leonelli, dba Kovacs-Frey Pharmacy; Market Pharmacy, Inc.; and Mark Beckwith were plaintiffs-appellees below in case numbers 12-55067 and 12-55332. California Medical Transportation Association, Inc.; GMD Transportation, Inc.;

PARTIES TO THE PROCEEDING—Continued

and Lonny Slocum were plaintiffs-appellees below in case numbers 12-55103 and 12-55334 and plaintiffs-appellants in 12-55554. These parties are petitioners in this Court in case number 13-253.

Respondents are Kathleen Sebelius, Secretary of the United States Department of Health and Human Services, and Toby Douglas, Director of the Department of Health Care Services of the State of California.

CORPORATE DISCLOSURE STATEMENT

California Medical Association, California Hospital Association, California Pharmacists Association, National Association of Chain Drug Stores, California Association of Medical Product Suppliers, and California Dental Association have no parent corporations, and no publicly held company owns 10% or more of their stock.

American Medical Response West has the following parent companies: Envision Healthcare Holdings Inc. (formerly known as CDRT Holding Corporation); Envision Healthcare Corporation (formerly known as Emergency Medical Services Corporation); AMR Holdco Inc.; and American Medical Response, Inc.

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PETITION FOR A WRIT OF CERTIORARI

Petitioners California Medical Association, California Hospital Association, California Pharmacists Association, National Association of Chain Drug Stores, California Association of Medical Product Suppliers, California Dental Association, and American Medical Response West respectfully petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Ninth Circuit.

OPINIONS BELOW

The opinion of the Ninth Circuit (App., *infra*, 1a-45a) is reported at 716 F.3d 1235. The opinion of the district court in *California Medical Association v. Douglas* (App., *infra*, 46a-88a) is reported at 848 F. Supp. 2d 1117. The opinion of the district court in *California Hospital Association v. Douglas* (App., *infra*, 89a-128a) is unreported.

JURISDICTION

The Ninth Circuit issued an opinion on December 13, 2012. Petitioners filed petitions for rehearing en banc. On May 24, 2013, the Ninth Circuit withdrew its December 13, 2012 opinion, issued a superseding opinion, and denied the petitions for rehearing en banc. App., *infra*, 12a-13a.

On August 14, 2013, Justice Kennedy granted an extension of time within which to file a petition for a writ of certiorari to and including September 21, 2013.

This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

Title 42 U.S.C. §§ 1316, 1396a(a)(30); 42 C.F.R. §§ 430.15, 430.16, 430.18; and Section 14105.192 of the California Welfare and Institutions Code are set forth in the appendix to the petition. App., *infra*, 129a-149a.

INTRODUCTION

The courts of appeals are intractably divided over what level of deference courts must give to informal agency interpretations of statutes that the agencies administer.

Three circuits—the First, Second, and Eighth—hold that cursory or implicit statutory interpretations made by an agency outside the context of formal rulemaking or formal adjudication receive deference only under *Skidmore v. Swift & Co.*, 323 U.S. 134 (1944). That is so even where Congress expressly has delegated authority to the agency to promulgate regulations interpreting or implementing the statute. Those circuits hold that if the agency's interpretation is not performed in the exercise of that formal rulemaking or formal adjudicative authority, only *Skidmore* deference is warranted. That is especially true where no meaningful explanation of the agency's interpretation is given.

By contrast, five other circuits—the Third, Fifth, Sixth, Ninth, and D.C.—hold that implicit agency interpretations made by an agency outside a formal rulemaking or adjudicatory process are entitled to deference under *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). In those circuits, as long as the agency is acting pursuant to authority granted by Congress, *Chevron* deference is given. That is so even if the agency’s interpretation is only implicit—i.e., where the court believes the agency must have interpreted the statute in a particular way, even if the agency never explained its interpretation.

The disagreement among the courts of appeals has profound consequences here. This case involves, at best, an implicit interpretation by a regional officer of the federal Centers for Medicare and Medicaid Services (“CMS”), which is a division of the United States Department of Health and Human Services (“HHS”). The CMS officer approved California’s steep cuts to the rates at which many Medicaid providers (e.g., doctors, hospitals, pharmacies, and 911 ambulance providers) are paid for providing services to beneficiaries. California’s reimbursement rates under its state-run Medicaid program, Medi-Cal, already were among the Nation’s lowest. Yet California proposed 10% or steeper cuts for many Medi-Cal service providers.

Having appropriate reimbursement rates in place is critical to ensure Medicaid beneficiary access. Medicaid provides crucial access to health care for some

60 million Americans, nearly 9 million of whom are in California. Medicaid beneficiaries are among the most vulnerable members of society, including needy children and the disabled. Health-care providers are not required, however, to accept Medicaid patients. If Medicaid reimbursement rates are set too low, providers of quality care will drop out of the system. Medicaid beneficiaries therefore will lose sufficient access to quality health-care services.

To prevent that, Congress established a standard in the Medicaid Act for setting Medicaid-provider reimbursement rates. Congress mandated that each State's Medicaid program set payment rates that "are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. § 1396a(a)(30)(A) ("Section 30(A)").

The Secretary of HHS ("Secretary") has never promulgated authoritative rules establishing any particular process that a State must go through to show that its proposed reimbursement rates are sufficient to meet the Section 30(A) standard. That is true despite the Secretary's assurance to this Court in December 2010 that such a formal regulation was forthcoming within a year.

Lacking any guidance from the Secretary, the Ninth Circuit previously had interpreted Section 30(A) as requiring States to set reimbursement rates that "bear a reasonable relationship" to the "costs of

providing quality services.” *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491, 1496 (9th Cir. 1997). The State has “the burden of justifying any rate that substantially deviates from such determined costs.” *Id.* at 1500. The court of appeals held that States “must rely on responsible cost studies” to evaluate provider costs. *Id.* at 1496.

The California Department of Health Care Services (“DHCS”) submitted the State’s reimbursement rate cuts to CMS for approval. It is undisputed, however, that DHCS did not consider any cost studies for most of the categories of service for which DHCS proposed rate cuts. Had it done so, DHCS would have seen that the new payment rates for many services are substantially below the providers’ own costs. Consequently, implementing the cuts likely would drive Medicaid providers out of the program and impede access by beneficiaries to the quality health care required by the Medicaid Act.

Despite DHCS’s failure to consider cost studies, a CMS Associate Regional Administrator—acting under authority delegated by the Secretary—approved the cuts. The approval was in a succinct letter without any discussion of whether cost studies are required under Section 30(A).

Although there was no evidence the CMS Associate Regional Administrator considered whether cost studies were required, the Ninth Circuit concluded that the Secretary necessarily must have interpreted Section 30(A) as not requiring any particular

methodology on the part of States. The Ninth Circuit presumed that the CMS Associate Regional Administrator had rejected the Ninth Circuit’s prior authoritative construction of Section 30(A). The court so concluded even though there was no indication that this supposed interpretation by the CMS Associate Regional Administrator represented the views of the Secretary.

Not only did the Ninth Circuit conclude this represented an implicit “interpretation” of the statute, the court gave that supposed interpretation *Chevron* deference that trumped the court of appeals’ prior precedent. App., *infra*, 27a-28a (citing *National Cable & Telecomms. Ass’n v. Brand X Internet Servs.*, 545 U.S. 967 (2005)). The Ninth Circuit consequently held that CMS’s approval of the new rates was not arbitrary and capricious under the Administrative Procedures Act (“APA”).

Four other circuits—the Third, Fifth, Sixth, and D.C. Circuits—likewise would have given *Chevron* deference to the approval letters. But had this case been brought in the First, Second, or Eighth Circuits, the CMS Regional Administrator’s implicit informal interpretation would have received only *Skidmore* deference. Under the *Skidmore* framework, CMS’s approval would have been arbitrary and capricious (as the district court here held).

Thus, not only is the circuit conflict real and entrenched, it has serious consequences in this case

for millions of Medicaid beneficiaries and thousands of service providers.

The petition should be granted.

STATEMENT OF THE CASE

A. Statutory And Regulatory Framework

1. Medicaid is a federal-state partnership that provides health coverage to nearly 60 million Americans, including children, pregnant women, needy families, the blind, the elderly, and the disabled. States establish and administer their own Medicaid programs and determine the type, amount, duration, and scope of services provided. Medicaid is jointly funded by the federal government and States, with the federal government providing the majority of the financial contribution.

To receive federal funding, States' individualized Medicaid plans must comply with federal law governing matters such as which population groups are entitled to services and what services are provided at what cost. Those requirements are imposed by the Medicaid Act and regulations promulgated by the Secretary.

2. Before a State may modify its Medicaid plan, it must receive federal approval. CMS must review and approve or reject any proposed amendment to a state Medicaid plan. App., *infra*, 18a. Such an amendment is referred to as a State Plan Amendment. *Ibid*.

The ten CMS Regional Administrators review State Plan Amendments under authority delegated to them by the Secretary. *Ibid.*; 42 U.S.C. § 1396a(b); 42 C.F.R. § 430.15(b). The CMS Regional Administrator has 90 days in which to review and either approve or reject a State Plan Amendment. 42 U.S.C. § 1316(a)(1). If the CMS Regional Administrator fails to act within 90 days, the proposed amendment is deemed approved by operation of law. 42 C.F.R. § 430.16(a).

No formal hearing is required when the CMS Regional Administrator approves a State Plan Amendment. *See* 42 C.F.R. § 430.15(b). CMS Regional Administrators approve hundreds of State Plan Amendments each year, generally in perfunctory letters stating simply that the amendment is approved.

By contrast, for rejections, the process is more formal. Only the CMS Administrator (as opposed to one of the Regional Administrators) has authority to disapprove a State Plan Amendment. 42 C.F.R. § 430.15(c)(1). The “Administrator does not make a final determination of disapproval without first consulting the Secretary.” *Id.* § 430.15(c)(2). If the State Plan Amendment is rejected, the State is entitled to petition for reconsideration, and the Secretary is required to conduct a formal adjudication pursuant to the APA. 42 U.S.C. § 1316(a)(2). If the State remains dissatisfied, it may petition for review in the court of appeals for the circuit in which the State is located. *Id.* § 1316(a)(3).

Beneficiaries, providers, and other interested parties have no express opportunity for input unless CMS denies a State Plan Amendment and the State appeals that denial to the Secretary. *See* 42 C.F.R. § 430.18.

3. The Medicaid Act establishes a particular standard that every State's Medicaid plan must meet concerning payment rates to benefit providers (e.g., doctors, hospitals, pharmacies, and 911 ambulance providers) for services provided under the plan. 42 U.S.C. § 1396a(a)(30)(A). Under Section 30(A), a State's Medicaid plan must "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." *Ibid.*

The Secretary has not promulgated any regulation concerning what criteria States must consider under Section 30(A) before setting new provider-reimbursement rates, even though the statute was last amended in 1989.

In the absence of any such regulation, the Ninth Circuit interpreted Section 30(A) in 1997 as requiring States to set reimbursement rates that "bear a reasonable relationship" to the "costs of providing quality services." *Orthopaedic Hospital*, 103 F.3d at 1496. The court of appeals held that States have the "burden of justifying any rate that substantially deviates from such determined costs." *Id.* at 1500. States

“must rely on responsible cost studies” to evaluate provider costs. *Id.* at 1496.

In the more than 16 years since the decision in *Orthopaedic Hospital*, the Secretary has not promulgated any regulation either agreeing or disagreeing with the court of appeals’ interpretation of Section 30(A). That is true despite that, in December 2010, the Secretary “committed to conducting a rulemaking proceeding over the next year that will result in an authoritative interpretation of Section 1396a(a)(30)(A).” Brief for United States as Amicus Curiae at 8, 11, *Maxwell-Jolly v. Independent Living Ctr. of S. Cal., Inc.*, 132 S. Ct. 1204 (2012) (No. 09-958). The Secretary made that commitment in the context of successfully urging this Court to deny review of a question of Section 30(A)’s interpretation. *Maxwell-Jolly v. Independent Living Ctr. of S. Cal., Inc.*, 131 S. Ct. 992 (2011) (granting certiorari only on other question presented).

In 2011, the Secretary did propose, through notice-and-comment rulemaking, a regulation to implement Section 30(A). Medicaid Program; Methods for Assuring Access to Covered Services, 76 Fed. Reg. 26342 (May 6, 2011). The proposed rule, however, has not been implemented. The proposed rule would have required a State to allow interested providers and beneficiaries an opportunity to comment upon proposed provider payment rates if an amendment would reduce those rates. The rule also would have required a State to demonstrate that beneficiaries will continue to have sufficient access to services under the

new rates. *Id.* at 26361. Similar to the Ninth Circuit’s requirement, the proposed rule would require the State’s submission to include data concerning the impact of the new rates on providers, including a comparison of the proposed rates and provider costs. *Ibid.*

B. Factual Background

The California legislature in 2011 enacted legislation authorizing the Director of DHCS (“Director”) to implement a 10% (and in some instances more than 10%) across-the-board rate cut for Medi-Cal fee-for-service benefits. Cal. Welf. & Inst. Code § 14105.192(d)(1). The statute provides that the rate cuts “shall be implemented only if the director determines that the payments that result from the application of this section will comply with applicable federal Medicaid requirements.” *Id.* § 14105.192(m).

Pursuant to that legislation, the Director decided to implement reimbursement-rate cuts for virtually all categories of Medi-Cal services: pharmacy services; durable medical equipment; emergency and non-emergency medical transportation; certain physician, clinic, and dental services; and services provided by distinct-part nursing facilities (i.e., skilled nursing facilities operated by hospitals as distinct parts within those hospitals). App., *infra*, 19a.

DHCS then submitted two State Plan Amendments to CMS for approval of the Medi-Cal cuts. *Ibid.* DHCS submitted reports purporting to demonstrate that the rate cuts would not significantly affect beneficiary

access to health coverage. Even though the Ninth Circuit's interpretation of Section 30(A) required DHCS to consider providers' costs, DHCS's studies "did not review cost data with respect to most of the services subject to the rate reduction." App., *infra*, 19a-20a.

Petitioners were denied an opportunity timely to review the materials submitted by DHCS. C.A. Supp. E.R. 2-8. Once a State Plan Amendment is submitted, negotiations occur exclusively and privately between CMS and the State, and most disputes between CMS and the State are resolved during these negotiations. Petitioners nonetheless submitted comments to CMS explaining that the proposed rate reductions would harm beneficiary access to needed services. App., *infra*, 20a. The comments contained, for example, a report demonstrating that most distinct-part nursing facilities already operate at a loss. *Ibid.*

Notwithstanding DHCS's failure to consider the cost of providing the affected services, the Associate Regional Administrator of the Division of Medicaid & Children's Health Operations for Region IX approved both State Plan Amendments. App., *infra*, 21a, 49a, 91a.

The approval letters were "succinct." App., *infra*, 21a; *see* App., *infra*, 150a-155a. The approval letters stated that the "State was able to provide metrics which adequately demonstrated beneficiary access." App., *infra*, 21a, 151a, 154a. There is no reference in the letters to any interpretation of Section 30(A) adopted by the Secretary. Nor did either letter

provide “any reasons on its face as to why provider costs should not be considered in determining whether the [State Plan Amendment’s] rate reduction will result in lower quality of care or decreased access to services.” App., *infra*, 63a.

The State Plan Amendment approvals did not involve a formal adjudication. App., *infra*, 60a; *see* 42 U.S.C. § 1316(a). There was no opportunity for interested members of the public (including beneficiaries or providers) to brief legal arguments, to be heard at a hearing, to receive reasoned decisions at multiple levels within the agency, or to submit exceptions to those decisions. App., *infra*, 61a; *see* 42 C.F.R. § 430.18. Indeed, there was “no formal decision in which the Secretary set forth her reasoning.” App., *infra*, 61a-62a.

C. Proceedings Below

Petitioners are professional and trade associations representing the interests of Medi-Cal service providers, including physicians, hospitals, pharmacists, national pharmacy chains, dentists, and durable-medical-equipment suppliers. App., *infra*, 47a-48a. Petitioners also include a Medi-Cal provider of emergency-medical-transportation services. App., *infra*, 48a.

Petitioners and other Medi-Cal providers and beneficiaries filed four suits against the Secretary and the Director, challenging the reimbursement-rate reductions. App., *infra*, 21a. Petitioners were plaintiffs in two of those suits. The challengers brought

claims against the Secretary under the APA and against the Director under the Supremacy Clause of the United States Constitution. App., *infra*, 14a.¹

1. Proceedings in the district court

The district court granted preliminary injunctions restraining the Director from implementing the rate cuts and staying the Secretary’s approval of the reductions. App., *infra*, 87a-88a, 127a-128a.

In so concluding, the district court rejected the Secretary’s contention that *Chevron* deference is owed her implicit interpretation that Section 30(A) does not require cost studies. The district court explained it was “significant that the Secretary’s approval of [the State Plan Amendments] did not involve a formal adjudication accompanied by the procedural safeguards justifying *Chevron* deference.” App., *infra*, 60a-61a, 102a. “[T]here was no hearing, no record, no opportunity for interested parties to present evidence, and

¹ The issue here is distinct from that reviewed in *Douglas v. Independent Living Center of Southern California, Inc.*, 132 S. Ct. 1204 (2012). There, the question presented was whether Medicaid recipients and providers may maintain a cause of action under the Supremacy Clause to enforce Section 30(A) by asserting that the provision preempts a state law reducing reimbursement rates. The Ninth Circuit did not reach the Supremacy Clause issue in this case. App., *infra*, 41a-43a. It is not presented here. Moreover, unlike *Douglas*, this case involves an APA action against the Secretary for which there indisputably is a private right of action. See *Douglas*, 132 S. Ct. at 1210 (“respondents’ basic challenge now presents the kind of legal question that ordinarily calls for APA review”).

no formal decision in which the Secretary set forth her reasoning.” App., *infra*, 61a-62a, 102a-103a.

Having concluded *Chevron* deference was inappropriate, the district court declined to follow the implicit interpretation of the approval letters because that “proffered interpretation directly contradicts the law in the Ninth Circuit.” App., *infra*, 65a, 106a. Under that law, “because CMS failed to consider whether DHCS relied on responsible cost studies,” the district court held that “CMS failed to consider a relevant factor.” App., *infra*, 66a, 107a.

Finding that there thus was a strong probability that the approval of the State Plan Amendments would be found to be arbitrary and capricious, and considering the balance of hardships, the district court issued preliminary injunctions. App., *infra*, 66a, 107a.

2. *Proceedings in the Ninth Circuit*

The Ninth Circuit vacated the injunctions. The court acknowledged that DHCS “did not review cost data with respect to most of the services subject to the rate reduction,” as required by the Ninth Circuit’s decision in *Orthopaedic Hospital*. App., *infra*, 20a. Nevertheless, the court held that “*Orthopaedic Hospital* does not control the outcome in these cases.” App., *infra*, 15a. Instead, the court held that the “succinct” approval letters were entitled to controlling deference under *Chevron*, and thus trumped the circuit’s own previous interpretation of the statute. App., *infra*, 27a-38a.

The Ninth Circuit granted *Chevron* deference even though the approval letters contained no explicit interpretation of Section 30(A). The court reasoned that “the Secretary has now set forth her interpretation, through her approvals of the [State Plan Amendments], that § 30(A) does not prescribe any particular methodology a State must follow before its proposed rates may be approved.” App., *infra*, 27a.

The court acknowledged that State Plan Amendment approvals lack any procedural formality. “When the Secretary disapproves a proposed plan amendment, a State has the ‘opportunities to petition for reconsideration, brief its arguments, be heard at a formal hearing, receive reasoned decisions at multiple levels of review, and submit exceptions to those decisions.’” App., *infra*, 31a (citation omitted). By contrast, for State Plan Amendment approvals, “the Medicaid program does not provide interested parties with similar opportunities.” *Ibid.* Nevertheless, the court held that, “despite the lack of formal procedures available for interested parties, the Secretary’s exercise of discretion in the ‘form and context’ of a [State Plan Amendment] approval deserves *Chevron* deference.” App., *infra*, 33a.

REASONS FOR GRANTING THE PETITION

THE LEVEL OF DEFERENCE OWED AN AGENCY'S IMPLICIT, INFORMAL STATUTORY INTERPRETATION IS AN IMPORTANT QUESTION DIVIDING THE COURTS OF APPEALS

This case presents a straightforward but important legal question of agency deference that has sharply divided the courts of appeals. Three circuits would apply only *Skidmore* deference to the CMS Regional Administrator's implicit interpretation of Section 30(A) here. Five other circuits would give *Chevron* deference to the mere act of approving the State Plan Amendment, whether or not accompanied by an express meaningful explanation of the agency's interpretation of the statute.

This Court's review of the question presented is needed now. The appropriate level of deference has enormous consequences for millions of Medicaid beneficiaries and providers in this case alone. And outside the Medicaid context, the level of formality required to warrant *Chevron* deference is an important, recurring question. This case is an ideal vehicle for the Court to decide the issue. The petition should be granted.

A. The Courts Of Appeals Are Intractably Divided Over The Level Of Deference Owed Informal Agency Interpretations Of Statutes That The Agency Is Charged With Administering

The courts of appeals are in conflict about the measure of deference owed to cursory agency approvals. This significant divide shows no sign of resolving itself. Rather, it is well developed and ripe for this Court to intervene.

1. Unlike the Ninth Circuit here, three circuits accord only *Skidmore* deference to informal agency interpretations with *perfunctory* reasoning

The First, Second, and Eighth Circuits grant only *Skidmore* deference to informal agency approvals or interpretations. This is so even where Congress delegated authority to interpret the statute at issue. The question these circuits consider is whether the agency exercised that authority pursuant to procedures “tending to foster the fairness and deliberation that should underlie a pronouncement of such force.” *United States v. Mead Corp.*, 533 U.S. 218, 230 (2001).

a. For example, in *Estate of Landers v. Leavitt*, the Second Circuit refused to extend *Chevron* deference to an informal CMS interpretation of a Medicare statute. 545 F.3d 98, 105-107 (2d Cir. 2008). There, CMS had set forth its interpretation in an agency manual, and it expressly had applied that

interpretation in denying Medicare benefits to three beneficiaries. *Id.* at 104.

The Second Circuit acknowledged that Congress had delegated rulemaking authority to the Secretary. *Id.* at 105. But the court concluded that was only “the first half” of the test for *Chevron* deference. *Ibid.* Examining the nature of CMS’s interpretation, the court concluded it was insufficiently formal to receive *Chevron* deference. *Id.* at 105-107. The court explained that “agency manuals, as a class, are generally ineligible for *Chevron* deference.” *Id.* at 106 (citing *Mead*, 533 U.S. at 234). Instead, the Second Circuit construed the statute in the first instance, giving only *Skidmore* deference. *Id.* at 108-111.

Similarly, in *Rabin v. Wilson-Coker*, the Second Circuit considered how much deference to give CMS’s interpretation of a provision of the Medicaid Act. 362 F.3d 190, 198 (2d Cir. 2004). CMS’s interpretation had been “stated or implied in several different sources, none of which is a published regulation.” *Id.* at 197. The State in that case sought “a heightened and all but conclusive deference to CMS’s interpretation,” arguing that Congress had re-enacted the statute without change subsequent to CMS’s interpretation. *Ibid.* The Second Circuit refused to accord such deference, in part because of an unwillingness to “assume Congress’s awareness of an administrative interpretation that does not result from notice and comment rulemaking.” *Ibid.*

Instead, the Second Circuit held that the level of deference owed the agency's interpretation depended on "the agency's expertise, the care it took in reaching its conclusions, the formality with which it promulgates its interpretations, the consistency of its views over time, and the ultimate persuasiveness of its arguments." *Id.* at 198 (quoting *Community Health Ctr. v. Wilson-Coker*, 311 F.3d 132, 138 (2d Cir. 2002) (citing *Mead*, 533 U.S. at 234-235)).

Considering those factors, the Second Circuit declined to adopt CMS's interpretation and instead interpreted the statute itself. *Id.* at 198-200. The court observed that "[t]he formality of CMS's interpretation is at an intermediate level between a published recommendation and an interpretation advanced only in litigation." *Id.* at 198. Moreover, "there is no indication in the record of the process through which CMS arrived at its interpretation." *Ibid.* There also was no evidence CMS took into account a contrary appellate interpretation. *Ibid.* The Second Circuit explained it therefore could not "say with confidence that CMS's interpretation came about as the result of a reasoned process." *Ibid.* See also *Sai Kwan Wong v. Doar*, 571 F.3d 247, 258-259 (2d Cir. 2009) (according *Skidmore* deference to informal CMS interpretation where the agency had not exercised its rulemaking authority); *Natural Res. Def. Council, Inc. v. FAA*, 564 F.3d 549, 564 (2d Cir. 2009) (refusing to extend *Chevron* deference to agency interpretive orders where interpretation was not set forth in promulgated regulation through formal rulemaking).

b. Similarly, the Eighth Circuit does not extend *Chevron* deference to perfunctory interpretations by CMS administrators.

In *Kai v. Ross*, the Eighth Circuit refused to accord *Chevron* deference to a letter from an Associate Regional Administrator of the Health Care Financing Administration, now known as CMS. 336 F.3d 650, 655 & n.1 (8th Cir. 2003). The letter set forth a statutory interpretation under which the plaintiffs were ineligible for benefits. *Ibid.* In refusing to accord *Chevron* deference, the Eighth Circuit reasoned that “the letter is not a regulation of the Department of Health and Human Services, nor is it part of generally published advice, for example, a practice manual distributed nationwide.” *Ibid.* Rather, “[i]t is simply a letter from the Associate Administrator of the region of Health Care Financing Administration of which Nebraska is a part.” *Ibid.*

The Eighth Circuit explained: “We should consider it respectfully, and, indeed, we have done so, but it is worth no more than its inherent persuasive value.” *Ibid.* (citing *Skidmore*, 323 U.S. at 140). Applying *Skidmore*, the court concluded that the letter was not persuasive and was therefore entitled to “no legal weight.” *Ibid.*

c. The First Circuit likewise has accorded only *Skidmore* deference to CMS’s implicit interpretation of the Medicaid Act made in the context of administrative approvals.

In *Bryson v. Shumway*, the plaintiffs challenged a state Medicaid program that CMS had approved through a statutory waiver provision. 308 F.3d 79, 82-83 (1st Cir. 2002). Like an approval of a State Plan Amendment, no formal process is required for CMS to approve a waiver request. *Id.* at 82. The plaintiffs argued that the challenged approval violated the waiver provision of the Medicaid Act because the waiver did not accommodate at least 200 individuals. *Id.* at 84-85. The First Circuit rejected the plaintiffs' view as not the best reading of either the statutory language or the relevant regulation promulgated by the agency. *Id.* at 85-87.

Of significance here, the First Circuit also looked to the fact that CMS had "approved waiver plans that anticipate serving fewer than 200 individuals, such as the plan at issue" there. *Id.* at 87. But in contrast to the regulation, which the First Circuit gave *Chevron* deference, *id.* at 86-87, the court reasoned: "[b]ecause the approval process did not utilize formal procedures, it may not be entitled to *Chevron* deference, but there remains the deference owed agencies due to their 'specialized experience.'" *Id.* at 87 (citation omitted).

2. Five circuits give Chevron deference to implicit agency interpretations made in the course of routine approvals of state plans

On the other side of the divide, the Third, Fifth, Sixth, Ninth, and D.C. Circuits have interpreted this

Court's precedents to allow *Chevron* deference to informal agency actions. They have so held even where there is little or no evidence of agency deliberation, and in some cases no explicit agency interpretation at all.

a. The D.C. Circuit accords *Chevron* deference to a statutory interpretation implicit in a CMS Regional Administrator's approval of a State Plan Amendment. *Pharmaceutical Research & Mfrs. of Am. v. Thompson* ("*PhRMA*"), 362 F.3d 817, 821-822 (D.C. Cir. 2004).

According to the D.C. Circuit, because "Congress expressly conferred on the Secretary authority to review and approve state Medicaid plans," that conferral manifests Congress' "intent that the Secretary's determinations, based on interpretation of the relevant statutory provisions, should have the force of law." *Id.* at 822. The court rejected an argument that *Chevron* deference should not apply because implicit statutory interpretations in State Plan Amendment approvals "are not the result of a formal administrative process, do not involve agency expertise," and are akin to interpretations contained in agency policy statements and manuals. *Id.* at 821.

b. Relying on the D.C. Circuit's decision in *PhRMA*, the Fifth Circuit similarly accords *Chevron* deference to CMS approvals of state Medicaid proposals, despite the cursory nature of the approvals.

In *S.D. ex rel. Dickson v. Hood*, the Fifth Circuit held that a CMS Regional Administrator's approval of

a State Plan Amendment is “an implicit interpretation of the [Medicaid] Act,” which is entitled to *Chevron* deference. 391 F.3d 581, 595-596 & n.13 (5th Cir. 2004). The court explained that CMS’s previous “approval of state plans affording coverage for the provision of incontinence supplies as a proper cost of home health care services demonstrates that the agency construes § 1396d(a)(7) as encompassing that type of medical care or service.” *Id.* at 596 (citing *PhRMA*, 362 F.3d at 821-822). Accordingly, the court deferred to that implicit interpretation under *Chevron*, concluding that the statutory term “home health care services” must be construed to include incontinence supplies. *Ibid.*

c. Likewise relying on the D.C. Circuit, the Sixth Circuit gives *Chevron* deference to statutory constructions made implicitly in the course of CMS’s routine review of State Plan Amendments.

In *Harris v. Olszewski*, CMS reviewed and approved Michigan’s proposal to use a single-source contract for providing incontinence products to all Medicaid recipients in Michigan. 442 F.3d 456, 460, 467 (6th Cir. 2006). The Medicaid Act normally proscribes such contracts under a freedom-of-choice provision requiring States to allow eligible individuals to obtain medical assistance from any qualified provider. *Id.* at 460. But that provision contains an exception for “medical devices.” *Id.* at 465-466.

The Sixth Circuit concluded that by approving Michigan’s single-source contract, CMS must have

interpreted the “medical devices” exception to encompass incontinence products. *Id.* at 467. The court explained CMS “was required to find that the amendment satisfied all statutory requirements.” *Ibid.* In carrying out its duties, CMS “was exercising Congress’s express delegation of specific interpretive authority, and accordingly the agency’s approval of the state plan amendment is entitled to *Chevron* deference.” *Ibid.* (citation and internal quotation marks omitted) (citing *PhRMA*, 362 F.3d at 821; *S.D.*, 391 F.3d at 596). The Sixth Circuit expressly rejected the notion that the lack of administrative formality precluded *Chevron* deference. *Id.* at 470.

d. In the decision below, the Ninth Circuit joined the D.C., Fifth, and Sixth Circuits, expressly “agree[ing] with the D.C. Circuit’s reasoning” in *PhRMA*. App., *infra*, 34a-35a.

The Ninth Circuit concluded that the “Secretary has now set forth her interpretation, through her approvals of the [State Plan Amendments].” App., *infra*, 27a. The court acknowledged that those approval letters were “succinct” and that there was a “lack of formal procedures available for interested parties.” App., *infra*, 21a, 33a. Indeed, the interpretations were purely implicit: the CMS Associate Regional Administrator gave no explanation for her interpretation of the Medicaid Act, nor was there any indication that this represented the views of the Secretary. The approval of the State Plan Amendments did nothing more than implicitly reject the Ninth Circuit’s prior settled construction; they offered no alternative

construction of the statute. App., *infra*, 63a. Nevertheless, the court held that *Chevron* deference was warranted.

e. Finally, the Third Circuit recently followed the decision in this case, purporting to accord *Chevron* deference to an agency interpretation of the Medicaid Act “inherent” in CMS’s approval of a State Plan Amendment, while nevertheless holding that approval arbitrary and capricious. *Christ the King Manor, Inc. v. Secretary, U.S. Dep’t of Health & Human Servs.*, Nos. 12-3401, 12-3501, slip op. at 25-44 (3d Cir. Sept. 19, 2013).

In *Christ the King Manor*, the Third Circuit reviewed a challenge to CMS’s approval of a State Plan Amendment that adjusted Pennsylvania’s method for determining Medicaid reimbursement rates to private nursing facilities. *Id.* at 5. Turning first to the level of deference, the Third Circuit acknowledged that any interpretation in the approval was merely “inherent.” *Id.* at 26. Nevertheless, the court analyzed that interpretation under the *Chevron* framework, reasoning that “Congress delegated to the agency the responsibility to make interpretive decisions regarding which state plans satisfy the [Medicaid] Act’s requirements.” *Id.* at 28.

The Third Circuit then held that CMS’s inherent interpretation in that case was “not a ‘permissible construction of the statute’ entitled to deference under *Chevron*.” *Id.* at 41. Because CMS’s interpretation was only inherent, the Third Circuit had to infer the interpretation by “examin[ing] the record [CMS]

had before it during the SPA approval process.” *Id.* at 32. The court of appeals noted that the “record [wa]s remarkably thin” regarding the State’s proposed rate methodology. *Id.* at 32-33. The court of appeals concluded that “[t]here is no indication that the agency ‘examine[d] the relevant data,’ nor did it ‘articulate a satisfactory explanation for its action.’” *Id.* at 44. The court thus held the agency’s approval arbitrary and capricious. *Ibid.*

3. *The conflict is substantial and often outcome-determinative*

The courts of appeals’ disagreement over the appropriate level of deference is established, developed, and entrenched—and often, as here, outcome determinative. This Court’s review is warranted.

a. The outcome of this case would have been different in the First, Second, and Eighth Circuits.

Had the State Plan Amendment here been proposed by New York, the informality of the interpretation, as well as the lack of any “indication in the record of the process through which CMS arrived at its interpretation,” would have meant only *Skidmore* deference would have applied. *Rabin*, 362 F.3d at 198. Indeed, the Second Circuit has explained that the type of “nonprecedential letter ruling” here is even less formal than an interpretation in an agency manual, which is itself “‘beyond the *Chevron* pale.’” *Estate of Landers*, 545 F.3d at 106, 110 (quoting *Mead*, 533 U.S. at 234).

Likewise, had it been Nebraska's State Plan Amendment, no *Chevron* deference would have been accorded the letter from the Associate Regional Administrator because it "is not a regulation of the Department of Health and Human Services." *Kai*, 336 F.3d at 655.

Finally, had the State Plan Amendment been proposed by Massachusetts, the CMS Regional Administrator's approval would not have received *Chevron* deference. The mere fact of approval is not enough in the First Circuit where, as here, "the approval process did not utilize formal procedures." *Bryson*, 308 F.3d at 87.

b. One need look no further than this case to see the effect of applying the different deference standards. The merits of the APA claims here turn entirely on the question presented.

Applying *Skidmore* deference, the district court held that the CMS Regional Administrator's approval was arbitrary and capricious. App., *infra*, 66a. Under *Skidmore*, the CMS Regional Administrator's implicit interpretation of Section 30(A) was not entitled to controlling weight and could not trump prior Ninth Circuit precedent. App., *infra*, 65a. Under that governing precedent, the State's consideration of responsible cost studies is a requisite to approval of a State Plan Amendment that proposes to cut provider reimbursement rates. App., *infra*, 66a. CMS's failure to consider the lack of cost studies thus "entirely failed to consider an important aspect of the problem" and

constituted arbitrary and capricious agency action. *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983); see 5 U.S.C. § 706(2)(A).

By contrast, the Ninth Circuit applied the *Chevron* framework, and the result was the opposite. Deferring to the agency, the Ninth Circuit held that the State Plan Amendment approval was *not* arbitrary and capricious because under the CMS Associate Regional Administrator's implicit interpretation, consideration of cost studies is unnecessary. But for the Ninth Circuit's application of *Chevron*, prior Circuit precedent would have foreclosed that conclusion. As this Court explained in *Brand X*, an agency lacks discretion to interpret a statute differently from a pre-existing judicial decision "as to agency interpretations to which *Chevron* is inapplicable." 545 U.S. at 983. As to those interpretations, "the court's prior ruling remains binding law." *Ibid*.

B. This Issue Is Important And Recurring

The issue presented in this case is too consequential to let it percolate. The lower courts are in disarray regarding the level of deference that should be given routine, informal agency approvals. Yet the choice between *Chevron* and *Skidmore* deference can make an enormous difference. In this case alone, the deference issue decided the outcome, thereby impacting millions of individuals' access to health care.

1. CMS's approval of a State Plan Amendment is a routine, commonplace event. Over just the past four years, CMS Regional Administrators approved

over 1300 State Plan Amendments.² Simply by virtue of the sheer volume of State Plan Amendments that are processed by local CMS offices, the Ninth Circuit's decision has the result of potentially bestowing *Chevron* deference on hundreds of decisions by mid-level CMS personnel each year. Each approval decision can be of critical importance to Medicaid beneficiaries and providers, affecting access to needed medical care for impoverished residents. The sheer frequency with which CMS reviews and approves changes to state Medicaid plans makes it extremely important to have a settled understanding of the effects of those choices.

The significance becomes all the more clear once one understands the import of even a single State Plan Amendment. Between both the federal and state contributions, Medi-Cal alone is a nearly \$70 billion program.³ The State Plan Amendments here implement 10% (or greater) cuts for many services. Accordingly, literally billions of dollars ride on the issue presented in just this single case. And the number of beneficiaries that could be affected is staggering; there are nearly 9 million beneficiaries of Medi-Cal. That is not to mention the impact on doctors, hospitals, and other employees in the healthcare industry.

² <http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Plan-Amendments/Medicaid-State-Plan-Amendments.html>.

³ http://www.dhcs.ca.gov/dataandstats/reports/mceestimates/Documents/2013_May_Estimate/May_2013_Approp_Changes.pdf.

Ultimately at stake here is the ability of Medi-Cal beneficiaries to access quality services. Medicaid payment rates are closely linked with the willingness of physicians to serve Medi-Cal beneficiaries. See Steven Zuckerman, et al., *Health Affairs, Trends: Changes in Medicaid Physician Fees, 1998-2003: Implications for Physician Participation* (June 2004).⁴ Yet numerous medical specialists, including pediatric surgeons, obstetricians and gynecologists, otolaryngologists, and dentists all have reported that the actual cost of providing care is already well above what Medi-Cal reimburses for their services. See *Clayworth v. Bonta*, 295 F. Supp. 2d 1110, 1116 n.5 (E.D. Cal. 2003) (finding Medi-Cal reimbursement rates for Ob/Gyn services set below provider costs), *rev'd on other grounds*, 140 F. App'x 677 (9th Cir. 2005); David Skaggs, et al., *Access to Orthopedic Care for Children with Medicaid Versus Private Insurance in California*, 107 Pediatrics 1405, 1406 (2001) (finding that cost of treatment by pediatric orthopedic surgeon exceeded Medi-Cal reimbursement); Evan Halper, *Further Fee Cuts Force a Medi-Cal Exodus: Doctors are Rejecting New Patients*, L.A. Times, Mar. 24, 2008 (reporting Medi-Cal reimbursement for tonsillectomies is insufficient to cover surgical costs).⁵

⁴ Available at <http://content.healthaffairs.org/content/early/2004/06/23/hlthaff.w4.374.full.pdf>.

⁵ Available at <http://articles.latimes.com/2008/mar/24/local/me-medical24>.

Indeed, California already suffers from a critically low provider-to-beneficiary ratio: there are only 46 primary-care providers for every 100,000 beneficiaries in the State, well below the commonly cited minimum guideline of 60 to 80 providers per 100,000 people. California HealthCare Foundation, *California Health Care Almanac: Medi-Cal Facts and Figures 52* (2009).⁶ Moreover, rates of participation in Medi-Cal are even lower among medical and surgical specialists. *Ibid.* “The supply of physicians available to Medi-Cal patients is significantly less than that available to the general population.” Andrew B. Bindman, et al., *California HealthCare Foundation, Physician Participation in Medi-Cal, 2008*, at 14 (2010).⁷ More broadly, a recent study conducted by the Government Accountability Office indicated that 95% of physicians who have opted out of participating in Medicaid cite low reimbursement rates as a reason. Government Accountability Office, *Report GAO-11-624, Medicaid and CHIP: Most Physicians Serve Covered Children But Have Difficulty Referring Them for Specialty Care* 18 (2011).⁸

Delaying resolution of the question presented would therefore needlessly hinder access to health care for millions of the most vulnerable citizens. It is

⁶ Available at <http://www.chcf.org/publications/2009/09/medical-facts-and-figures>.

⁷ Available at <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/P/PDF%20PhysicianParticipationMediCal2008.pdf>.

⁸ Available at <http://www.gao.gov/assets/330/320559.pdf>.

therefore critical that the deference issue be decided now, and in this case.

2. Because of the conflict among the circuits, the effect of even a single regional officer's agency actions will vary geographically. CMS Regional Administrators make the decision to approve or disapprove a State Plan Amendment. But the geographic jurisdiction of CMS's regional offices is not aligned with that of the federal circuits. For example, CMS Region 6 is responsible for reviewing State Plan Amendments submitted by Arkansas, Louisiana, New Mexico, Oklahoma, and Texas.⁹ The federal courts in those same States are governed by one of the Fifth, Eighth, or Tenth Circuits—and at least two of these circuits have conflicting views about the deference owed to implicit agency “interpretations” like those issued through State Plan Amendment approvals. *See supra* pp. 21, 23-24.

This means that the same regional officer, applying the same interpretation and using the same procedures, may receive different levels of deference depending on which State's amendment she is reviewing and where her actions are challenged. Particularly because Medicaid is a federal-state cooperative, this disparity in treatment undermines the effectiveness of the program. This Court should establish much needed uniformity now.

⁹ <http://www.cms.gov/About-CMS/Agency-Information/RegionalOffices/Downloads/DallasRegionalOffice.pdf>.

C. The Ninth Circuit's Decision Is Incorrect

The decision below not only exacerbates a circuit conflict, the Ninth Circuit also chose the wrong side of the divide. The decision below incorrectly granted *Chevron* deference to agency action that does not warrant it.

1. “*Chevron* deference * * * is not accorded merely because the statute is ambiguous and an administrative official is involved.” *Gonzales v. Oregon*, 546 U.S. 243, 258 (2006). Nor is it enough that Congress “delegated authority to the agency generally to make rules carrying the force of law.” *Mead*, 533 U.S. at 226-227. Rather, the agency interpretation at issue also must have been “promulgated in the exercise of that authority.” *Id.* at 227.

Here, although Congress has given the Secretary authority to issue regulations implementing the Medicaid Act and having the force of law, that authority has not been exercised. The Secretary committed in 2010 that within a year she would exercise that authority and issue a definitive interpretation of Section 30(A). She announced a proposed rule in the Federal Register and elicited comments. But no rule having the force of law has been promulgated. All that happened here was approval by a CMS Associate Regional Administrator of a State Plan Amendment in a perfunctory letter without any statement of how the agency views Section 30(A).

Such an approval is a routine event that occurs hundreds of times each year.¹⁰ Each approval governs only the specific application at hand. 42 C.F.R. §§ 430.15, 430.16. The process used to approve State Plan Amendments is “cursory at best.” *AMISUB (PSL), Inc. v. Colorado Dep’t of Soc. Servs.*, 879 F.2d 789, 794 (10th Cir. 1989). Indeed, since approvals are not intended to have precedential value, approvals are not published or made readily available in any accessible form to the public or the participating States.

The Ninth Circuit was wrong to conclude that such approvals are worthy of the same level of deference as the Secretary’s *disapproval* of a State Plan Amendment. App., *infra*, 31a. A disapproval affords a State and other affected parties “‘opportunities to petition for reconsideration, brief its arguments, be heard at a formal hearing, receive reasoned decisions at multiple levels of review, and submit exceptions to those decisions.’” *Ibid.* (quoting *Alaska Dep’t of Health & Soc. Servs. v. Centers for Medicare & Medicaid Servs.*, 424 F.3d 931, 939 (9th Cir. 2005)). In “the

¹⁰ For example, for the approximate two-year period from June 1, 2009 through July 31, 2011, CMS approved 640 State Plan Amendments. Centers for Medicare & Medicaid Services, Medicaid State Plan Amendments, <https://www.cms.gov/MedicaidGenInfo/StatePlan/list.asp> (accessed July 11, 2011). During that same period, there were only four state requests for reconsideration. 74 Fed. Reg. 29703 (June 23, 2009); 75 Fed. Reg. 80058 (Dec. 21, 2010); 76 Fed. Reg. 34711 (June 14, 2011); 76 Fed. Reg. 44591 (July 26, 2011).

case of an approval, however, the Medicaid program does not provide interested parties with similar opportunities.” *Ibid.*

As such, a disapproval has far more of the hallmarks of an agency interpretation meriting *Chevron* deference. *Mead*, 533 U.S. at 229-231. “It is fair to assume generally that Congress contemplates administrative action with the effect of law when it provides for a relatively formal administrative procedure tending to foster the fairness and deliberation that should underlie a pronouncement of such force.” *Id.* at 230. No such formal process occurred here.

2. To be sure, this Court in certain specific circumstances has “found reasons for *Chevron* deference even when no such administrative formality was required and none was afforded.” *Id.* at 231. But that requires an indication that Congress and the agency intended the pronouncements to have the “force of law.” *Id.* at 232. Determining whether agency action satisfies this test “depends in significant part upon the interpretive method used and the nature of the question at issue.” *Barnhart v. Walton*, 535 U.S. 212, 222 (2002). It requires, at a minimum, “the legislative type of activity that would naturally bind more than the parties to the ruling.” *Mead*, 533 U.S. at 232.

There is no statutory indication that Congress intended approval of State Plan Amendments by CMS Regional Administrators to have the force of law and to be binding on anyone other than the State. The statute governing State Plan Amendment

approvals provides simply that “[w]henver a State plan is submitted to the Secretary by a State for approval * * * , [she] shall, not later than 90 days after the date the plan is submitted to [her], make a determination as to whether it conforms to the requirements for approval under such subchapter.” 42 U.S.C. § 1316(a)(1). Nothing in that text demonstrates any congressional intent for State Plan Amendment approvals to have the effect of making new law to implement the Medicaid Act.

Nor is there “in the agency practice itself any indication” that CMS “ever set out with a lawmaking pretense in mind when it undertook” to review the State Plan Amendments. *Mead*, 533 U.S. at 233. There is no indication on the face of the approval letters here that CMS even considered, much less adopted, any particular interpretation of Section 30(A). The only purported interpretation of Section 30(A) is an implicit one inferred by the Ninth Circuit. That inference amounts to nothing more than a presumed rejection of the court of appeals’ prior settled statutory interpretation; it contains no affirmative interpretation of the statute’s intended meaning or proper application.

There was no process involving “fairness and deliberation” concerning the interpretation of Section 30(A). *Id.* at 230. There was no opportunity for interested parties to be heard or to petition for review at higher levels within the agency. Nor was there even a reasoned opinion or statement explaining the approval or the interpretation.

In short, “the agency did not engage in rulemaking procedures, it did not carefully consider differing points of view of those affected, it did not set forth its views in a manual intended for widespread use, nor has it in any other way announced an interpretation that Congress would have ‘intended * * * to carry the force of law.’” *Wos v. E.M.A. ex rel. Johnson*, 133 S. Ct. 1391, 1403 (2013) (Breyer, J., concurring) (quoting *Mead*, 533 U.S. at 221).

Indeed, the supposed interpretation of Section 30(A) here has even fewer signs of a legal pronouncement having the force of law than an interpretation set forth in an agency’s opinion letter or manual. At least with respect to policy statements, agency manuals, and enforcement guidelines, the agency’s interpretation actually is set forth in writing. Yet interpretations in those settings are not entitled to *Chevron* deference. *Christensen v. Harris County*, 529 U.S. 576, 587 (2000); see *Wos*, 133 S. Ct. at 1402.

The same should be true here. An interpretation that must be inferred from a letter that was issued with no procedural protections or formality whatsoever is the antithesis of a pronouncement having the force of law. It is “beyond the *Chevron* pale.” *Mead*, 533 U.S. at 234. If it were otherwise, agencies might avoid promulgating regulations altogether. Such a result would severely undermine “the notice and predictability” to regulated parties that formal rulemaking is meant to promote. *Christopher v. SmithKline Beecham Corp.*, 132 S. Ct. 2156, 2168 (2012) (quoting *Talk Am., Inc. v. Michigan Bell Tel.*

Co., 131 S. Ct. 2254, 2266 (2011) (Scalia, J., concurring)).

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX A

FOR PUBLICATION

**UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT**

MANAGED PHARMACY CARE, a California corporation; INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC., a California corporation; CALIFORNIA FOUNDATION FOR INDEPENDENT LIVING CENTERS, a California corporation; GERALD SHAPIRO, PHARM D, DBA Upton Pharmacy and Gift Shoppe; SHARON STEEN, DBA Central Pharmacy; TRAN PHARMACY, INC., a California corporation, DBA Tran Pharmacy; ODETTE LEONELLI, DBA Kovacs-Frey Pharmacy; MARKET PHARMACY, INC., DBA Market Pharmacy; MARK BECKWITH,

Plaintiffs-Appellees,

v.

KATHLEEN SEBELIUS, Secretary of the United States Department of Health and Human Services,

Defendant,

and

TOBY DOUGLAS, Director of the Department of Health Care Services of the State of California,

Defendant-Appellant.

No. 12-55067

D.C. No.

2:11-cv-09211-
CAS-MAN

CALIFORNIA HOSPITAL ASSOCIATION,
Plaintiff-Appellee,

v.

TOBY DOUGLAS, Director of the
Department of Health Care
Services of the State of California,

Defendant-Appellant,

and

KATHLEEN SEBELIUS, Secretary of
the United States Department of
Health and Human Services,

Defendant.

No. 12-55068

D.C. No.
2:11-cv-09078-
CAS-MAN

CALIFORNIA MEDICAL
TRANSPORTATION ASSOCIATION, INC.,
a California corporation;
GMD TRANSPORTATION, INC.,
a California corporation;
LONNY SLOCUM, an individual,

Plaintiffs-Appellees,

v.

TOBY DOUGLAS, Director of the
Department of Health Care
Services of the State of California,

Defendant-Appellant,

and

KATHLEEN SEBELIUS, Secretary of
the United States Department of
Health and Human Services,

Defendant.

No. 12-55103

D.C. No.
2:11-cv-09830-
CAS-MAN

CALIFORNIA MEDICAL ASSOCIATION;
CALIFORNIA DENTAL ASSOCIATION;
CALIFORNIA PHARMACISTS ASSOCIATION;
NATIONAL ASSOCIATION OF CHAIN
DRUG STORES; CALIFORNIA
ASSOCIATION OF MEDICAL PRODUCT
SUPPLIERS; AIDS HEALTHCARE
FOUNDATION; AMERICAN MEDICAL
RESPONSE WEST; JENNIFER ARNOLD,

Plaintiffs-Appellees,

v.

TOBY DOUGLAS, Director of the
Department of Health Care
Services of the State of California,

Defendant-Appellant,

and

KATHLEEN SEBELIUS, Secretary of
the United States Department of
Health and Human Services,

Defendant.

No. 12-55315

D.C. No.
2:11-cv-09688-
CAS-MAN

CALIFORNIA HOSPITAL ASSOCIATION,
Plaintiff-Appellee,

v.

TOBY DOUGLAS, Director of the
Department of Health Care
Services of the State of California,
Defendant,

and

KATHLEEN SEBELIUS, Secretary of
the United States Department of
Health and Human Services,
Defendant-Appellant.

No. 12-55331

D.C. No.
2:11-cv-09078-
CAS-MAN

MANAGED PHARMACY CARE, a California corporation; INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC., a California corporation; CALIFORNIA FOUNDATION FOR INDEPENDENT LIVING CENTERS, a California corporation; GERALD SHAPIRO, PHARM D, DBA Upton Pharmacy and Gift Shoppe; SHARON STEEN, DBA Central Pharmacy; TRAN PHARMACY, INC., a California corporation, DBA Tran Pharmacy; ODETTE LEONELLI, DBA Kovacs-Frey Pharmacy; MARKET PHARMACY, INC., DBA Market Pharmacy; MARK BECKWITH,

Plaintiffs-Appellees,

v.

KATHLEEN SEBELIUS, Secretary of the United States Department of Health and Human Services,

Defendant-Appellant,

and

TOBY DOUGLAS, Director of the Department of Health Care Services of the State of California,

Defendant.

No. 12-55332

D.C. No.

2:11-cv-09211-
CAS-MAN

CALIFORNIA MEDICAL
TRANSPORTATION ASSOCIATION, INC.,
a California corporation;
GMD TRANSPORTATION, INC.,
a California corporation;
LONNY SLOCUM, an individual,

Plaintiffs-Appellees,

v.

TOBY DOUGLAS, Director of the
Department of Health Care
Services of the State of California,

Defendant,

and

KATHLEEN SEBELIUS, Secretary of
the United States Department of
Health and Human Services,

Defendant-Appellant.

No. 12-55334

D.C. No.
2:11-cv-09830-
CAS-MAN

CALIFORNIA MEDICAL ASSOCIATION;
CALIFORNIA DENTAL ASSOCIATION;
CALIFORNIA PHARMACISTS ASSOCIATION;
NATIONAL ASSOCIATION OF CHAIN
DRUG STORES; CALIFORNIA ASSOCIATION
OF MEDICAL PRODUCT SUPPLIERS;
AIDS HEALTHCARE FOUNDATION;
AMERICAN MEDICAL RESPONSE
WEST; JENNIFER ARNOLD,

Plaintiffs-Appellees,

v.

TOBY DOUGLAS, Director of the
Department of Health Care
Services of the State of California,

Defendant,

and

KATHLEEN SEBELIUS, Secretary of
the United States Department of
Health and Human Services,

Defendant-Appellant.

No. 12-55335

D.C. No.
2:11-cv-09688-
CAS-MAN

CALIFORNIA HOSPITAL ASSOCIATION;
G. G., an individual; I. F.,
an individual; R. E., an
individual; A. W., an individual;
A. G., an individual,

Plaintiffs-Appellants,

v.

TOBY DOUGLAS, Director of the
Department of Health Care
Services of the State of California;
KATHLEEN SEBELIUS, Secretary of
the United States Department of
Health and Human Services,

Defendants-Appellees.

No. 12-55535

D.C. No.
2:11-cv-09078-
CAS-MAN

CALIFORNIA MEDICAL ASSOCIATION;
CALIFORNIA DENTAL ASSOCIATION;
CALIFORNIA PHARMACISTS ASSOCIATION;
NATIONAL ASSOCIATION OF CHAIN
DRUG STORES; CALIFORNIA ASSOCIATION
OF MEDICAL PRODUCT SUPPLIERS;
AIDS HEALTHCARE FOUNDATION;
AMERICAN MEDICAL RESPONSE
WEST; JENNIFER ARNOLD,

Plaintiffs-Appellants,

v.

TOBY DOUGLAS, Director of the
Department of Health Care
Services of the State of California;
KATHLEEN SEBELIUS, Secretary of
the United States Department of
Health and Human Services,

Defendants-Appellees.

No. 12-55550

D.C. No.
2:11-cv-09688-
CAS-MAN

CALIFORNIA MEDICAL
TRANSPORTATION ASSOCIATION, INC.,
a California corporation;
LONNY SLOCUM, an individual;
GMD TRANSPORTATION, INC.,
a California corporation,

Plaintiffs-Appellants,

v.

TOBY DOUGLAS, Director of the
Department of Health Care
Services of the State of California;
KATHLEEN SEBELIUS, Secretary of
the United States Department of
Health and Human Services,

Defendants-Appellees.

No. 12-55554

D.C. No.
2:11-cv-09830-
CAS-MAN

ORDER AND
OPINION

Appeal from the United States District Court
for the Central District of California
Christina A. Snyder, District Judge, Presiding

Argued and Submitted
October 10, 2012—Pasadena, California

Filed May 24, 2013

Before: Stephen S. Trott, Andrew J. Kleinfeld,
and M. Margaret McKeown, Circuit Judges.

Order;
Opinion by Judge Trott

COUNSEL

Lindsey Powell, United States Attorneys' Office, Washington, D.C., for Defendant-Appellant Kathleen Sebelius.

Kamala D. Harris, California Attorney General; Julie Weng-Gutierrez, Senior Assistant Attorney General; Karin S. Schwartz (argued), Susan M. Carson, and Jennifer M. Kim, Supervising Deputy Attorneys General; Gregory D. Brown, Joshua N. Sondheimer, and Jonathan E. Rich, Deputy Attorneys General, San Francisco, California, for Defendant-Appellant Toby Douglas.

Lynn S. Carman, Medicaid Defense Fund, San Anselmo, California; Lloyd A. Bookman and Jordan B. Keville, Hooper, Lundy & Bookman, P.C., Los Angeles, California; Stanley L. Friedman, Law Offices of Stanley L. Friedman, Los Angeles, California; Craig J. Cannizzo, Hooper, Lundy & Bookman, P.C., San Francisco, California; for Plaintiffs-Appellees-Cross-Appellants.

Jessica Lynn Ellsworth, Hogan Lovells US LLP, Washington, D.C., for amicus curiae.

ORDER

The Opinion filed December 13, 2012, and appearing at 705 F.3d 934 (9th Cir. 2012) is withdrawn. It may not be cited as precedent by or to this court or any district court of the Ninth Circuit. A superseding opinion will be filed concurrently with this order.

The panel as constituted above has voted to deny the petitions for rehearing. Judge McKeown has voted to deny the petitions for rehearing en banc and Judges Trott and Kleinfeld so recommend.

The full court has been advised of the suggestion for rehearing en banc and no judge of the court has requested a vote on it. Fed. R. App. P. 35(b).

The petitions for rehearing and the petitions for rehearing en banc are **DENIED**.

No future petitions for panel rehearing or rehearing en banc shall be entertained.

OPINION

TROTT, Circuit Judge:

In the four cases giving rise to these eleven consolidated appeals, Kathleen Sebelius, Secretary of the Department of Health and Human Services (“HHS”), and Toby Douglas, Director of the California Department of Health Care Services (“DHCS”), appeal the district court’s grant of preliminary injunctions in favor of various providers and beneficiaries of Medi-Cal, California’s Medicaid program (“Plaintiffs”). The injunctions prohibit the Director and DHCS from implementing reimbursement rate reductions authorized by the California legislature and approved by the Secretary. The injunctions also stay the Secretary’s approval. Plaintiffs cross-appeal the court’s modification of its orders to allow the rate reductions

as to Medi-Cal services provided before the injunctions took effect.

Plaintiffs assert claims against the Secretary under the Administrative Procedures Act (“APA”) and against the Director under the Supremacy Clause of the United States Constitution, claiming that the reimbursement rate reductions do not comply with 42 U.S.C. § 1396a(a)(30)(A) (hereafter “§ 30(A)”). In support of their claims, Plaintiffs rely primarily on our decision in *Orthopaedic Hospital v. Belshe*, 103 F.3d 1491 (9th Cir. 1997). In *Orthopaedic Hospital*, the federal government was not a party. As such, we did not address whether deference was owed to the Secretary’s interpretation of the statute. Instead, we interpreted § 30(A) as requiring a state seeking to reduce Medicaid reimbursement rates first to consider the costs of providing medical services subject to the rate reductions. DHCS did not consider such studies in all of the Medicaid services subject to the rate reductions. The Secretary points out that Congress expressly delegated to her the authority and responsibility to approve state Medicaid plans. She argues that her approval of the rate reductions, including her view that § 30(A) does not necessarily require cost studies (or any other particular methodology), is entitled to deference, overrides *Orthopaedic Hospital*, and complies with the APA.

In addition to joining the Secretary’s arguments, the Director contends that Plaintiffs cannot maintain a direct cause of action under the Supremacy Clause for violation of § 30(A). Although we have previously

discussed this issue in a case where the Secretary had not acted, *Independent Living Center of Southern California v. Shewry*, 543 F.3d 1050 (9th Cir. 2008), the Director argues that our holding in that case is not binding in a situation where, as here, the Secretary has already exercised her discretion to approve the rate reductions as consistent with federal law.

The district court held that Plaintiffs in all four cases were likely to succeed on the merits of their APA and Supremacy Clause claims, and that the Plaintiffs in one case were likely to succeed on their claim under the Takings Clause of the United States Constitution. The court also concluded that Plaintiffs would suffer irreparable harm absent the injunctions and that the injunctions favored the public interest. We have jurisdiction under 28 U.S.C. § 1292(a)(1), and we conclude that the district court misapplied the applicable legal rules and thus did not appropriately exercise its discretion.

We hold that (1) *Orthopaedic Hospital* does not control the outcome in these cases because it did not consider the key issue here—the Secretary’s interpretation of § 30(A), (2) the Secretary’s approval of California’s requested reimbursement rates—including her permissible view that prior to reducing rates states need not follow any specific procedural steps, such as considering providers’ costs—is entitled to deference under *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), and (3) the Secretary’s approval complies with the APA. We further hold that Plaintiffs are unlikely to

succeed on the merits of their Supremacy Clause claims against the Director because—assuming that the Supremacy Clause provides a private right of action even where the Secretary has acted—the Secretary has reasonably determined that the State’s reimbursement rates comply with § 30(A). Finally, we hold that none of the Plaintiffs has a viable takings claim because Medicaid, as a voluntary program, does not create property rights. The district court’s orders concluding that Plaintiffs are likely to succeed on their claims must be reversed, the preliminary injunctions vacated, and the cases remanded for further proceedings consistent with this opinion. We dismiss Plaintiffs’ cross-appeals as moot.

I

BACKGROUND

“Medicaid is a cooperative federal-state program through which the federal government reimburses states for certain medical expenses incurred on behalf of needy persons.” *Alaska Dep’t of Health and Soc. Servs. v. Ctrs. for Medicare & Medicaid Servs.* (“*Alaska DHSS*”), 424 F.3d 931, 934 (9th Cir. 2005). States do not have to participate in Medicaid, but those that choose to do so “must comply both with statutory requirements imposed by the Medicaid Act and with regulations promulgated by the Secretary of [HHS].” *Id.* at 935. Every State’s Medicaid plan must

provide such methods and procedures relating to the utilization of, and the payment for,

care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and *to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers* so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

42 U.S.C. § 1396a(a)(30)(A) (emphasis added).

Recognizing that availability and access to health care, particularly for children, is of vital national importance, Congress established in 2009 the Medicaid and CHIP Payment and Access Commission (“MACPAC”). Children’s Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, § 506, 123 Stat. 8, 91 (codified at 42 U.S.C. § 1396(a)). MACPAC is charged with studying beneficiary access to health care under the Medicaid and CHIP programs and “mak[ing] recommendations to Congress, the Secretary, and States concerning . . . access policies.” 42 U.S.C. § 1396(b)(1)(B). MACPAC reviewed 30 years of research and issued its first report to Congress in March 2011. *See* MACPAC, March 2011 Report to the Congress on Medicaid and CHIP, p. 126, *available at* <http://www.macpac.gov/reports>. MACPAC came up with a three-part framework for analyzing access in light of the factors set forth in § 30(A)—MACPAC’s analysis considers (1) the needs of enrollees, (2) provider availability, and (3) utilization of

services. *Id.* at 127; *see also* 76 Fed. Reg. 26342, 26343 (May 6, 2011) (notice of proposed rule interpreting and implementing § 30(A)).

Congress expressly delegated to the Secretary the responsibility and the authority to administer the Medicaid program and to review state Medicaid plans and plan amendments for compliance with federal law. 42 U.S.C. § 1396a(b) (“The Secretary shall approve any plan which fulfills” the statutory requirements). The Secretary, in turn, delegated that responsibility and authority to the regional administrator for the Center for Medicare and Medicaid Services (“CMS”). 42 C.F.R. § 430.15(b); *see also Alaska DHSS*, 424 F.3d at 935. CMS must review and approve or reject any proposed amendment to a state Medicaid plan. Such an amendment is referred to as a State Plan Amendment (“SPA”).

The State of California has tried on several occasions to reduce reimbursement rates to providers of certain Medi-Cal services through the SPA process. The rates involved in these appeals were initiated by Assembly Bill 97, where the legislature stated,

In order to minimize the need for drastically cutting enrollment standards or benefits during times of economic crisis, it is crucial to find areas within the program *where reimbursement levels are higher than required* under the standard provided in [§ 30(A)] and *can be reduced in accordance with federal law*.

Cal. Welf. & Inst. Code § 14105.192(a)(2) (emphasis added). The statute granted the Director the authority

to identify where reimbursement rates could be reduced and instructed the Director *not* to implement any reductions unless and until the Director (1) determined that the reductions “will comply with applicable federal Medicaid requirements” and (2) obtained federal approval. *Id.* § 14105.192(m), (o)(1).

Pursuant to that authority, DHCS studied the potential impact of rate reductions on many Medi-Cal services, reviewing data collected and analyzed over several years in the process. The Director concluded that reimbursement rates could be reduced consistently with federal law for pharmacy services; durable medical equipment; emergency and non-emergency medical transportation; certain physician, clinic, and dental services; and services provided by “distinct part nursing facilities” (“DP/NFs”). DP/NFs are skilled nursing facilities operated by hospitals as distinct parts within those hospitals. Rates for most of these services were to be reduced ten percent from current rate levels, though some were to be reduced ten percent from rate levels as they existed in 2008 to 2009.

DHCS prepared two SPAs for submission to CMS. Federal officials were in frequent contact with the Director during this process. SPA 11-010 requested approval of the rate reductions for DP/NF services; SPA 11-009 requested approval of the rate reductions for all of the other services at issue.

In support of SPAs 11-009 and 11-010, DHCS submitted access studies for each of the affected services. These studies reviewed data focused primarily

on enrollee needs, provider availability, and utilization of services—the same factors MACPAC uses in its access analyses. Although DHCS included studies of providers' costs with respect to some of the services, such as certain pharmacy costs and costs incurred by DP/NFs, it did not review cost data with respect to most of the services subject to the rate reduction. The studies concluded that SPAs 11-009 and 11-010 are unlikely to diminish access.

DHCS also submitted an 82-page monitoring plan, which identified 23 different measures DHCS will study on a recurring basis to ensure the SPAs do not negatively affect beneficiary access. These measures address the three categories of factors MACPAC identified as affecting access: beneficiary data, provider availability data, and service utilization data. Included among the data DHCS will monitor are changes in Medi-Cal and dental enrollment, primary care supply ratios, provider participation rates, bed vacancy rates, visits to emergency rooms, and preventable hospitalization rates.

Various providers and provider groups, including some of the Plaintiffs, offered extensive input to CMS as well. For example, the California Hospital Association (“CHA”) wrote to the agency multiple times to express its disapproval of the SPAs. CMS considered a special report commissioned by CHA; the report concluded most DP/NFs operate at a loss. CHA and the California Medical Association (“CMA”) submitted a survey purporting to show that the reductions would inhibit access. As CMS later noted, there were

several shortcomings with this survey, including that it was conducted over nine days and involved only 763 California residents.

CMS approved both SPAs. The approval letters were succinct, but they explained that, “[i]n light of the data CMS reviewed, the monitoring plan, and [CMS’s] consideration of stakeholder input,” DHCS had submitted sufficient information to show that its SPAs complied with § 30(A). “As part of the analysis of this amendment, the State was able to provide metrics which adequately demonstrated beneficiary access,” including (1) the “[t]otal number of providers by type and geographic location and participating Medi-Cal providers by type and geographic area,” (2) the “[t]otal number of Medi-Cal beneficiaries by eligibility type,” (3) “[u]tilization of services by eligibility type over time,” and (4) an “[a]nalysis of benchmark service utilization where available.” CMS approved the reduced rates retroactively to June 1, 2011.

Four groups of Plaintiffs filed suit against the Secretary and the Director in the United States District Court for the Central District of California. *Managed Pharmacy Care v. Sebelius*, D. Ct. No. 2:11-cv-09211-CAS-MAN (Appeal Nos. 12-55067 & 12-55332) (“the MPC case”), was filed by five pharmacies, a pharmacy organization, an independent living center, a state association of independent living centers, and a Medi-Cal beneficiary. *California Medical Association v. Douglas*, D. Ct. No. 2:11-cv-09688-CAS-MAN (Appeal Nos. 12-55335, 12-55315, & 12-55550) (“the CMA case”), was filed by professional associations

representing the interests of physicians, dentists, pharmacists, suppliers of durable medical equipment, providers of care for AIDS patients, providers of emergency medical transportation, and a Medi-Cal beneficiary. *California Medical Transportation Association v. Douglas*, D. Ct. No. 2:11-cv-09830-CAS-MAN (Appeal Nos. 12-55334, 12-55103, & 12-55554) (“the *CMTA* case”), was filed by a provider of non-emergency medical transportation services, a trade association representing other such providers, and a Medi-Cal beneficiary. *California Hospital Association v. Douglas*, D. Ct. No. 2:11-cv-09078-CAS-MAN (Appeal Nos. 12-55331, 12-55068, & 12-55535) (“the *CHA* case”), was filed by five Medi-Cal beneficiaries and a trade association representing the interests of DP/NFs.

The district court declined to defer to the Secretary’s approval of the SPAs and granted Plaintiffs’ motions for preliminary injunctions. The court determined that our decision in *Orthopaedic Hospital* required the State to consider cost data prior to submitting the SPAs to CMS and disagreed with DHCS’s research methodology with respect to the potential impact of the reductions on beneficiary access. For example, the district court determined that the State’s participating pharmacy list incorrectly included some pharmacies, that the analysis of DP/NFs improperly considered freestanding nursing facilities, and that DHCS’s geographic analysis was flawed because it focused on an urban-rural county model rather than one based on physical location. The court determined

also that CMS's acceptance of the monitoring plan was inappropriate because "at best the monitoring plan creates a potential response after a quality deficiency has been identified." Thus, the district court held, Plaintiffs were likely to succeed on their APA claims that the SPAs violate § 30(A). The court also held that the Supremacy Clause provides a private right of action to challenge the reimbursement rates as violating § 30(A) and that Plaintiffs were likely to prevail on those claims as well. In the *CHA* case, the district court entered the preliminary injunction on the additional ground that because state law places certain restrictions on how and when DP/NFs may stop treating Medicaid patients, CHA would likely succeed on its takings claim.

In the *MPC*, *CMTA*, and *CHA* cases, the injunctions initially prohibited the Director from applying the rate reductions to any services rendered after June 1, 2011. In the *CMA* case, however, the court determined that enjoining the reductions as to services rendered before the injunctions took effect would violate the State's Eleventh Amendment sovereign immunity and limited its injunction accordingly. On motions of the Director, the district court modified the other injunctions along the same lines.

The Secretary and the Director appeal. Plaintiffs cross-appeal the district court's decision to allow the new rates with respect to Medicaid services rendered before the effective date of the injunctions.

II**STANDARD OF REVIEW**

A preliminary injunction is an “extraordinary remedy” and is appropriate only when the party seeking the injunction “establish[es] that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest.” *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 24, 20 (2008).

We review the district court’s grant of a preliminary injunction for abuse of discretion. *Beno v. Shalala*, 30 F.3d 1057, 1063 (9th Cir. 1994). We must first determine whether the district court “identified and applied the correct legal rule to the relief requested.” *United States v. Hinkson*, 585 F.3d 1247, 1263 (9th Cir. 2009) (en banc). If not, that error of law necessarily constitutes an abuse of discretion. *Id.* at 1261. If, however, the district court identified and applied the correct legal rule, we will reverse only if the court’s decision “resulted from a factual finding that was illogical, implausible, or without support in inferences that may be drawn from the facts in the record.” *Id.* at 1263.

In considering Plaintiffs’ APA claims, we must follow “additional requirements for review.” *Earth Island Inst. v. Carlton*, 626 F.3d 462, 468 (9th Cir. 2010). Under the APA, we may not set aside agency action unless that action is “arbitrary, capricious, an abuse of discretion, or otherwise not in accordance

with law.” 5 U.S.C. § 706(2)(A). This standard is met only where the party challenging the agency’s decision meets a heavy burden of showing that “the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.” *Motor Vehicle Mfrs. Ass’n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

III

APA CLAIMS AGAINST THE SECRETARY

A

We first consider whether our decision in *Orthopaedic Hospital* is dispositive of the issues in these appeals.

In *Orthopaedic Hospital*, a hospital and hospital association challenged California’s reduction of reimbursement rates for providers of hospital outpatient services, arguing that DHCS reduced the rates “without proper consideration of the effect of hospital costs” on the § 30(A) factors of efficiency, economy, quality of care, and beneficiary access. 103 F.3d at 1492. The State did not dispute that it had not considered providers’ costs of offering Medicaid services, but argued that its reductions nonetheless complied

with § 30(A) because the statute did not require it to study such costs.

HHS was not a party in *Orthopaedic Hospital*, and we did not have the benefit of the agency's position regarding the requirements of § 30(A). We owed no deference to the State's position that § 30(A) does not require cost studies because "[a] state agency's interpretation of federal statutes is not entitled to the deference afforded a federal agency's interpretation of its own statutes." *Id.* at 1495. We thus had to determine "the proper interpretation" of the statute on our own. *Id.* at 1496.

We interpreted § 30(A) as requiring the State to consider providers' cost of services prior to setting reimbursement rates for those services:

The statute provides that *payments* for services must be consistent with efficiency, economy, and quality of care, and that those *payments* must be sufficient to enlist enough providers to provide access to Medicaid recipients. [DHCS] cannot know that it is setting rates that are consistent with efficiency, economy, quality of care and access without considering the costs of providing such services. It stands to reason that the *payments* for hospital outpatient services must bear a reasonable relationship to the costs of providing quality care incurred by efficiently and economically operated hospitals.

Id.

Plaintiffs contend that a simple application of *Orthopaedic Hospital* decides these cases. We disagree, for two reasons.

First, we recognized in *Orthopaedic Hospital* that our standard of review might have been different had the agency spoken on the issue. *Id.* at 1495 (noting “the deference afforded a federal agency’s interpretation of its own statutes” under *Chevron*). This is because “*Chevron*’s policy underpinnings emphasize the expertise and familiarity of the federal agency with the subject matter of its mandate and the need for coherent and uniform construction of federal law nationwide.” *Id.* (internal quotation marks omitted). Because the agency was not a party to the litigation and had not yet set forth its position on the requirements of § 30(A), there was no issue of whether we should defer to the agency. These appeals, however, present just that question.

Second, the Secretary has now set forth her interpretation, through her approvals of the SPAs, that § 30(A) does not prescribe any particular methodology a State must follow before its proposed rates may be approved. CMS explicitly approved California’s SPAs as consistent with the requirements of § 30(A) even though cost data was not available with respect to all of the services, thereby determining that the lack of cost studies did not preclude California from reducing Medi-Cal reimbursement rates. “A court’s prior judicial construction of a statute trumps an agency construction otherwise entitled to *Chevron* deference only if the prior court decision holds that its

construction follows from the unambiguous terms of the statute and thus leaves no room for agency discretion.” *Nat’l Cable & Telecomm. Ass’n v. Brand X Internet Servs.* (“*Brand X*”), 545 U.S. 967, 982 (2005); *Garfias-Rodriguez v. Holder*, No. 09-72603, ___ F.3d ___, slip op. 12583, 12599, 2012 WL 5077137, *7 (9th Cir. Oct. 19, 2012) (en banc) (concluding that, pursuant to *Brand X*, our prior construction of two provisions of the Immigration and Nationality Act did not survive a contrary reading by the Board of Immigration Appeals). Although *Orthopaedic Hospital* was grounded in the language of the statute—as are all of our statutory interpretation cases—we did not hold that our view of § 30(A) represented the *only* reasonable interpretation of that statute. We read the statute in the absence of an authoritative agency construction and decided the case accordingly. And although we cited *Orthopaedic Hospital* with approval in *Alaska DHSS*, there was no *Brand X* issue to consider in that case. *See Alaska DHSS*, 424 F.3d at 940.

For these reasons, *Orthopaedic Hospital* does not automatically render the SPA approvals arbitrary and capricious.

B

We now consider whether the Secretary’s approval based on her view that § 30(A) does not impose a particular process on the States is entitled to *Chevron* deference. This familiar standard requires a court to

abide by an agency's interpretation or implementation of a statute it administers if Congress has not directly spoken "to the precise question at issue" and if the agency's answer is "permissible" under the statute. *Chevron*, 467 U.S. at 842-43.

But not every administrative act is entitled to *Chevron* deference. *United States v. Mead Corp.*, 533 U.S. 218 (2001). In reviewing an "administrative implementation of a particular statutory provision," we defer to the agency's decision (1) "when it appears that Congress delegated authority to the agency generally to make rules carrying the force of law," and (2) "the agency interpretation claiming deference was promulgated in the exercise of that authority." *Id.* at 226-27.

Arguably, the Supreme Court has already concluded that SPA approvals meet the *Chevron/Mead* standard by stating that "[t]he Medicaid Act commits to the federal agency the power to administer a federal program. And here the agency has acted under this grant of authority [by approving a SPA]. That decision carries weight." *Douglas v. Indep. Living Ctr. of S. Cal.*, ___ U.S. ___, 132 S. Ct. 1204, 1210 (2012). Because the *Douglas* Court also recognized that the deference question had not been fully argued, *id.* at 1211, we proceed with our own analysis. We keep in mind, however, that we afford "considered dicta from the Supreme Court . . . a weight that is greater than ordinary judicial dicta as prophecy of what that Court might hold." *United States v. Montero-Camargo*, 208

F.3d 1122, 1132 n.17 (9th Cir. 2000) (en banc) (internal quotation marks omitted).

The first prong of the *Mead* standard is easily satisfied in these cases: “The Secretary shall approve any plan which fulfills the conditions specified” in the statute. 42 U.S.C. § 1396a(b). Congress expressly delegated to the Secretary the authority to interpret § 30(A) and to determine whether a State’s Medicaid program conforms to federal requirements.

The second *Mead* prong—whether the Secretary interpreted § 30(A) and approved California’s SPAs within the exercise of her delegated authority—depends on the “form and context” of the approvals. *Price v. Stevedoring Servs. of Am., Inc.*, 697 F.3d 820, 826 (9th Cir. 2012) (en banc). “Delegation of such authority may be shown in a variety of ways, as by an agency’s power to engage in adjudication or notice-and-comment rulemaking, or by some other indication of a comparable congressional intent.” *Mead Corp.*, 533 U.S. at 227.

We have already considered the application of *Chevron* to the SPA process. In *Alaska DHSS*, the Secretary *disapproved* a SPA, concluding that Alaska’s proposal to raise reimbursement rates was inconsistent with § 30(A)’s standards of efficiency and economy. 424 F.3d at 940. In doing so, CMS exercised its authority, delegated by Congress, to review Medicaid plans. Thus, we deferred to the agency’s disapproval, holding that the statutory terms “efficiency”

and “economy” left a “gap that [CMS] permissibly filled via case-by-case adjudication.” *Id.*

There does not appear to be any logical reason why Congress would delegate to the Secretary the discretion to decide that a proposed SPA *violates* § 30(A), but choose to withhold from her that same discretion if she decides the SPA *complies* with § 30(A). The nature of her authority is the same in both instances. Nonetheless, the district court distinguished *Alaska DHSS* because that case relied in part on “the formal administrative process afforded the State” in the case of a SPA disapproval. *Alaska DHSS*, 424 F.3d at 939.

When the Secretary disapproves a proposed plan amendment, a State has the “opportunities to petition for reconsideration, brief its arguments, be heard at a formal hearing, receive reasoned decisions at multiple levels of review, and submit exceptions to those decisions.” *Id.* In the case of an approval, however, the Medicaid program does not provide interested parties with similar opportunities (although they may certainly avail themselves of the formal process provided in a suit under the APA). This difference, argue the Plaintiffs, shows that *Chevron* deference is not appropriate to CMS’s SPA approvals.

It is true that *Alaska DHSS* relied on the formal petition process afforded the State in the case of a disapproval. But that was not the only reason we deferred to the agency’s decision. Section 30(A)’s “undefined terms ‘efficiency’ and ‘economy’ leave a gap

that [CMS] permissibly filled,” and the agency appropriately “elucidate[d] the meaning of the statute . . . via case-by-case adjudication.” *Id.* at 940. CMS did the same thing here.

Importantly, we recognized in *Alaska DHSS* that the formal process afforded the State was “clear evidence that Congress intended [the agency’s] final determination to carry the force of law.” *Id.* at 939 (emphasis added) (internal quotation marks and alteration omitted). But formal process is not the only evidence of such congressional intent. In the absence of formal procedures, courts must determine whether there are “any *other* circumstances reasonably suggesting” that Congress intended deference to an agency decision. *Mead Corp.*, 533 U.S. at 231 (emphasis added). There are many such circumstances to consider. For example, “the interstitial nature of the legal question, the related expertise of the [a]gency, the importance of the question to administration of the statute, the complexity of that administration, and the careful consideration the [a]gency has given the question over a long period of time” are all factors favoring *Chevron* deference. *Barnhart v. Walton*, 535 U.S. 212, 222 (2002).

Considering all the evidence of *Chevron* delegation in these cases, we hold that the balance tips to the side of deference. The language of § 30(A) is “broad and diffuse.” *Sanchez v. Johnson*, 416 F.3d 1051, 1060 (9th Cir. 2005). The statute uses words like “consistent,” “sufficient,” “efficiency,” and “economy,” without describing any specific steps a State

must take in order to meet those standards. The statute’s amorphous language “suggest[s] that the agency’s expertise is relevant in determining its application.” *Douglas*, 132 S. Ct. at 1210.

Medicaid administration is nothing if not complex. Determining a plan’s compliance with § 30(A), as well as its compliance with a host of other federal laws, is central to the program because a State cannot participate in Medicaid without a plan approved *by the Secretary* as consistent with those laws. The executive branch has been giving careful consideration to the ins and outs of the program since its inception, and the agency is the expert in all things Medicaid. And let us not forget that “a very good indicator of delegation meriting *Chevron* treatment [is an] express congressional authorization[] to engage in the process of rulemaking or adjudication that produces regulations or rulings for which deference is claimed.” *Mead Corp.*, 533 U.S. at 229. That express delegation is precisely what we have here. Therefore, despite the lack of formal procedures available for interested parties, the Secretary’s exercise of discretion in the “form and context” of a SPA approval deserves *Chevron* deference. *Price*, 697 F.3d at 826.¹

¹ In a letter submitted pursuant to Rule 28(j) of the Federal Rules of Appellate Procedure, the CMA and CHA Plaintiffs rely on *Price* in support of their argument that *Chevron* does not apply to SPA approvals. But *Price* considered whether a statutory interpretation advanced by an agency *in litigation* was

(Continued on following page)

In holding that *Chevron* applies to SPA approvals, we reach a conclusion similar to that reached by the D.C. Circuit. In *Pharmaceutical Research and Manufacturers of America v. Thompson*, 362 F.3d 817, 819 (D.C. Cir. 2004), then-Secretary Thompson of HHS approved a Michigan SPA designed to implement “a low-cost state prescription drug coverage program [] for beneficiaries of Medicaid.” The plaintiffs there, as here, argued that SPA approvals “are not the result of a formal administrative process” and are therefore “akin to ‘interpretations contained in policy statements, agency manuals, and enforcement guidelines,’ which are ‘beyond the *Chevron* pale.’” *Id.* at 821 (quoting *Mead Corp.*, 533 U.S. at 234).

The D.C. Circuit rejected this argument because it

overlooks the nature of the Secretary’s authority. This is *not a case of implicit delegation of authority* through the grant of general implementation authority. In the case of the Medicaid payment statute, the *Congress expressly conferred on the Secretary authority to review and approve state Medicaid plans as a condition to disbursing federal Medicaid payments. . . .* In carrying out this duty, the Secretary is charged with ensuring that each

entitled to deference. Undertaking a *Chevron/Mead* analysis, we concluded that Congress did not intend the *litigating positions* of the Director of the Office of Workers’ Compensation Programs to have the force of law. *Price*, 697 F.3d at 830-31. The Secretary’s decision here is a very different animal.

state plan complies with a vast network of specific statutory requirements Through this “express delegation of specific interpretive authority,” *Mead*, 533 U.S. at 229, 121 S. Ct. at 2172, the Congress manifested its intent that the Secretary’s determinations, based on interpretation of the relevant statutory provisions, should have the force of law.

Id. at 821-22 (emphasis added). Therefore, the court deferred to the agency’s approval of the Michigan SPA and also determined that the agency did not violate the APA. *Id.* at 825-27.

We agree with the D.C. Circuit’s reasoning. See *Alaska DHSS*, 424 F.3d at 939 (citing *Pharm. Research Mfrs. of Am.* with approval). The Medicaid program is a colossal undertaking, jointly funded by the federal government and the States. Congress explicitly granted the Secretary authority to determine whether a State’s Medicaid plan complies with federal law. The Secretary understands the Act and is especially cognizant of the all-important yet sometimes competing interests of efficiency, economy, quality of care, and beneficiary access. It is well within the Secretary’s mandate to interpret the statute via case-by-case SPA adjudication.

Because Congress intended SPA approvals to have the force of law, we now ask whether the Secretary’s interpretation that § 30(A) requires a *result*, not a particular *methodology* such as cost studies, is based on a “permissible” reading of § 30(A).

Chevron, 467 U.S. at 843. We have no doubt that it is.

The statute says nothing about cost studies. It says nothing about any particular methodology. See *Holder v. Martinez Gutierrez*, ___ U.S. ___, 132 S. Ct. 2011, 2017 (2012) (deferring to the Board of Immigration Appeals’ reading of 8 U.S.C. § 1229b(a) because the statute “does not mention imputation [of a parent’s years of residence to a child], much less require it”). Rather, by its terms § 30(A) requires a substantive result—reimbursement rates must be consistent with efficiency, economy, and quality care, and sufficient to enlist enough providers to ensure adequate beneficiary access. Congress did not purport to instruct the Secretary *how* to accomplish these substantive goals. That decision is left to the agency.

The idea that a State should consider providers’ costs prior to reducing reimbursement rates seems at first blush to be logical. As we stated in *Orthopaedic Hospital*, “costs are an integral part of the consideration.” 103 F.3d at 1496. But even then, we acknowledged that beneficiary access to Medicaid services “appears to be driven to a degree by factors independent of costs of the services.” *Id.* at 1498. An agency’s interpretation “prevails if it is a reasonable construction of the statute, whether or not it is the only possible interpretation or even the one a court might think best.” *Martinez Gutierrez*, 132 S. Ct. at 2017. The position that costs might or might not be one appropriate measure by which to study beneficiary access, depending on the circumstances of each

State's plan, is entirely reasonable. Each State participating in Medicaid has unique, local interests that come to bear. The Secretary must be free to consider, for each State, the most appropriate way for that State to demonstrate compliance with § 30(A).

Moreover, the term "cost" is not as free from ambiguity as the Plaintiffs would have us believe. When one shops at a retail outlet and sees a price on an item, the cost to the consumer is that price, period. But when one attempts to determine *how* the price or cost to the consumer has been calculated, a whole host of intangibles come into play, such as cost of goods, depreciation, profit, overhead, deferred compensation, advertising, etc. The term "cost" may also include items such as contract prices to suppliers and service providers, which may themselves be negotiated and reduced if reimbursement rates are reduced. Nowhere in this record have we been able to find a description by the Plaintiffs of a *useful* definition of costs; and that term is anything but a talisman solving all problems or providing answers to complicated questions.

We note that our sister circuits have agreed that § 30(A) "does not require any 'particular methodology' for satisfying its substantive requirements as to modifications of state plans." *Rite-Aid of Pa., Inc. v. Houstoun*, 171 F.3d 842, 851 (3d Cir. 1999); *Minn. HomeCare Ass'n, Inc. v. Gomez*, 108 F.3d 917, 918 (8th Cir. 1997) (per curiam) ("The Medicaid Act . . . does not require the State to utilize any prescribed method of analyzing and considering said factors.");

Methodist Hospitals, Inc. v. Sullivan, 91 F.3d 1026, 1030 (7th Cir. 1996) (“Nothing in the language of § 1396a(a)(30), or any implementing regulation, requires a state to conduct studies in advance of every modification. It requires each state to produce a *result*, not to employ any particular methodology for getting there.”). Today, we join them.

We defer to the Secretary’s decision that SPAs 11-009 and 11-010 comply with § 30(A). The district court’s failure to give *Chevron* deference is an error of law that necessarily constitutes an abuse of discretion. *Hinkson*, 585 F.3d at 1263.

C

Our final inquiry with respect to Plaintiffs’ APA claims is whether the agency’s approvals were arbitrary and capricious. Agency action is arbitrary and capricious when the agency relies on factors Congress has not intended it to consider, fails to consider an important aspect of the problem, or offers an explanation that runs counter to the evidence before the agency. *Motor Vehicle Mfrs. Ass’n*, 463 U.S. at 43. We must uphold an agency action—even if it is made with “less than ideal clarity”—as long as “the agency’s path may reasonably be discerned” from the record. *Id.* (internal quotation marks omitted).

Plaintiffs urge us to conclude that the SPA approvals are arbitrary and capricious because the agency “failed to independently assess the statutory factors” of efficiency, economy, quality of care, and

beneficiary access and, in fact, made “no reference” to these requirements when approving the SPAs. But that is not an accurate representation of the record.

CMS’s approvals themselves refute Plaintiffs’ argument, stating, “We conducted our review of your submittal *with particular attention to the statutory requirements at [§ (30)(A)].*” (emphasis added). CMS concluded that the SPA “complies with all applicable requirements.” With respect to the access requirement of § 30(A), the approvals state that the lower rates are permissible because the State “provide[d] metrics which adequately demonstrated beneficiary access.” DHCS’s analysis considered (1) the “[t]otal number of providers by type and geographic location and participating Medi-Cal providers by type and geographic area,” (2) the “[t]otal number of Medi-Cal beneficiaries by eligibility type,” (3) “[u]tilization of services by eligibility type over time,” and (4) an “[a]nalysis of benchmark service utilization where available.” This approach tracks MACPAC’s three-prong framework for analyzing access: (1) the needs of Medicaid beneficiaries, (2) the availability of providers, and (3) the utilization of services. *See* MACPAC March 2011 Report, p. 127.

The agency also appropriately considered the State’s monitoring plan. The district court rejected the monitoring plan because it “merely creates a potential response after an access or quality deficiency has been identified.” We do not agree that the State’s 82-page comprehensive plan is irrelevant or superfluous. The statute cannot logically require that every

single potential problem—no matter how unlikely—be predicted, identified, and resolved *before* SPA approval. DHCS’s monitoring plan supports the reasonable conclusion that the rate reductions are not expected negatively to impact beneficiary access, but that if such problems occur, the State can quickly respond and address them. It was not arbitrary or capricious for the agency to consider California’s monitoring plan.

The district court delved into the minutiae of the Secretary’s approval, picking apart DHCS’s research and finding potential flaws—an inappropriate exercise when reviewing agency action under the APA. Hundreds of pages of analysis submitted by DHCS support the Secretary’s conclusion that the SPAs comply with § 30(A) and are unlikely to affect beneficiary access in a detrimental way. Plaintiffs cite to other evidence that contradicts DHCS’s evidence of sufficient beneficiary access. But CMS considered this “stakeholder input” when making its determinations, and the agency’s decision to credit DHCS’s evidence over that submitted by other parties was reasonable. “[W]here there is conflicting evidence in the record, the [agency’s] determination is due deference—especially in areas of [its] expertise.” *Nat’l Parks & Conserv. Ass’n v. U.S. Dep’t of Transp.*, 222 F.3d 677, 682 (9th Cir. 2000).

The “Secretary shall approve” plans and plan amendments that comply with the requirements set forth in § 30(A). 42 U.S.C. § 1396a(b). *How* should the Secretary determine that compliance? Under the APA

the answer must be, in any way that is not “arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.” 5 U.S.C. § 706(2). CMS’s decision that SPAs 11-009 and 11-010 meet the requirements of § 30(A) neither failed to consider an important aspect of the problem, nor relied on factors Congress did not intend it to consider. Because the agency’s path can reasonably be discerned, Plaintiffs cannot succeed on their APA claims.

IV

SUPREMACY CLAUSE CLAIMS AGAINST THE DIRECTOR

Although § 30(A) does not create any substantive rights enforceable under 42 U.S.C. § 1983, *Sanchez*, 416 F.3d at 1060 (9th Cir. 2005), we held in *Independent Living Center of Southern California v. Shewry* (“*ILC I*”) that “a plaintiff seeking injunctive relief under the Supremacy Clause on the basis of federal preemption need not assert a federally created ‘right’ . . . but need only satisfy traditional standing requirements.” 543 F.3d 1050, 1058 (9th Cir. 2008). The Supreme Court denied certiorari. 129 S. Ct. 2828 (2009). We reaffirmed *ILC I*’s holding in a later appeal in the same case. *See Indep. Living Ctr. of S. Cal. v. Maxwell-Jolly* (“*ILC II*”), 572 F.3d 644, 650 n.7 (9th Cir. 2009) (*vacated sub nom.*, *Douglas*, 132 S. Ct. 1204).

The Supreme Court granted certiorari in *ILC II*, along with a number of other Ninth Circuit cases, to

consider whether the Supremacy Clause grants a private cause of action for violation of § 30(A). The Secretary was not a party in any of the cases. At the time of the oral argument, the Secretary had not yet approved the reimbursement rates at issue, which had been authorized by California Assembly Bills 5 and 1183. Later, however, the Secretary *did* approve the new rates, concluding that they complied with § 30(A). After receiving supplemental briefing on the effect of the Secretary's action, the Supreme Court vacated those cases in *Douglas v. Independent Living Center of Southern California*, 132 S. Ct. at 1208.

All of the Justices agreed that the Secretary's approval of California's rate reductions "does not change the underlying substantive question, namely whether California's statutes are consistent with [§ 30(A)]." *Id.* at 1210; *see also id.* at 1213-14 (Roberts, C.J., dissenting) ("[T]he CMS approvals have no impact on the question before this Court."). Justice Breyer's majority opinion concluded, however, that the approvals "may change the answer" and that in the new posture of the cases it was appropriate to remand for us to consider the Supremacy Clause issue in the first instance.

The cases vacated and remanded by *Douglas* are currently in mediation. The question we face in those cases is whether the Supremacy Clause allows a private party to enforce a federal statute that creates no substantive rights, even where the administrative agency charged with the implementation and enforcement of the statute has already acted. *Douglas*

did not resolve that question, and we need not do so here.

Even assuming there were a cause of action under the Supremacy Clause where, as here, the Secretary has acted—a position we do not necessarily believe the Court would endorse—at this stage it is sufficient to say that Plaintiffs are unlikely to succeed on the merits on their Supremacy Clause claim against the Director for the very same reason they are unlikely to prevail on their APA claims against the Secretary. The Secretary has reasonably decided that SPAs 11-009 and 11-010 comply with federal law. That is the end of the matter for the purposes of this appeal of the injunction.

V

CHA'S TAKINGS CLAIM

The Takings Clause of the Constitution prohibits the government from taking private property for public use without just compensation. U.S. Const., amend. V. Because participation in Medicaid is voluntary, however, providers do not have a property interest in a particular reimbursement rate. *See Erickson v. U.S. ex rel. HHS*, 67 F.3d 858, 862 (9th Cir. 1995) (“[P]laintiffs do not possess a property interest in continued participation in Medicare, Medicaid, or the federally-funded state health care programs.”). Despite this well-established principle, the district court held that CHA was likely to succeed on its takings claim because, as a result of state laws

restricting the expulsion of patients from skilled nursing facilities, “the hospitals’ continued participation in Medi-Cal is compulsory at least until such time as alternate arrangements are made for patients receiving skilled nursing services.” The district court was not persuaded by the fact that “the hospitals in this case accepted the restrictions to their services when they voluntarily elected to participate in Medi-Cal” because “they did so before the State enacted [Assembly Bill] 97.”

But regardless of when providers decide to participate in Medi-Cal, they can hardly expect that reimbursement rates will never change. The fact that States may submit SPAs and request approval for lower rates is enough to end the inquiry. Neither the State nor the federal government “promised, explicitly or implicitly,” that provider reimbursement rates would never change. *Cervoni v. Sec’y of Health, Educ. & Welfare*, 581 F.2d 1010, 1018 (1st Cir. 1978) (holding that a provider of Medicare does not have a property interest in continued payments under Part B); *see also Franklin Mem’l Hosp. v. Harvey*, 575 F.3d 121, 129-30 (1st Cir. 2009) (holding that there can be no unconstitutional taking where a provider “voluntarily participates in a regulated program”). CHA cannot succeed on its takings claim.

V

CONCLUSION

For the foregoing reasons, we reverse the district court's decisions and vacate the preliminary injunctions in all four cases. We remand for further proceedings consistent with this opinion.

Appeal Nos. 12-55067, 12-55332, 12-55331, 12-55068, 12-55334, 12-55103, 12-55335, and 12-55315 are REVERSED, the INJUNCTIONS VACATED, and the cases REMANDED.

Appeal Nos. 12-55535, 12-55554, and 12-55550 are DISMISSED as MOOT.

APPENDIX B

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
WESTERN DIVISION

CALIFORNIA MEDICAL)	Case No.
ASSOCIATION; et al,)	CV 11-9688 CAS (MANx)
Plaintiffs,)	ORDER GRANTING
vs.)	PRELIMINARY
TOBY DOUGLAS; et al.;)	INJUNCTION
Defendants.)	
_____)	

I. INTRODUCTION AND BACKGROUND

On November 21, 2011, plaintiffs California Medical Association, Inc. (“CMA”), et al. filed the instant action against Toby Douglas, Director of the California Department of Health Care Services (the “Director”) and Kathleen Sebelius, Secretary of the U.S. Department of Health and Human Services (the “Secretary”). Plaintiffs filed their First Amended Complaint (“FAC”) on December 30, 2011.

The California Department of Health Care Services (“DHCS”) is a California agency charged with the administration of California’s Medicaid program, Medi-Cal. The Secretary is responsible for administering the Medicaid program at the federal level. Through her designated agent, the Centers for Medicare and Medicaid Services (“CMS”), the Secretary

is responsible for reviewing and approving policy changes that states make to their Medicaid programs.

Plaintiff CMA is a professional association representing the interests of physicians in California. Plaintiff California Dental Association (“CDA”) is a professional association representing the interests of dentists in California. Plaintiff California Pharmacists Association (“CPhA”) is a professional association representing the interests of California pharmacists.¹ Plaintiff National Association of Chain Drug Stores (“NACDS”) is a national association whose members include 18 national pharmacy chains in California with over 3,100 individual pharmacies throughout the State. Plaintiff California Association of Medical Product Suppliers (“CAMPS”) is a trade organization

¹ The Director argues that the present action is redundant and that Plaintiffs cannot establish irreparable harm as to pharmacy services in light of this Court’s prior ruling in *Managed Pharmacy Care v. Sebelius*, CV No. 11-09211, (C.D. Cal. Dec. 28, 2011), enjoining enforcement of the rate reduction with respect to pharmacy providers. The Court finds this argument unavailing because the issuance of a preliminary injunction in an overlapping case does not operate to moot a parallel action because the original order is “subject to reopening.” *See, e.g., Exxon Mobil Corp. v. Saudi Basic Indus. Corp.*, 544 U.S. 280, 291 n.7 (2005); 13B Wright et al., *Federal Practice and Procedure* § 3533.2.1, 832 (3d ed. 2008) (“mootness may be denied because the decision is subject to reopening or appeal”). In this case, the Director has already filed an appeal of the preliminary injunction this Court issued in the *Managed Pharmacy Care*. Further, plaintiffs in this case present different legal theories and new developments that were not presented in *Managed Pharmacy Care*.

representing the interests of durable medical equipment (“DME”) suppliers in California.² Plaintiff AIDS Healthcare Foundation (“AHF”) is the largest provider of medical care for AIDS patients in California. Plaintiff American Medical Response West (“AMR”) provides emergency medical transportation (“EMT”) services in California. Plaintiff Jennifer Arnold is an individual whose infant son is a Medi-Cal beneficiary. Plaintiffs Does 1 through 25 are individuals residing in California that receive outpatient services through the Medi-Cal program.

On March 25, 2011, California Governor Edmund G. Brown Jr. signed into law Assembly Bill 97 (“AB 97”), the health budget trailer bill for California fiscal year 2011-2012. AB 97 enacted significant payment reductions for many classes of services provided under the Medi-Cal program. Most significantly for the purposes of the instant action, AB 97 enacted California Welfare and Institutions Code § 14105.192, which authorizes the Director to reduce the Medi-Cal payment rates for various services, including physician, clinic, dental, pharmaceutical, EMT and DME and medical supply services, effective June 1, 2011. Pursuant to Welfare and Institutions Code § 14105.192(n), the Director is required to seek any federal approvals necessary prior to implementing the rate reduction.

² The Court refers to CMA, CMDA, CPhA, NACDS, and CAMPS collectively as the “associational plaintiffs.”

DHCS submitted proposed State Plan Amendment (“SPA”) 11-009 to CMS on June 30, 2011, seeking federal approval of the rate reduction and incorporation of that reduction into California’s Medi-Cal State Plan. On September 27, 2011, CMS issued a letter to DHCS requesting additional information concerning the proposed rate reduction. This Request for Additional Information (“RAI”) focused on the impact of the rate reduction on access to services. DHCS responded with analyses of the rate reduction’s impact on access and a plan for monitoring access. On October 27, 2011, in a letter from the Associate Regional Administrator of the Division of Medicaid & Children’s Health Operations, CMS provided notice to the Director and DHCS that it had approved the SPA. Contemporaneously with the approval letter, the Associate Regional Administrator also sent a “companion letter” by which CMS gave notice to the Director and DHCS that it had “identified additional issues” that were “not in compliance with current regulations, statute, and CMS guidance.”

Plaintiffs allege that CMS’ approval of the SPA was in violation of 42 U.S.C. § 1396a(a)(30)(A) (“Section

30(A))”,³ the Supremacy Clause,⁴ FAC ¶¶ 70-72, and the Due Process Clause of the 14th Amendment to the U.S. Constitution.⁵ *Id.* ¶¶ 73-79. Plaintiffs further allege that the Secretary’s approval of the SPA violated the Administrative Procedure Act (“APA”), 5 U.S.C. § 701 *et seq.* because the Secretary failed to appropriately consider certain factors including the impact of the rate reduction on access to and quality of medical services. *Id.* ¶¶ 66-69.

On December 30, 2011, plaintiffs filed the instant motion seeking a preliminary injunction restraining the Director from implementing the rate reduction. On January 17, 2011, the Director and the Secretary filed separate oppositions to plaintiffs’ motion. Plaintiffs replied on January 23, 2011. A hearing was held January 30, 2011. After carefully considering the parties’ arguments, the Court find[s] and concludes as follows.

³ Section 30(A) states in pertinent part that a State plan for medical assistance must:

provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

⁴ U.S. Const. art. VI, cl. 2.

⁵ U.S. Const. amend. XIV.

II. LEGAL STANDARD

A preliminary injunction is an “extraordinary remedy.” *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 9 (2008). The Ninth Circuit summarized the Supreme Court’s recent clarification of the standard for granting preliminary injunctions in *Winter* as follows: “[a] plaintiff seeking a preliminary injunction must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest.” *Am. Trucking Ass’ns, Inc. v. City of Los Angeles*, 559 F.3d 1046, 1052 (9th Cir. 2009); *see also Cal. Pharms. Ass’n v. Maxwell-Jolly*, 563 F.3d 847, 849 (9th Cir. 2009) (“*Cal. Pharms. I*”). Alternatively, “‘serious questions going to the merits’ and a hardship balance that tips sharply towards the plaintiff can support issuance of an injunction, so long as the plaintiff also shows a likelihood of irreparable injury and that the injunction is in the public interest.” *Alliance for the Wild Rockies v. Cottrell*, 632 F.3d 1127, 1132 (9th Cir. 2011); *see also Indep. Living Ctr. of So. Cal. v. Maxwell-Jolly*, 572 F.3d 644, 657-58 (9th Cir. 2009) (“*ILC II*”). A “serious question” is one on which the movant “has a fair chance of success on the merits.” *Sierra On-Line, Inc. v. Phoenix Software, Inc.*, 739 F.2d 1415, 1421 (9th Cir. 1984).

III. DISCUSSION

A. Standing

Before turning to the merits of plaintiffs' motion, the Court first addresses the Director's arguments that plaintiffs lack standing to bring this case.

1. Concrete Injury

The Director argues that plaintiffs have not alleged an "actual and imminent injury" because plaintiffs' alleged injury relies on a "tenuous thread of assumptions contingent upon possibilities." Director's Opp'n at 13.

The Court rejects this argument because plaintiffs' alleged injuries are concrete rather than speculative or conjectural. In order to establish standing to assert a claim, a plaintiff must: (1) demonstrate an injury in fact, which is concrete, distinct and palpable, and actual or imminent; (2) establish a causal connection between the injury and the conduct complained of; and (3) show a substantial likelihood that the requested relief will remedy the alleged injury in fact. *See McConnell v. Fed'l Election Comm'n*, 540 U.S. 93, 225-26 (2003). In this case, plaintiffs allege that if implemented, the challenged rate reduction would inflict concrete financial injury on Medi-Cal participating service providers. *See Indep. Living Ctr. of So. Cal. v. Shewry*, 543 F.3d 1050, 1065 (9th Cir. 2008) ("*ILC I*"). *ILC I* also establishes that Medi-Cal beneficiaries have standing to challenge a Medi-Cal rate reduction when they allege they will be [sic]

“put at risk of injury by implementation of the . . . payment cuts’ because those cuts will reduce . . . access to quality services.” *Id.* Accordingly, plaintiffs have Article III standing.

2. Prudential Standing

The Director argues that plaintiffs’ lack prudential standing to enforce Section 30(A) because plaintiffs seek to enforce rights belonging to a third party, CMS. According to the Director, this Section does not confer individual entitlements on any private parties, but instead serves as a “yardstick” by which the federal government may assess a state’s performance under the Medicaid Act. Director’s Opp’n at 14. Moreover, to the extent that plaintiffs’ claims rely on the Supremacy Clause, the Director argues that they run afoul of the bar against considering generalized grievances in that plaintiffs are not attempting to vindicate any right personal to them, but instead invoke the Supremacy Clause as an “all-purpose cause of action to compel a state’s compliance with federal law.” *Id.* at 15 (citing *Valley Forge Christian Coll. v. Amer. United for Sep. of Church and State*, 454 U.S. 464, 483 (1982)).

The Court finds the Director’s prudential standing arguments unavailing. In assessing prudential standing, a court need not “inquire whether there has been a congressional intent to benefit the would-be plaintiff,” but instead must determine only whether the plaintiff’s interests are among those “arguably

. . . to be protected” by the statutory provision. *Nat’l Credit Union v. First Nat’l Bank & Trust Co.*, 552 U.S. 479, 489 (1998). This “zone of interest” test “is not meant to be demanding.” *Clarke v. Secs. Indus. Ass’n*, 479 U.S. 388, 399-400 (1987). To this end, Section 30(A) establishes standards by which payments to providers are set. Accordingly, Medi-Cal beneficiaries and providers are undoubtedly within the zone of interests protected by Section 30(A). Further, the Court finds that contrary to the Director’s assertion, plaintiffs are not alleging a “generalized grievance.” This is so because plaintiffs have alleged that the associational plaintiffs’ members and Medi-Cal beneficiaries will be directly harmed by the implementation of the rate reduction.

3. Associational Standing

The Director maintains that the associational plaintiffs cannot establish associational standing on behalf of providers because any injury suffered by a provider will be particular to that provider. Director’s Opp’n at 16. The Director further contends that the associational plaintiffs and AHF do not have standing on behalf of Medi-Cal beneficiaries because the associational plaintiffs and AHF do not represent beneficiaries’ interest, because the associational plaintiffs and AHF fail to allege how representing Medi-Cal recipients’ interests is germane to their purposes, and because whether an individual beneficiary has a legitimate claim will require an individualized determination. *Id.* at 16-17.

The Director's associational standing arguments also fail. An association has standing to sue on behalf of its members if (1) they would have standing to sue in their own right; (2) the interests it seeks to protect are germane to the organization's purpose; and (3) participation by the individual members is not necessary to resolve the claim. *Hunt v. Wash. State Apple Advertising Comm'n*, 432 U.S. 333, 343 (1997). The Ninth Circuit has recognized that when an association is pursuing an action for only declaratory and injunctive relief on behalf of its members, participation in the action by individual members is not required. *See Associated Gen'l Contractors of Am. v. Metropolitan Water Dist. of So. Cal.*, 159 F.3d 1178, 1181 (9th Cir. 1998). Here, plaintiffs are not seeking monetary relief, so participation of individual Medi-Cal providers is not required. Next, other courts have held that because individual medical providers would have third-party standing to represent the interests of their patients, associations representing those providers can also represent the interests of patients. *See, e.g., Penn. Psychiatric Soc'y v. Green Spring Health Svcs., Inc.*, 280 F.3d 278, 288-94 (3d Cir. 2002); *New Jersey Protection & Advocacy v. New Jersey Dep't of Educ.*, 563 F. Supp. 2d 474, 481-84 (D.N.J. 2008). Accordingly, in this case, the associational plaintiffs' members would have standing to represent the interests of their Medi-Cal patients and therefore the associational plaintiffs have standing to do the same. More fundamentally, even if the associational plaintiffs did not have standing to represent Medi-Cal beneficiaries, it would not alter the Court's ability to

reach the merits of the controversy because an individual Medi-Cal beneficiary whose standing is not challenged is a plaintiff in this case.

Having rejected each of the Director's standing arguments, the Court now turns to the merits of plaintiffs' motion.

B. Likelihood of Success on the Merits

1. Plaintiffs' Section 30(A) Claim Against the Secretary

Plaintiffs argue that they are likely to succeed on the merits of their Section 30(A) claim against the Secretary because CMS failed to apply controlling law in evaluating SPA 11-009 and therefore acted arbitrarily and capriciously.

Under the APA, a reviewing court must affirm an agency's determination unless it is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). "A decision is arbitrary and capricious if the agency 'has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.'" *O'Keefe's, Inc. v. U.S. Consumer Prod. Safety Comm'n*, 92 F.3d 940, 942 (9th Cir. 1996) (quoting *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983)).

If a statute is silent or ambiguous with respect to a specific question, the issue for the court is whether the agency's answer is based on a permissible construction of the statute. *Chevron U.S.A. v. NRDC*, 467 U.S. 837, 842-43 (1984). *Chevron* deference is required "when it appears that Congress delegated authority to the agency generally to make rules carrying the force of law, and . . . the agency interpretation claiming deference was promulgated in the exercise of that authority." *United States v. Mead Corp.*, 533 U.S. 218, 226-27 (2001).

a. CMS' Companion Letter

As an initial matter, plaintiffs argue that CMS' approval was "internally inconsistent" and therefore arbitrary and capricious because CMS "conceded" in its companion letter that it did not have a comprehensive plan from which it could determine if SPA 11-009 complied with federal law.

42 C.F.R. § 430.10 requires that a State plan be a comprehensive written statement containing all information necessary for CMS to determine whether the plan can be approved. CMS' companion letter to the letter approving SPA 11-009 acknowledged that CMS "reviews SPAs in the context of the overall state Plan for consistency with the requirements of section 1902(a) of the Social Security Act." The letter states:

Section 1902(a)(30)(A) of the Social Security Act (the Act) requires the procedures related to payments include a comprehensive description of the methods and standards used

to set payment rates. Attachment 4.19-B illustrates how non-institutional providers will be reimbursed and must contain comprehensive State plan language. . . . In addition, since the State plan is the basis for Federal financial participation, it is important that payment methodologies documented in the State plan are understandable and auditable. Absent the descriptions of these criteria, CMS will not be able to determine that the State plan language meets the requirements set forth in 42 CFR 447.252(b), 42 CFR 447.10, and Section 1902(a)(30)(A) of the Act.

According to plaintiffs, the companion letter “provides CMS’ own admission” that when CMS approved SPA 11-009, the resulting State Plan did not comply with various federal Medicaid requirements. Mot. at 10-11. Plaintiffs argue that CMS’ inquiry “indicates that at the time CMS approved SPA 11-009, CMS did not know what California’s current reimbursement rates actually were.” *Id.* at 11. Therefore, plaintiffs argue that CMS could not determine whether the resulting rates complied with Section 30(A), and that such “internally contradictory agency reasoning” renders the approval of SPA 11-009 “arbitrary and capricious.” *Id.* (citing *Ariz. Cattle Growers’ Ass’n v. U.S. Fish and Wildlife*, 273 F.3d 1229, 1236 (9th Cir. 2001)).

In opposition, the Secretary argues that CMS issued the companion letter to begin a separate process to resolve “peripheral issues” with the State Plan,

and not to address problems with SPA 11-009. Thus, the Secretary contends that the companion letter does not reflect any inconsistency in CMS' position, but instead merely shows that CMS determined that tangential technical matters should not delay the approval of an acceptable SPA. Secretary's Opp'n at 12-13.

The Court agrees with the Secretary that plaintiffs' argument fails because it rests on an improper understanding of the process CMS uses to review SPAs. Rather than show an "internal inconsistency," the companion letter is merely part of CMS' process by which it reviews the specific proposed amendment and evaluates whether it complies with the Medicaid Act and separately determines whether other parts of a state plan, not at issue in the proposed SPA, may need to be revised to comply with statutory requirements. *See* State Medicaid Director Letter No. 10-020, October 1, 2010 (attached to Secretary's Opp'n as Exhibit A). Under its process for reviewing SPAs, even if it discovers peripheral issues in a state plan that need to be addressed, CMS will not refrain from approving an SPA it deems acceptable. In this case, the companion letter explains that the State Plan is inadequate because it fails to comprehensively explain certain rates in a way that third parties and auditors would understand. The Court does not believe that the companion letter reflects a determination by CMS that changes to those rates are inconsistent with Section 30(A).

b. Cost Studies

Plaintiffs contend that CMS' approval of SPA 11-009 was arbitrary and capricious because CMS failed to consider whether DHCS relied on credible cost studies and developed rates reasonably related to provider costs as the Ninth Circuit has held is required under Section 30(A). Mot. at 11 (citing *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491, 1492, 1496, 1500 (9th Cir. 1997) *cert. denied*, *Belshe v. Orthopaedic Hosp.*, 522 U.S. 1044 (1998)).

In opposition, the Secretary contends that CMS' contrary interpretation of Section 30(A), upon which it based its approval of SPA 11-009, is entitled to *Chevron* deference notwithstanding the Ninth Circuit's decision in *Orthopaedic Hospital* that a state must consider "responsible cost studies."

Although Section 30(A) leaves room for interpretation,⁶ the Court does not believe the agency's interpretation is owed *Chevron* deference with respect to the approval at issue in this case. In this respect, the Court finds significant that the Secretary's approval of SPA 11-009 did not involve a formal adjudication

⁶ The Court notes that Section 30(A) does not explicitly mention provider costs or cost studies and that three other circuit courts have determined that CMS need not consider provider costs in deciding whether or not to approve a State Plan Amendment. See *Rite Aid of Pa. Inc. v. Houstoun*, 171 F.3d 842, 853 (3d Cir. 1999); *Methodist Hosps., Inc. v. Sullivan*, 91 F.3d 1026, 1030 (7th Cir. 1996); *Minn. HomeCare Ass'n v. Gomez*, 108 F.3d 917, 918 (8th Cir. 1997) (*per curiam*).

accompanied by the procedural safeguards justifying *Chevron* deference. Instead, the Secretary's issued her interpretation of Section 30(A) in a letter to DHCS. This kind of interpretation is of the very type for which the Supreme Court has declined to extend *Chevron* deference. See e.g., *Christensen v. Harris County*, 529 U.S. 576, 586-88 (2000) (holding that informal agency interpretations of a statute such as those contained in an opinion letter, policy statement, agency manuals, or enforcement guidelines, are not entitled to *Chevron*-style deference). *Alaska Dept. of Health and Social Servs. v. CMS*, 424 F. 3d 931 (9th Cir. 2005), upon which the Secretary relies, is inapposite. In *Alaska*, the Ninth Circuit deferred to the Secretary's interpretation of Section 30(A) and upheld the denial of a State Plan Amendment. In finding that the CMS Administrator's final determination "carr[ie]d] the force of law" necessary for *Chevron* deference, the court highlighted "the formal administrative process afforded the State," with "opportunities to petition for reconsideration, brief its legal arguments, be heard at a formal hearing, receive reasoned decisions at multiple levels of review and submit exceptions to those decision." *Alaska*, 424 F. 3d at 939. None of these procedural safeguards was incorporated in the SPA approval process at issue in this case, in which there was no hearing, no record, no opportunity for interested parties to present evidence, and no formal decision in which the Secretary

set forth her reasoning.⁷ Accordingly, the Secretary's approval of SPA 11-009 did not include the "hallmarks of 'fairness and deliberation,'" to which *Chevron* deference is owed. *See Alaska*, 424 F. 3d at 939 (quoting *Mead*, 533 U.S. at 226-27).⁸

⁷ 42 U.S.C. § 1316(a), which governs CMS' consideration of State Plan Amendments, does not require any type of hearing when the Secretary approves a State Plan Amendment. 42 U.S.C. § 1316(a)(1). In contrast, where the Secretary rejects a State's proposed Amendment, the State is entitled to petition the Secretary for reconsideration of the issue, and the Secretary is required to hold a hearing. 42 U.S.C. § 1316(a)(2). For this reason, *Chevron* deference is more appropriate for the disapproval of a State Plan Amendment.

⁸ The Secretary's reliance on *Dickson v. Hood*, 391 F. 3d 581 (5th Cir. 2004), and *Harris v. Olszewski*, 442 F. 3d 456 (6th Cir. 2006), is similarly misplaced. In *Dickson*, a Medicaid recipient alleged that the Louisiana Department of Health and Hospitals violated his federal rights by refusing to pay for medically prescribed disposable incontinence underwear. *Id.* at 584. The court merely afforded deference to the Secretary's interpretation of "home health care services" as embodied in a regulation previously promulgated pursuant to formal notice-and-comment rulemaking. *Id.* at 594. *Harris* involved a challenge to Michigan's single source provider contract for incontinence supplies as violating the Medicaid Act's freedom of choice provisions. 442 F. 3d at 460. Neither of these cases involved a challenge to the Secretary's approval of a State Plan Amendment or the appropriate level of deference required to be afforded to such approvals.

Similarly, the Supreme Court's decision in *Chase Bank U.S.A, N.A. v. McCoy*, 131 S. Ct. 871 (2011), cited by the Director for the proposition that an agency's amicus brief deserves deference, does not compel a contrary result. This is so because that case involved an agency's interpretation of its own regulation rather than the statutory scheme itself. *See id.*, 131 S. Ct at 880.

The Court does not believe that the Court of Appeals for the District of Columbia Circuit's determination in *PhRMA v. Thompson*, 362 F.3d 817, 822 (D.C. Cir. 2004), compels a contrary result in this case. Here, the decision of the Associate Regional Administrator of the Division of Medicaid & Children's Health Operations approving the SPA, as set forth in the October 27 approval letter, is conclusory in nature. It does not provide any reasons on its face as to why provider costs should not be considered in determining whether the SPA's rate reduction will result in lower quality of care or decreased access to services. Given the logical and empirical relationship between reimbursement rates and the willingness of providers to make services available that the Ninth Circuit found was the case in *Orthopaedic Hospital*, the absence of a reasoned decision to not require cost studies to justify the SPA makes the decision to approve the SPA less appropriate for *Chevron* deference. Further, the record reflects that CMS states even though it "does not currently interpret [Section 30(A)] of the Act to require cost studies in order to demonstrate compliance," CMS is "currently reviewing and refining, in a rulemaking proceeding, guidance on how states can adequately document access to services," suggesting that a formal notice and comment rulemaking process, accompanied by the procedural safeguards of such a proceeding, is contemplated by CMS. See Dkt. No. 23-2, at 1; June 17, 2011 Letter from CMS to DHCS. Besides the fact that no explanation is given for not requiring cost studies other than the statement that CMS "believe[s] the appropriate

focus is on access,” this statement by CMS suggests that its position regarding cost studies is not necessarily settled. Thus, although the court noted in *PhRMA* that *Chevron* deference may be warranted even when no administrative formality was required and none was afforded, the circumstances of this case call into question whether *Chevron* deference is appropriate.⁹

Having determined that *Chevron* deference is inappropriate, the Court now turns to whether the Secretary’s interpretation that cost studies are not required under Section 30(A) is “entitled to respect” under *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944).

The Court answers this question in the negative. *Skidmore* instructs that “[t]he weight accorded to an administrative judgment in a particular case will depend upon the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all of those factors which give it power to persuade, if lacking power to control.” 323 U.S. at 140. *Skidmore* respect is not owed for two reasons. First, in apparent

⁹ Further, in *PhRMA*, not only did the record support the reasonableness of the Secretary’s decision that the SPA at issue would make it less likely that needy persons would become eligible for Medicaid, thereby impacting Medicaid services, the court noted that an intervening decision of the Supreme Court supported the trial court’s decision to grant summary judgment in favor of the Secretary. 362 F. 3d at 821.

conflict with the Secretary's position in this case, in *Alaska*, the Secretary asked the Ninth Circuit to uphold her disapproval of a State Plan Amendment because Alaska failed to analyze provider costs. Specifically, the Secretary argued:

The requirements of § 1396(a)(30)(A) are . . . not so flexible as to allow the [State] to ignore the costs of providing services. For payment rates to be consistent with efficiency, economy, quality of care and access, they must bear a reasonable relationship to provider costs.

Alaska, Resp. Br., 2004 WL 3155124, at 32 (citing *Orthopaedic Hospital*, 103 F. 3d at 1499).¹⁰ In addition to this inconsistency in agency position, the Secretary's proffered interpretation directly contradicts the law in the Ninth Circuit. See *Orthopaedic Hospital*, 103 F. 3d at 1497. Thus, while the Court recognizes that in appropriate circumstances, an agency may change its position on the construction of a statute, the Court finds that in light of the circumstances of this case, the Secretary's conclusory interpretation that Section 30(A) does not require consideration of cost studies is of limited "power to persuade," and is therefore not entitled to respect under *Skidmore*.

¹⁰ Importantly, under *Skidmore*, courts consider whether the agency has acted consistently. See *Federal Express Corp. v. Holowecki*, 552 U.S. 389, 399 (2008); *Good Samaritan Hosp. v. Shalala*, 508 U.S. 402, 417 (1993).

Accordingly, because CMS failed to consider whether DHCS relied on responsible cost studies, the Court finds that CMS failed to consider a relevant factor, and therefore that there is a strong probability that its approval of SPA 11-009 will be found to be arbitrary and capricious.

In any event, the Court finds that whether the Secretary's interpretation of Section 30(A) as embodied in the approval of SPA 11-009 is owed deference presents a "serious question going to the merits." *See Alliance for the Wild Rockies*, 632 F.3d at 1132; *ILC II*, 572 F.3d at 657-58; *Sierra On-Line, Inc.*, 739 F.2d at 1421. In light of the balance of the hardships, which the Court believes tips strongly in plaintiffs' favor as discussed below, the Court finds that the issuance of a preliminary injunction is warranted.

C. Access to Quality Services

Before considering plaintiffs attacks on the specific analyses employed by the CMS, the Court first addresses plaintiffs' arguments regarding CMS' general methodology.

Plaintiffs contend that contrary to the Secretary's approval letter, the content of the administrative record before the Secretary did not "demonstrate a baseline of beneficiary access that . . . is consistent with Section 30(A)." Mot. at 13. According to plaintiffs, the Director's access analyses failed to include a meaningful comparison of the Medi-Cal population to the general population, any analysis of access on a local

geographic level, any analysis based on the actual healthcare needs of the Medi-Cal population, or any attempt to project the rate reduction's impact on access to quality services. *Id.* at 14.

In opposition, the Secretary argues that CMS properly considered all Section 30(A) factors. According to the Secretary, CMS reasonably concluded based on the evidence before it that the rate reduction would not harm beneficiary access to services. Secretary's Opp'n at 15. Additionally, the Secretary argues that the monitoring plan submitted by the State makes clear that it is addressing access to high quality care.¹¹ *Id.* at 13. Further, the Secretary asserts that independent provisions of federal and state law ensure high quality of care. *Id.*

The Court finds that plaintiffs have shown a substantial likelihood of success on the merits of their claim that CMS' acceptance of DHCS' access analyses and monitoring plan was arbitrary and capricious. In this regard, the Court finds significant that DHCS' access analyses failed to include projections of what impact the rate reduction would have on beneficiary

¹¹ Under the State's plan, DHCS will monitor a set of "early warning" measures, including change in Medi-Cal enrollment, provider participation rates, and calls to the Medi-Cal help line. Any indication of a reduction in beneficiaries' access to services would trigger a prompt response from DHCS, and if DHCS concludes that an access problem results from a reduction in payment, DHCS will "immediately take action to change the payment levels." DHCS is required to abide by the monitoring plan as a condition of CMS' approval of SPA 11-009.

access or comparisons of Medi-Cal payment rates to Medicare payment rates, average commercial payment rates or provider costs.¹² Furthermore, DHCS' analyses lack any meaningful geographic comparisons.¹³ This is so because DHCS reviewed access by "geographic peer groups," which apparently have nothing to do with geographic proximity and include providers from disparate regions of the State. Next, the Court finds it likely that the Secretary's acceptance of the monitoring plan as adequately ensuring access to quality services will also be found to be arbitrary and capricious. This is so because the monitoring plan merely creates a potential response after an access problem has been identified. To the extent reduced rates cause providers to close their doors, increased rates will not necessarily result in the reopening of those facilities. More fundamentally, during the period between the detection of an access problem and its potential remedy through increased reimbursements, Medi-Cal beneficiaries will necessarily suffer from reduced access to services. Finally, the Ninth Circuit has found it unreasonable to rely on

¹² The Court notes that in a proposed rulemaking, CMS proposed that an access review should include comparisons of Medicaid payments to either Medicare payment rates, the average commercial payment rates, or the applicable Medicaid allowable costs. 76 Fed. Reg. at 26361.

¹³ As noted above, Section 30(A) requires that care and services be available to Medi-Cal beneficiaries at least to the extent they are available to the general population in the geographic area.

independent provisions of federal and state law to ensure quality of care, precisely what the monitoring plan purports to do here. *See Orthopaedic Hospital*, 103 F.3d at 1497 (“The Department, itself, must satisfy the requirement that the payments themselves be consistent with quality care.”).¹⁴

i. Physician and Clinic Services

According to plaintiffs, despite overwhelming evidence that Medi-Cal rates prior to the rate reduction did not ensure sufficient access to care, the Director erroneously determined that a ten percent reduction would not adversely affect beneficiary access. Mot. at 16. Plaintiffs point to several purported defects in the Director’s methodology including that: (1) the Director “consistently and grossly overrepresents” the number of physicians in California and the number participating in Medi-Cal; (2) the Director consistently fails to adjust his counts of physicians to his counts of beneficiaries when calculating beneficiary to physician ratios; (3) the Director’s utilization data is inadequate because it does not account for the level of patient need; and (4) the utilization data is inadequate because it does not account for the type of

¹⁴ For the reasons stated above, the Secretary’s contrary interpretation in this case is not owed *Chevron* deference because the approval of a State Plan Amendment does not include the “hallmarks of ‘fairness and deliberation’” to which deference is owed. *See Alaska*, 424 F. 3d at 939 (quoting *Mead*, 533 U.S. at 226-27)

provider serving the beneficiary or the location of service.¹⁵ *Id.* at 16.

In opposition, the Secretary argues that CMS considered all information before it, and determined that the proposed rate cuts would not harm access. Secretary's Opp'n at 18. Further, the Secretary maintains that much of the input from providers was "very general" and did [not] provide specific examples or data on beneficiary impact. *Id.* The Secretary also contends that CMS considered the various studies and research literature included in the record, and concluded that these did not undermine the State's conclusion that the State's conclusion would not harm beneficiary access. *Id.* (citing Fan Decl. ¶ 5). The Secretary highlights that the studies upon which plaintiffs rely do not account for the fact that Medi-Cal beneficiaries rely heavily upon federally qualified

¹⁵ In support of their argument that the Director's analyses were fatally flawed, plaintiffs submit the declarations of two purported experts, Drs. Grumbach and Zuckerman. The Secretary argues that the experts' declarations were not before the agency and therefore should not be considered by the Court. Secretary's Opp'n at 16. This argument is not persuasive. A court may accept evidence outside the administrative record "to permit explanation or clarification of technical terms or subject matter involved in the agency action under review" or "for background information." *Public Power Council v. Johnson*, 674 F.2d 791, 794 (9th Cir. 1982); *see also Asarco, Inc. v. EPA*, 616 F.2d 1153, 1160 (9th Cir. 1980). Plaintiffs properly introduce the expert declarations to provide background as to the information before CMS with respect to its finding that access to services would not be impaired by the rate reduction. The Court considers the experts' declarations exclusively for this purpose.

health centers (“FQHCs”) and rural health clinics (“RHCs”), which were not subject to the rate reduction. *Id.* at 19. Finally, the Secretary argues that there was no information in the record indicating that the data provided by the State was erroneous, but instead that the State relied on data that CMS considers reliable. *Id.*

The Court agrees with plaintiffs that the specific methodology by which the Director analyzed beneficiary access to physician and clinic services was likely fundamentally flawed. In this respect, the Court finds two factors particularly concerning. First, the Director based his conclusion that Medi-Cal beneficiaries continued to have access to services on data related to how many physicians submitted at least one claim per year to Medical [sic]. The fact that a given number of physicians have submitted at least one claim per year to Medi-Cal does not necessarily reflect that those physicians see Medi-Cal patients on a regular basis. Next, the Court is troubled by DHCS’ reliance on FQHCs and RHCs to serve beneficiaries. Even if Medi-Cal beneficiaries heavily utilize FQHCs and RHCs, it does not constitute comparable access to care within the meaning of Section 30(A) to effectively limit Medi-Cal beneficiaries to such facilities.

ii. Dental Services

Plaintiffs maintain that CMS and other governmental agencies have for years identified a lack of access to dental services for Medi-Cal beneficiaries.

Mot. at 17. According to plaintiffs, in response to continuing access problems, in 2001, CMS issued a letter to all State Medicaid Directors in which it stated that “significant shortfalls in beneficiary receipt of dental services, together with evidence that Medicaid reimbursement rates fall below the 50th percentile of providers’ fees in the marketplace, create a presumption of noncompliance” with Section 30(A). *Id.* (citing Crall Decl. Ex. 11). Since that time, plaintiffs assert that CMS has targeted California as one of 16 states with low dental utilization rates, and a 2010 Government Accounting Office report stated that California had the seventh lowest dental utilization rate in the United States. *Id.* (citing Crall Decl. Ex. 2; Crall Decl. Ex. 4). In this context, plaintiffs argue that it was arbitrary and capricious for CMS to approve SPA 11-009 as to pediatric dental services. Further, plaintiffs assert that the Director relied on erroneous data relating to dental utilization rates. In support of this argument, plaintiffs points [sic] to that the utilization statistics reported by the Director in his analysis are between 13.8 and 17 percentage points higher than what the Director annually reports to CMS and what other research reports. *Id.* at 18 (citing Cannizzo Decl. Ex. 5-9). Further, plaintiffs note that the Director’s count of dentists participating in Medi-Cal for 2008 outnumbers those reported by the Centers for Disease Control without explanation. *Id.* (citing Cannizzo Decl. Ex. 10).

In opposition, the Secretary argues that the State’s access study showed that the percentage of

Medi-Cal enrolled children between the ages of zero and 20 with an annual dental visit between 2007 and 2009 was in line with the national average. Further, according to the Secretary, the State's analysis showed that the percentage of children using dental services increased from 45.3% in 2007 to 49.2% in 2009, lending further support to CMS's conclusion that the rate reduction would not negatively affect access. Secretary's Opp'n at 20. The Secretary also contends that there is no conflict between the data presented in the State's access analysis and the data in the Director's submissions to CMS because the methodologies used in each analysis is distinct. Finally, the Secretary argues that plaintiffs' claim that there are large geographic areas of California where Medi-Cal beneficiaries cannot access dental services is "vastly overstated" as CDC's State Oral Health Profile shows that 53 out of 58 counties have an enrolled Medicaid dentist. *Id.* at 21 (citing Dkt. No. 79-3, Ex. 10).

The Court believes plaintiffs' arguments are persuasive. In reaching this conclusion, the Court finds significant that CMS' State Medicaid Director Letter established that a low beneficiary utilization rate along with reimbursement rates that fall below 50 percent of providers' fees in the marketplace "create a presumption of noncompliance" with Section 30(A). Crall Decl. Ex. 11. Because neither CMS nor DHCS provide any evidence that Medi-Cal's reimbursement rates are above 50 percent of providers' fees and California's utilization rate is among the lowest in

the country, that presumption should apply here. Further, the Court also finds concerning that CMS acknowledges that only 53 of 58 counties have a Medi-Cal enrolled dentist, and that even in those counties, CMS apparently had no information before it to suggest that beneficiaries had comparable access to dentists as the general population.

iii. Pharmacy Services

Plaintiffs argue that the record before CMS demonstrated that the Director could not lawfully implement the rate reduction with respect to pharmacy services. Mot. at 18. In this respect, plaintiffs maintain that CPhA provided evidence to CMS demonstrating that the rate reduction would result in pharmacies being paid less than their costs for most drugs and in turn to decreased beneficiary access as a result of pharmacies refusing to provide services to Medi-Cal patients. *Id.* Plaintiffs assert that the Director's analysis included "several deficiencies" including that it relied on pharmacy utilization, which plaintiffs maintain is not an accurate indicator of access. *Id.* Finally, plaintiffs contend that "[b]ecause the Director failed to conduct a competent access study," on December 16, 2011, he was "forced to acknowledge" that for certain drugs, providers, or geographic areas, the ten percent reduction may impede access to selected Medi-Cal drug benefits and "possibly result in a violation of federal Medicaid law." *Id.* (quoting DHCS Proposal to Adjust Provider Payment Reductions for Selected Medi-Cal Drug Product Payments).

The Secretary responds that her approval of the Director's analysis was not arbitrary and capricious because: (1) California pays pharmacies based on Average Wholesale Price ("AWP"), an extremely inflated payment method with no real bearing on the actual cost pharmacies pay for drugs;¹⁶ (2) the AWP metric would allow Medi-Cal pharmacies to still realize a profits [sic] even after the rate reduction; and (3) in 2008, when a prior rate reduction was in effect, Medi-Cal utilization rates for pharmacy services increased. Secretary's Opp'n at 21-22.

The Court finds that there are two particular areas of concern regarding CMS' analysis of the rate reduction's impact on access to pharmacy services. First, the Secretary's argument regarding how pharmacies are reimbursed appears to rest on a misunderstanding of Medi-Cal pharmacy reimbursement. In this respect, Medi-Cal does not reimburse pharmacies the full amount of a drug's AWP. Instead, reimbursement is calculated by subtracting 17 percent from AWP. Cal. Welf. & Inst. Code § 14105.45(b)(3). Accordingly, California already accounts for the fact that AWP has been found to be an inflated price metric. Second, the Court does not believe utilization data is an accurate indicator of access in the pharmacy context because it reflects only whether a pharmacy services Medi-Cal beneficiaries. It fails to capture

¹⁶ AWP was found to be an inflated price metric in *In re Pharm. Indus. Average Wholesale Price Litig.*, 230 F.R.D. 61, 67-60 [sic] (D. Mass. 2005).

whether a pharmacy refuses to dispense a particular drug as a result of inadequate reimbursement.

iv. EMT Services

Plaintiffs' arguments regarding the CMS' analysis of the rate reduction on EMT services overlap with their general objections described above. Although the Court agrees with plaintiffs that the Director's access analysis inadequately considered provider costs and improperly relied on independent provisions of state and federal law which mandate the provision of EMT services, the Court declines to recreate its discussion on these points.

v. DME and Supply Services

Plaintiffs contend that based on the evidence in the record, CMS' approval of SPA 11-009 with respect to DME was arbitrary and capricious. Mot. at 20. According to plaintiffs, CMS should have known that a ten percent rate reduction could not be implemented without reducing the services provided to Medi-Cal beneficiaries because DME providers only average a five percent pretax profit margin. *Id.* at 21. Further, plaintiffs argue that there was no analysis with respect to medical suppliers and that CMS "had no basis" upon which to conclude that access would be preserved after the implementation of the rate reduction. *Id.*

The Secretary responds that the Director's access analysis indicates that utilization of DME services remained constant over a three-year period despite earlier cuts, with fluctuations upward, and that the number of available suppliers has increased as enrollment has expanded. Opp'n at 24. The Secretary argues that plaintiffs' assertion that a ten percent rate reduction would necessarily result in reduction of access relies on the faulty assumption that providers are incapable of adapting to new rates. *Id.* at 25. Further, the Secretary maintains that it was reasonable for CMS to credit the Director's analysis over "self-serving" survey responses from DME suppliers.¹⁷

The Court does not believe the CMS' analysis of the rate reduction contained specific flaws particular to DME services. However, because the Court believes the Director's analysis did not properly consider provider costs and failed to include a projection of the rate reduction's impact on access to DME services, the Court finds that plaintiffs have shown that they are likely to prevail on their claim that CMS'

¹⁷ The Secretary notes that "medical supply services" are not included in the definition of DME, but are instead listed as a subcategory of "home health services." Secretary's Opp'n at 24 n. 16 (citing 42 U.S.C. § 1395x(m)(4), (n)). Therefore, according to the Secretary, because the State declined to implement the rate reduction for home health services, "medical supply services" are not subject to the rate reduction. The Court does not believe this to be the case because medical supplies are explicitly listed on Supplement 15 of Attachment 4.19-B of the California State Plan as subject to the Rate Reduction.

approval of SPA 11-009 with respect to DME supply services was arbitrary and capricious.

In sum, the Court believes plaintiffs are likely to succeed on the merits of their claim that CMS' acceptance of the access analyses and monitoring plan was arbitrary and capricious, and in any event, that the issue at least presents a "serious question going to the merits." Because the Court finds that the balance of hardships tips strongly in plaintiffs' favor, a preliminary injunction is appropriate on this basis as well. See *Alliance for the Wild Rockies*, 632 F.3d at 1132; *ILC II*, 572 F.3d at 657-58; *Sierra On-Line, Inc.*, 739 F.2d at 1421.

2. Plaintiffs' Section 30(A) Claim Against the Director

The Director argues that plaintiffs are unlikely to succeed on the merits of their Section 30(A) claim because they have no basis for asserting a private right of action under Section 30(A). Director's Opp'n at 22. The Director further contends that even if plaintiffs have a private right of action, they cannot demonstrate that AB 97 violates, and is thus preempted by, Section 30(A). In support of this argument, the Director points to CMS' approval of SPA 11-009, which the Director contends is owed deference. *Id.* at 18-20.

At this juncture, the Director's argument that plaintiffs lack a private right of action to enforce Section 30(A) fails. While plaintiffs lack a private right of action under 42 U.S.C. § 1983, see *Develop. Servs.*

Network v. Douglas, No. 11-55851 slip op. at 20533 (9th Cir. Nov. 30, 2011), Ninth Circuit case law establishes that Section 30(A) is enforceable by private parties under the Supremacy Clause. See *ILC I*, 543 F.3d at 1050-52; *ILC II*, 572 F.3d at 644; *Cal. Pharms. I*, 563 F.3d at 850-51. Although this issue is presently before the Supreme Court, unless and until this precedent is overruled, it controls here. See *Hart v. Massanari*, 266 F.3d 1155, 1171 (9th Cir. 2001). For the reasons articulated in Section B(1) *supra*, the Court finds that plaintiffs are likely to succeed on their claim that DHCS' failure to consider responsible cost studies and failure to adequately consider the effect of the rate reduction on access to and quality of care may be found to have violated Section 30(A). As noted above, the Court finds that these issues at least present "serious questions as to the merits" of plaintiffs' claim, and that the balance of hardships tips strongly in plaintiffs' favor. See *Alliance for the Wild Rockies*, 632 F.3d at 1132; *ILC II*, 572 F.3d at 657-58; *Sierra On-Line, Inc.*, 739 F.2d at 1421.

3. Plaintiffs' Takings Clause Claim

Plaintiffs assert that the rate reduction violates the Takings Clause of the Fifth Amendment of the U.S. Constitution as incorporated against the states through the Fourteenth Amendment of the U.S. Constitution. FAC ¶¶ 73-79. Plaintiffs argue that due to state laws that require EMT providers and emergency room physicians to provide emergency medical services regardless of a patient's ability to pay, the

Director's failure to adequately reimburse these providers for their services constitutes an unlawful taking of their property without just compensation. Mot. at 22.

The "Takings Clause" of the Fifth Amendment provides that private property shall not "be taken for public use, without just compensation." U.S. Const. amend. V. "In order to state a claim under the Takings Clause, a plaintiff must first demonstrate that he possesses a 'property interest' that is constitutionally protected." *Turnacliiff v. Westly*, 546 F.3d 1113, 1118-19 (9th Cir. 2008) (internal citations omitted).

The Court does not believe that plaintiffs have shown a likelihood of success on their Takings Clause claim. Ordinarily, a "[g]overnmental regulation that affects a group's property interests 'does not constitute a taking of property where the regulated group is not required to participate in the regulated industry.'" *Burditt v. U.S. Dept. of Health and Human Services*, 934 F.2d 1362, 1376 (5th Cir. 1991) (quoting *Whitney v. Heckler*, 780 F.2d 963, 972 (11th Cir. 1986)). In this case, plaintiffs' claim for unlawful taking fails because plaintiffs do not have a protected property interest. In this regard, the emergency room physicians and EMT providers voluntarily elect to provide emergency medical services, thereby accepting the various restrictions on their services, including statutory requirements to treat all patients whether such patients are privately insured, uninsured, or covered under Medi-Cal. Because these providers are under no legal compulsion to continue providing emergency

medical care, there is no valid property interest subject to a claim under the Takings Clause.

C. Risk of Irreparable Injury

Plaintiffs contend that the rate reduction will cause irreparable harm in two principal ways. First, plaintiffs argue that Medi-Cal providers will suffer substantial monetary losses as a result of the rate reduction, forcing them to severely curtail their services or close their businesses entirely. Next, as a result of these service reductions, plaintiffs contend that Medi-Cal beneficiaries will suffer severely limited access to care. Mot. at 23-24.

In opposition, the Director first argues that injury to individual providers is not a proper basis for injunctive relief [sic]. Director's Opp'n at 3. In any event, the Director argues that the declarations of individual providers upon which plaintiffs rely confirm that the rate reduction will not cause irreparable harm because these declarants assert that they have accepted inadequate Medi-Cal reimbursement in the past. *Id.* at 4-5. Further, the Director argues that CMS' approval of SPA 11-009 means that beneficiaries will not suffer reduced access to services, and that in any event, the monitoring plan California has adopted mitigates any potential access problem. *Id.* at 7-9 (citing *Midgett v. Tri-County Metro. Transp. Dist. of Or.*, 254 F. 3d 846, 850 (9th Cir. 2001) (holding that a defendant's procedures for monitoring compliance in the ADA context "show that Plaintiff does not face

a threat of immediate irreparable harm without an injunction”)).

The Court finds that plaintiffs have met their burden of showing irreparable harm in the absence of an injunction. In reaching this conclusion, the Court rejects the contention that California’s monitoring plan will necessarily prevent beneficiaries from being harmed. As discussed above, the Court believes that the monitoring plan at best presents a potential remedy *after* an access problem has been detected. Even if the monitoring plan could ensure that beneficiary access to services would not be reduced on the aggregate, the Ninth Circuit has held that as long as there is evidence showing that at least some Medi-Cal beneficiaries might lose services as a result of a rate reduction, irreparable harm is adequately demonstrated. *Cal. Pharms. Ass’n v. Maxwell-Jolly*, 596 F.3d 1098, 1114 (9th Cir. 2010) (“*Cal. Pharms. II*”). Here, plaintiffs have proffered substantial evidence that Medi-Cal providers will reduce or eliminate their services in response to the implementation of the rate reduction, suggesting that at least some beneficiaries would suffer reduced access to services. *See, e.g.*, Sprau Decl. ¶ 10 (pulmonologist and critical care physician will not accept new Medi-Cal patients); Chiang Decl. ¶ 18 (dentist will close office dedicated to serving Medi-Cal patients); Dunkel Decl. ¶ 9 (pharmacist will not accept new Medi-Cal patients or fill all Medi-Cal prescriptions); Stidham Decl. ¶¶ 7-10 (AHF no longer able to provide same level of services to Medi-Cal beneficiaries with HIV or AIDS). Furthermore,

because providers would be barred from recovering any reimbursement shortfall in an action at law due to California's Eleventh Amendment immunity, the Court finds plaintiffs have shown adequate irreparable injury to support an injunction on this basis as well. *See Cal. Pharms. I*, 563 F. 3d at 850-52.¹⁸

D. Balance of Hardships and Public Interest

The Director argues that injunctive relief would have a serious impact on the continuing financial health of the State of California. Director's Opp'n at 25. The Director also maintains that the public will suffer harm if an injunction issues because any injunction that prevents the implementation of a state statute [sic] inflicts injury on the State. Director's Opp'n at 24 (citing *Coalition for Economic Equity v. Wilson*, 122 F. 3d 718, 719 (9th Cir. 1997)).

Although cognizant of the State's fiscal difficulties, the Court believes that the balance of the equities and the public interest strongly favor the issuance of an injunction. In reaching this conclusion, the Court notes that the Ninth Circuit has held that the injury to a state caused by the injunction of one of

¹⁸ In this respect, the Director's argument that monetary loss to providers cannot be a basis for an injunction is unavailing. The Ninth Circuit has repeatedly rejected this precise argument. *See, e.g., Cal. Pharms. I*, 563 F. 3d at 850-51; *ILC II*, 572 F.3d at 658; *Cal. Pharms. II*, 596 F. 3d at 1113-14.

its statutes does not outweigh the public's interest in ensuring that state agencies comply with the law and protect beneficiaries' access to services. *ILC II*, 572 F. 3d at 658; *Cal. Pharms. II*, 596 F. 3d at 1114-15. Similarly, the State's fiscal crisis does not outweigh the serious irreparable injury plaintiffs would suffer absent the issuance of an injunction. *See ILC II*, 572 F. 3d at 658-59 ("State budgetary considerations do not . . . in social welfare cases, constitute a critical public interest that would be injured by the grant of preliminary relief. In contrast, there is a robust public interest in safeguarding access to health care for those eligible for Medicaid."); *see also Golden Gate Restaurant Ass'n v. City and County of San Francisco*, 512 F. 3d 1112, 1126 (9th Cir. 2008) (Where "there is a conflict between financial concerns and preventable human suffering . . . , the balance of hardships tips decidedly in favor of the latter.").

E. Application of the State's Eleventh Amendment Immunity

At oral argument, the Director argued that the Court cannot enjoin the Director from implementing the rate reduction because such an injunction would violate California's Eleventh Amendment immunity. Plaintiffs responded that an injunction restraining implementation of the rate reduction by the Director would not violate the State's Eleventh Amendment immunity because such relief would be prospective rather than retrospective in effect. Although the Eleventh Amendment bars suits against states in

both law and equity, a plaintiff may nonetheless maintain a federal action to compel a state official's prospective compliance with the plaintiff's federal rights. *Ex Parte Young*, 209 U.S. 123, 156 (1908) ("The State has no power to impart to [its officer] any immunity from responsibility to the supreme authority of the United States."). The Court may issue such an injunction even if the state's compliance will have an "ancillary effect" on the state treasury. *Edelman v. Jordan*, 415 U.S. 651, 662-63 (1974). However, this exception applies only to prospective relief; it does not permit retroactive injunctive relief. *Id.* at 668. The Court finds that to the extent the Director has already reimbursed providers for claims made after June 1, 2011, enjoining the Director from implementing the rate reduction would not violate the State's Eleventh Amendment immunity. This is so because such an injunction would merely preclude the Director from recovering funds already distributed. However, insofar as the Director has not yet reimbursed providers for services rendered between June 1, 2011, and the date of this order, the Court finds and concludes that an injunction restraining the implementation of the rate reduction would be contrary to the State's Eleventh Amendment immunity. In this respect, the Court is guided by the Ninth Circuit's explanation that "whether relief is prospective or retrospective in the Medicaid payment context turns on the date of service, not the date of payment." *ILC II*, 572 F.3d at 661, n. 19. Under this definition, an injunction precluding the Director from reducing payments for services already rendered would constitute

a retrospective award of damages in violation of the Eleventh Amendment.

F. Director's Motion for a Stay Pending Appeal

At oral argument, the Director orally moved for a stay of the preliminary injunction pending his appeal of this order. In deciding whether to issue a stay pending appeal, the Court considers “(1) whether the stay applicant has made a strong showing that he is likely to succeed on the merits; (2) whether the applicant will be irreparably injured absent a stay; (3) whether issuance of the stay will substantially injure the other parties interested in the proceeding; and (4) where the public interest lies.” *See Golden Gate Rest. Ass'n v. City & County of S.F.*, 512 F.3d 1112, 1115 (9th Cir. 2008) (citations omitted). The Court finds that the relevant factors do not weigh in favor of granting the Director's motion. Most importantly, there is no evidence that the Director will suffer irreparable injury absent a stay. By contrast, an issuance of a stay would substantially injure plaintiffs because providers would continue to lose considerable revenue that cannot be recouped and because Medi-cal beneficiaries would suffer from reduced access to services. Accordingly, the Court DENIES the Director's motion for a stay pending appeal.

IV. CONCLUSION

In accordance with the foregoing, the Court hereby GRANTS plaintiffs' motion for a preliminary injunction, and DENIES the Director's motion for a stay pending appeal.

IT IS HEREBY ORDERED as follows:

Defendant Toby Douglas, Director of the California Department of Health Care Services, his employees, his agents, and others acting in concert with him with actual notice of this order shall be, and hereby are, enjoined and restrained from violating federal law by implementing or otherwise applying the reduction of Medi-Cal reimbursement for services provided by physicians, clinics, dentists, pharmacists, ambulance providers and providers of medical supplies and durable medical equipment on or after June 1, 2011 for which the Director has already provided reimbursement, pursuant to Assembly Bill 97 enacted by the California Legislature in March 2011, as codified at California Welfare and Institutions Code § 14105.192, or to any other degree reducing current Medi-Cal rates for such services. This injunction does not preclude the Director from applying the rate reduction to services rendered between June 1, 2011, and the date of this order, for which reimbursement has not yet been provided.

IT IS HEREBY FURTHER ORDERED that, consistent with the foregoing, the October 27, 2011 decision by Defendant Kathleen Sebelius, Secretary of the Department of the United States Department of

Health and Human Services, approving the Medi-Cal reimbursement reduction codified at Welfare and Institutions Code § 14105.192, is hereby stayed.

Dated: January 31, 2012 /s/ Christina A. Snyder
CHRISTINA A. SNYDER
UNITED STATES
DISTRICT JUDGE

APPENDIX C

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
WESTERN DIVISION

CALIFORNIA HOSPITAL)	Case No.
ASSOCIATION; ET AL;)	CV 11-9078 CAS (MANx)
et al.,)	ORDER GRANTING
Plaintiffs,)	PRELIMINARY
vs.)	INJUNCTION
TOBY DOUGLAS; et al.;)	
Defendants.)	

I. INTRODUCTION AND BACKGROUND

On November 1, 2011, plaintiffs filed the instant action against Toby Douglas, Director of the California Department of Health Care Services (the “Director”) and Kathleen Sebelius, Secretary of the U.S. Department of Health and Human Services (the “Secretary”). Plaintiffs filed their First Amended Complaint (“FAC”) on November 18, 2011.

The California Department of Health Care Services (“DHCS”) is a California agency charged with the administration of California’s Medicaid program, Medi-Cal. The Secretary is responsible for administering the Medicaid program at the federal level. Through her designated agent, the Centers for Medicare and Medicaid Services (“CMS”), the Secretary is responsible for reviewing and approving policy

changes that states make to their Medicaid programs.

Plaintiff California Hospital Association (“CHA”) is a trade association representing the interests of hospitals in the State of California. Many of CHA’s member hospitals operate skilled nursing facilities that are distinct units within the hospital, commonly referred to as “DP/NFs.” Plaintiffs G.G., A.G., I.F., R.E., and A.W. are beneficiaries of the Medi-Cal program who require skilled nursing services.

On March 25, 2011, California Governor Edmund G. Brown Jr. signed into law Assembly Bill 97 (“AB 97”), the health budget trailer bill for California fiscal year 2011-2012. AB 97 enacted significant payment reductions for many classes of services provided under the Medi-Cal program. Most significantly for the purposes of the instant action, AB 97 enacted California Welfare and Institutions Code § 14105.192, which authorizes the Director to reduce the Medi-Cal payment rates for various categories of services, effective June 1, 2011. Most of the rate reductions called for are flat 10 percent reductions. However, pursuant to Welfare and Institutions Code § 14105.192(j), reimbursement for certain services may not exceed the reimbursement rates that were applicable to those claims of providers in the 2008-09 rate year, reduced by 10 percent. Among the services impacted by this provision are DP/NF services.

DHCS submitted proposed State Plan Amendment (“SPA”) 11-010 to CMS on June 30, 2011, seeking

federal approval of the rate reduction and incorporation of that reduction into California's Medi-Cal State Plan. On September 27, 2011, CMS issued a letter to DHCS requesting additional information concerning the proposed rate reduction. This Request for Additional Information ("RAI") focused on the impact of the rate reduction on access to services. DHCS responded with an "Access Analysis" and a plan for monitoring access. On October 27, 2011, in a letter from the Associate Regional Administrator of the Division of Medicaid & Children's Health Operations, CMS provided notice to the Director and DHCS that it had approved the SPA.

Plaintiffs seek a declaration that the rate reduction violates the Takings Clause of the Fifth Amendment to the United States Constitution, the Takings Clause of the California Constitution,¹ numerous provisions of the Medicaid Act,² and the Administrative Procedure Act ("APA"), 5 U.S.C. § 706 *et seq.* Prayer for Relief ¶ 1. Plaintiffs further seek a declaration that it was arbitrary, capricious, and an abuse of discretion for the Secretary to approve the SPA incorporating the rate reduction into California's State Plan. *Id.* ¶ 2. Plaintiffs also request that the Court set aside the Secretary's approval, and enjoin the Director from effectuating the rate reduction. *Id.* ¶¶ 3, 4.

¹ Cal. Const. art. 1, § 19.

² Specifically, plaintiffs allege violations of 42 U.S.C. § 1396a(a)(8) ("Section (a)(8)"), 42 U.S.C. § 1396a(a)(19) ("Section (a)(19)"), and 42 U.S.C. § 1396a(a)(30)(A) ("Section 30(A)").

On November 21, 2011, plaintiffs filed the present motion seeking a preliminary injunction restraining the Director from implementing the rate reduction. On December 2, 2011, the Court denied the Director's ex parte application for a stay of the proceedings. On December 5, 2011, the Director and the Secretary filed separate oppositions to plaintiffs' motion.³ Plaintiffs replied on December 9, 2011. The Court heard oral argument on December 19, 2011. After carefully considering the parties' arguments, the Court finds and concludes as follows.

II. LEGAL STANDARD

A preliminary injunction is an "extraordinary remedy." *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 9 (2008). The Ninth Circuit summarized the Supreme Court's recent clarification of the standard for granting preliminary injunctions in *Winter* as follows: "[a] plaintiff seeking a preliminary injunction must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm

³ Contemporaneously with his opposition, the Director submitted evidentiary objections to substantially all of plaintiffs' declarations in support of their motion for preliminary injunction. Dkt. No. 44. The Director argues that plaintiffs' declarations are inadmissible because they are irrelevant, not based on personal knowledge, improper opinion testimony by a lay witness, and include inadmissible hearsay evidence. *Id.* To the extent the Court relies on evidence contained within plaintiffs' declarations, as noted below, the Director's objections are overruled. The Director's other objections are overruled as moot.

in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest.” *Am. Trucking Ass’n, Inc. v. City of Los Angeles*, 559 F.3d 1046, 1052 (9th Cir. 2009); *see also Cal. Pharms. Ass’n v. Maxwell-Jolly*, 563 F.3d 847, 849 (9th Cir. 2009) (“*Cal. Pharms. I*”). Alternatively, “‘serious questions going to the merits’ and a hardship balance that tips sharply towards the plaintiff can support issuance of an injunction, so long as the plaintiff also shows a likelihood of irreparable injury and that the injunction is in the public interest.” *Alliance for the Wild Rockies v. Cottrell*, 632 F.3d 1127, 1132 (9th Cir. 2011); *see also Indep. Living Ctr. of So. Cal. v. Maxwell-Jolly*, 572 F.3d 644, 657-58 (9th Cir. 2009) (“*ILC II*”). A “serious question” is one on which the movant “has a fair chance of success on the merits.” *Sierra On-Line, Inc. v. Phoenix Software, Inc.*, 739 F.2d 1415, 1421 (9th Cir. 1984).

III. DISCUSSION

A. Standing

Before turning to the merits of plaintiffs’ motion, the Court first addresses the Director’s arguments that plaintiffs lack standing to bring this case.

1. Concrete Injury

The Director argues that plaintiffs have not alleged an “actual and imminent injury” because plaintiffs’ alleged injury relies on a “tenuous thread of

assumptions contingent upon possibilities.” Director’s Opp’n at 2.

The Court rejects this argument because plaintiffs’ alleged injuries are concrete rather than speculative or conjectural. In order to establish standing to assert a claim, a plaintiff must: (1) demonstrate an injury in fact, which is concrete, distinct and palpable, and actual or imminent; (2) establish a causal connection between the injury and the conduct complained of; and (3) show a substantial likelihood that the requested relief will remedy the alleged injury in fact. See *McConnell v. Fed’l Election Comm’n*, 540 U.S. 93, 225-26 (2003). In this case, plaintiffs allege that if implemented, the challenged rate reduction would inflict concrete financial injury on Medi-Cal participating hospitals. See *Indep. Living Ctr. of So. Cal. v. Shewry*, 543 F.3d 1050, 1065 (9th Cir. 2008) (“*ILC I*”). *ILC I* also establishes that Medi-Cal beneficiaries have standing to challenge a Medi-Cal rate reduction when they allege they will be “put at risk of injury by implementation of the . . . payment cuts” because those cuts will reduce . . . access to quality services.” *Id.* Accordingly, there can be little doubt that plaintiffs have Article III standing.

2. Prudential Standing

The Director argues that plaintiffs' lack prudential standing to enforce Sections (a)(19)⁴ and 30(A)⁵ because plaintiffs seek to enforce rights belonging to a third party, CMS. According to the Director, these Sections do not confer individual entitlements on any private parties, but instead serve as "yardsticks" by which the federal government may assess a state's performance under the Medicaid Act. Director's Opp'n at 3. Moreover, to the extent that plaintiffs' claims rely on the Supremacy Clause, the Director argues that they run afoul of the bar against considering generalized grievances in that plaintiffs are not attempting to vindicate any right personal to them, but

⁴ Section (a)(19) states that a State plan for medical assistance must:

provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of recipients.

⁵ Section 30(A) states in pertinent part that a State plan for medical assistance must:

provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

instead invoke the Supremacy Clause as an “all-purpose cause of action to compel a state’s compliance with federal law.” *Id.* at 4 (citing *Valley Forge Christian Coll. v. Amer. United for Sep. of Church and State*, 454 U.S. 464, 483 (1982)).

The Court finds the Director’s prudential standing arguments unavailing. In assessing prudential standing, a court need not “inquire whether there has been a congressional intent to benefit the would-be plaintiff,” but instead must determine only whether the plaintiff’s interests are among those “arguably . . . to be protected” by the statutory provision. *Nat’l Credit Union v. First Nat’l Bank & Trust Co.*, 552 U.S. 478, 489 (1998). This “zone of interest” test “is not meant to be demanding.” *Clarke v. Secs. Indus. Ass’n*, 479 U.S. 388, 399-400 (1987). To this end, Section (a)(19) mandates that state Medicaid agencies set policies consistent with the “best interests” of Medicaid beneficiaries, while Section 30(A) establishes standards by which payments to providers are set. Accordingly, Medi-Cal beneficiaries and providers are undoubtedly within the zone of interests protected by Sections (a)(19) and 30(A). Further, the Court finds that contrary to the Director’s assertion, plaintiffs are not alleging a “generalized grievance.” This is so because plaintiffs have alleged that CHA’s member hospitals and the individual-beneficiary plaintiffs will be directly harmed by the implementation of the rate reduction.

3. Associational Standing

The Director maintains that CHA cannot establish associational standing. Specifically, the Director argues that CHA does not have associational standing on behalf of hospitals because any injury suffered by a hospital will be particular to that hospital. Director's Opp'n at 4-5. The Director further contends that CHA does not have standing on behalf of Medi-Cal beneficiaries because CHA represents the interests of its member hospitals, rather than the patients of those hospitals, because CHA fails to allege how representing Medi-Cal recipients' interests is germane to CHA's purpose, and because whether an individual beneficiary has a claim under §§ (a)(8) and (a)(19) will require individualized determinations. *Id.* at 5-6.

The Director's associational standing arguments also fail. An association has standing to sue on behalf of its members if (1) they would have standing to sue in their own right; (2) the interests it seeks to protect are germane to the organization's purpose; and (3) participation by the individual members is not necessary to resolve the claim. *Hunt v. Wash. State Apple Advertising Comm'n*, 432 U.S. 333, 343 (1997). The Ninth Circuit has recognized that when an association is pursuing an action for only declaratory and injunctive relief on behalf of its members, participation in the action by individual members is not required. *See Associated Gen'l Contractors of Am. v. Metropolitan Water Dist. of So. Cal.*, 159 F.3d 1178, 1181 (9th Cir. 1998). Here, plaintiffs are not seeking

monetary relief, so participation of individual CHA member hospitals is not required. Next, other courts have held that because individual medical providers would have third-party standing to represent the interests of their patients, associations representing those providers can also represent the interests of patients. *See, e.g., Penn. Psychiatric Soc’y v. Green Spring Health Svcs., Inc.*, 280 F.3d 278, 288-94 (3d Cir. 2002); *New Jersey Protection & Advocacy v. New Jersey Dep’t of Educ.*, 563 F.Supp.2d 474, 481-84 (D.N.J. 2008). Accordingly, in this case, CHA’s member hospitals would have standing to represent the interests of their Medi-Cal patients and therefore that CHA has standing to do the same. More fundamentally, even if CHA did not have standing to represent Medi-Cal beneficiaries, it would not alter the Court’s ability to reach the merits of the controversy because there are individual Medi-Cal beneficiaries who are plaintiffs to this case whose standing is not challenged.

Having rejected each of the Director’s standing arguments, the Court now turns to the merits of plaintiffs’ motion.

B. Likelihood of Success on the Merits

1. Plaintiffs’ Section 30(A) Claim Against the Secretary

Plaintiffs argue that they are likely to succeed on the merits of their Section 30(A) claim against the Secretary because CMS failed to apply controlling law

in evaluating SPA 11-010 and therefore acted arbitrarily and capriciously.

Under the APA, a reviewing court must affirm an agency's determination unless it is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). "A decision is arbitrary and capricious if the agency 'has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.'" *O'Keefe's, Inc. v. U.S. Consumer Prod. Safety Comm'n*, 92 F.3d 940, 942 (9th Cir. 1996) (quoting *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983)).

If a statute is silent or ambiguous with respect to a specific question, the issue for the court is whether the agency's answer is based on a permissible construction of the statute. *Chevron U.S.A. v. NRDC*, 467 U.S. 837, 842-43 (1984). *Chevron* deference is required "when it appears that Congress delegated authority to the agency generally to make rules carrying the force of law, and . . . the agency interpretation claiming deference was promulgated in the exercise of that authority." *United States v. Mead Corp.*, 533 U.S. 218, 226-27 (2001).

a. Cost Studies

Plaintiffs first contend that CMS's approval of SPA 11-010 was arbitrary and capricious because CMS failed to consider whether DHCS relied on credible cost studies and developed rates reasonably related to provider costs as the Ninth Circuit has held is required under Section 30(A). Mot. at 9-10 (citing *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491, 1492, 1496, 1500 (9th Cir. 1997) *cert. denied*, *Belshe v. Orthopaedic Hosp.*, 522 U.S. 1044 (1998)).

In opposition, the Secretary contends that CMS's contrary interpretation of Section 30(A), upon which it based its approval of SPA 11-010, is entitled to *Chevron* deference notwithstanding the Ninth Circuit's decision in *Orthopaedic Hospital* that a state must consider "responsible cost studies." According to the Secretary, she has "consistently taken the position" that Section 30(A) does not require states to base payment rates on the costs incurred by providers even though this interpretation has not yet been incorporated into a final rule. Secretary's Opp'n at 8. The Secretary cites *Nat'l Cable & Telecom. Ass'n v. Brand X Internet Servs.* ("*Brand X*"), for the principle that "[a] court's prior judicial construction of a statute trumps an agency construction otherwise entitled to *Chevron* deference only if the prior court decision holds that its construction follows from the unambiguous terms of the statute and thus leaves no room for agency discretion." *Id.* (quoting *Brand X*, 545 U.S. 967, 982 (2005)). Because the Ninth Circuit has not held that its interpretation follows from the

unambiguous terms of the statute, the Secretary contends that her interpretation of the statute controls because it was made within the context of an adjudication that would normally be afforded *Chevron* deference. *Id.* at 9-10. The Secretary further argues that the Ninth Circuit has held that the Secretary's interpretation of Section 30(A), which formed the basis of the disapproval of a State Plan Amendment, is entitled to *Chevron* deference. *Id.* at 10 (citing *Alaska Dept. of Health and Social Servs. v. CMS*, 424 F.3d 931 (9th Cir. 2005) ("*Alaska*"). The Secretary contends that any distinction between the approval and the disapproval of a SPA is irrelevant to whether Congress delegated interpretative authority to the agency, thus mandating *Chevron* deference. *Id.* at 11 n. 5. The Secretary notes also that the Court of Appeals for the District of Columbia Circuit has determined that the Secretary's interpretation of the Medicaid statute made in connection with the approval of an SPA is entitled to *Chevron* deference. *Id.* at 11 (citing *PhRMA v. Thompson*, 362 F.3d 817, 822 (D.C. Cir. 2004)).

Although the Court agrees with the Secretary that Section 30(A) leaves room for interpretation,⁶ the

⁶ The Court notes that Section 30(A) does not explicitly mention provider costs or cost studies and that three other circuit courts have determined that CMS need not consider provider costs in deciding whether or not to approve a State Plan Amendment. *See Rite Aid of Pa. Inc. v. Houstoun*, 171 F.3d 842, 853 (3d Cir. 1999); *Methodist Hosps., Inc. v. Sullivan*, 91 F.3d

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Court does not believe the agency's interpretation is owed *Chevron* deference with respect to the approval at issue in this case. In this respect, the Court finds significant that the Secretary's approval of SPA 11-010 did not involve a formal adjudication accompanied by the procedural safeguards justifying *Chevron* deference. Instead, the Secretary issued her interpretation of Section 30(A) in a letter to DHCS. This kind of interpretation is of the very type for which the Supreme Court has declined to extend *Chevron* deference. See e.g., *Christensen v. Harris County*, 529 U.S. 576, 586-88 (2000) (holding that informal agency interpretations of a statute such as those contained in an opinion letter, policy statement, agency manuals, or enforcement guidelines, are not entitled to *Chevron*-style deference). The Secretary's reliance on *Alaska* misplaced [sic]. In *Alaska*, the Ninth Circuit deferred to the Secretary's interpretation of Section 30(A) and upheld the denial of a State Plan Amendment. In finding that the CMS Administrator's final determination "carr[ie]d the force of law" necessary for *Chevron* deference, the court highlighted "the formal administrative process afforded the State," with "opportunities to petition for reconsideration, brief its legal arguments, be heard at a formal hearing, receive reasoned decisions at multiple levels of review and submit exceptions to those decisions." *Alaska*, 424 F. 3d at 939. None of these procedural safeguards was

1026, 1030 (7th Cir. 1996); *Minn. Homecare Ass'n v. Gomez*, 108 F. 3d 917, 918 (8th Cir. 1997) (*per curiam*).

incorporated in the SPA approval process at issue in this case, in which there was no hearing, no record, no opportunity for interested parties to present evidence, and no formal decision in which the Secretary set forth her reasoning.⁷ Accordingly, the Secretary's approval of SPA 11-010 did not include the "hallmarks of 'fairness and deliberation,'" to which *Chevron* deference is owed. *See Alaska*, 424 F. 3d at 939 (quoting *Mead*, 533 U.S. at 226-27).⁸

⁷ 42 U.S.C. § 1316(a), which governs CMS's consideration of State Plan Amendments, does not require any type of hearing when the Secretary approves a State Plan Amendment. 42 U.S.C. § 1316(a)(1). In contrast, where the Secretary rejects a State's proposed Amendment, the State is entitled to petition the Secretary for reconsideration of the issue, and the Secretary is required to hold a hearing. 42 U.S.C. § 1316(a)(2). For this reason, *Chevron* deference is more appropriate for the disapproval of a State Plan Amendment.

⁸ The Secretary's reliance on *Dickson v. Hood*, 391 F. 3d 581 (5th Cir. 2004), *Harris v. Olszewski*, 442 F. 3d 456, 460 (6th Cir. 2006), and *West Virginia v. Thompson*, 475 F. 3d 204, 210-11 (4th Cir. 2007) is similarly misplaced. In *Dickson*, a Medicaid recipient alleged that the Louisiana Department of Health and Hospitals violated his federal rights by refusing to pay for medically prescribed disposable incontinence underwear. *Id.* at 584. The court merely afforded deference to the Secretary's interpretation of "home health care services" as embodied in a regulation previously promulgated pursuant to formal notice-and-comment rule-making. *Id.* at 594. *Harris* involved a challenge to Michigan's single source provider contract for incontinence supplies as violating the Medicaid Act's freedom of choice provisions. 442 F. 3d at 460. *West Virginia v. Thompson* merely held that the Secretary's interpretation of the Medicaid statute as embodied in the *disapproval* of a SPA was entitled to deference. None of these cases involved a challenge to the Secretary's approval of a State

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The Court does not believe that the Court of Appeals for the District of Columbia Circuit's determination in *PhRMA*, 362 F.3d at 822, compels a contrary result in this case. Here, the decision of the Associate Regional Administrator of the Division of Medicaid & Children's Health Operations approving the SPA, as set forth in the October 27 approval letter, is conclusory in nature. It does not provide any reasons on its face as to why provider costs should not be considered in determining whether the SPA's rate reduction will result in lower quality of care or decreased access to services. Given the logical and empirical relationship between reimbursement rates and the willingness of providers to make services available that the Ninth Circuit found was the case in *Orthopaedic Hospital*, the absence of a reasoned decision to not require cost studies to justify the SPA makes the decision to approve the SPA less appropriate for *Chevron* deference. Further, the record reflects that CMS states even though it "does not currently interpret [Section 30(A)] of the Act to require cost studies in order to demonstrate compliance," CMS is "currently reviewing and refining, in a rulemaking

Plan Amendment or the appropriate level of deference required to be afforded to such approvals.

Similarly, the Supreme Court's decision in *Chase Bank U.S.A., N.A. v. McCoy*, 131 S. Ct. 871 (2011), cited by the Director for the proposition that an agency's amicus brief deserves deference, does not compel a contrary result. This is so because that case involved an agency's interpretation of its own regulation rather than the statutory scheme itself. *See id.*, 131 S. Ct at 880.

proceeding, guidance on how states can adequately document access to services,” suggesting that a formal notice and comment rulemaking process, accompanied by the procedural safeguards of such a proceeding, is contemplated by CMS. *See* Dkt. No. 47-2, at 1; letter from CMS to DHCS. Besides the fact that no explanation is given for not requiring cost studies other than the statement that CMS “believe[s] the appropriate focus is on access,” this statement by CMS suggests that its position regarding cost studies is not necessarily settled. Thus, as the court noted in *PhRMA, Chevron* deference may be warranted even when no administrative formality was required and none was afforded, the circumstances of this case call into question whether *Chevron* deference is appropriate.⁹

Having determined that *Chevron* deference is inappropriate, the Court now turns to whether the Secretary’s interpretation that cost studies are not required under Section 30(A) is “entitled to respect” under *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944).

The Court answers this question in the negative. *Skidmore* instructs that “[t]he weight accorded to an

⁹ Further, in *PhRMA*, not only did the record support the reasonableness of the Secretary’s decision that the SPA at issue would make it less likely that needy persons would become eligible for Medicaid, thereby impacting Medicaid services, the court noted that an intervening decision of the Supreme Court supported the trial court’s decision to grant summary judgment in favor of the Secretary. 362 F. 3d at 821.

administrative judgment in a particular case will depend upon the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all of those factors which give it power to persuade, if lacking power to control.” 333 U.S. at 140. *Skidmore* respect is not owed for two reasons. First, in apparent conflict with the Secretary’s position in this case, in *Alaska*, the Secretary asked the Ninth Circuit to uphold her disapproval of a State Plan Amendment because Alaska failed to analyze provider costs. Specifically, the Secretary argued:

The requirements of § 1396(a)(30)(A) are . . . not so flexible as to allow the [State] to ignore the costs of providing services. For payment rates to be consistent with efficiency, economy, quality of care and access, they must bear a reasonable relationship to provider costs.”

Alaska, Resp. Br., 2004 WL 3155124, at 32 (citing *Orthopaedic Hospital*, 103 F. 3d at 1499).¹⁰ In addition to this inconsistency in agency position, the Secretary’s proffered interpretation directly contradicts the law in the Ninth Circuit. See *Orthopaedic Hospital*, 103 F. 3d at 1497. Thus, while the Court recognizes that in appropriate circumstances, an agency may

¹⁰ Importantly, under *Skidmore*, courts consider whether the agency has acted consistently. See *Federal Express Corp. v. Holowecki*, 552 U.S. 389, 399 (2008); *Good Samaritan Hosp. v. Shalala*, 508 U.S. 402, 417 (1993).

change its position on the construction of a statute, the Court finds that in light of the circumstances of this case, the Secretary's conclusory interpretation that Section 30(A) does not require consideration of cost studies is of limited "power to persuade," and is therefore not entitled to respect under *Skidmore*.

Accordingly, because CMS failed to consider whether DHCS relied on responsible cost studies, the Court finds that CMS failed to consider a relevant factor, and therefore that there is a strong probability that its approval of SPA 11-010 will be found to be arbitrary and capricious.

In any event, the Court finds that whether the Secretary's interpretation of Section 30(A) as embodied in the approval of SPA 11-010 is owed deference presents a "serious question going to the merits." See *Alliance for the Wild Rockies*, 632 F.3d at 1132; *ILC II*, 572 F. 3d at 657-58; *Sierra On-Line, Inc.*, 739 F.2d at 1421. In light of the balance of the hardships, which the Court believes tips strongly in plaintiffs' favor as discussed below, the Court finds that the issuance of a preliminary injunction is warranted.

b. Access

Plaintiffs next contend that even if the Secretary's approval of SPA 11-010 is owed deference, the approval still may be found to be arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law. Specifically, plaintiffs contend that the approval was arbitrary and capricious

because DHCS failed to consider facts that bear on the impact of the rate reduction on access to services. In particular, plaintiffs contend that the record demonstrates that the rate reduction would “devastate” access to skilled nursing care, especially in already underserved areas of the State. Mot. at 11-12. Because many DP/NFs are located in remote areas, plaintiffs maintain that they are often the only reasonably available source of skilled nursing, such that if they close or reduce services, access will be unavailable or patients will be forced to travel significant distances. Further, plaintiffs argue that DP/NFs frequently provide a higher level of skilled nursing care than the freestanding Skilled Nursing Facilities (“SNFs”) that the State and CMS assert will absorb patients. *Id.* at 12. Plaintiffs maintain that DHCS’s Access Analysis, on which CMS relied in approving SPA 11-010, is fatally flawed because *inter alia*: (1) it assumes complete interchangeability between freestanding SNFs and DP/NFs; (2) it evaluates access not by geographic location but instead by “geographic peer groups”; (3) it relies on non-predictive historical data; (4) it fails to consider that the number of Medical beneficiaries who would be likely to require skilled nursing care is increasing substantially; (5) it assumes all licensed beds are available when facilities frequently have beds that are not staffed and therefore not available for care; and (6) it assumes a facility can operate at 100% capacity when this is untrue due to factors such as the gender or age of patients. *Id.* at 14-16.

In opposition, the Secretary argues that CMS reached a “considered conclusion” that SPA 11-010 does not violate Section 30(A) after a three-year process in which the State submitted a “thorough analysis” of the rate reduction’s impact on access and a “comprehensive plan to measure and monitor access to services.” Secretary’s Opp’n at 14-15.¹¹ With respect to plaintiffs’ criticism that DHCS failed to consider the differences between DP/NFs and freestanding SNFs, the Secretary argues that because federal law, state law, and state licensing and certification requirements do not distinguish between DP/NFs and freestanding SNFs, a difference in the type of care DP/NFs choose to provide cannot form the basis of a Section 30(A) violation. *Id.* at 16-17. Accordingly, the Secretary argues that so long as the payment levels suffice to allow SNFs to operate at the level required by federal and state law, there can be no access violation. *Id.* at 17. With regard to plaintiffs’ charge that DHCS failed to evaluate access by geographic location, the Secretary contends that DHCS reasonably

¹¹ Under the State’s plan, DHCS will monitor a set of “early warning” measures, including change in Medi-Cal enrollment, provider participation rates, and calls to the Medi-Cal help line. Dkt. No 18-3, at 63-64. Any indication of a reduction in beneficiaries’ access to SNF services would trigger a prompt response from DHCS, and if DHCS concludes that an access problem results from a reduction in payment, DHCS will “immediately take action to change the payment levels.” *Id.* at 64. DHCS is required to abide by monitoring plan as a condition of CMS’s approval of SPA 11-010, and CMS may initiate a compliance action if the State does not act. Dkt. No. 18-2, at 19-20.

developed geographic peer groups for the purpose of clustering freestanding SNFs into county groupings with similar operating costs. *Id.* at 20-21. According to the Secretary, this approach allowed DHCS to determine whether access would be reduced in any particular type of geographic location. *Id.* at 21. Moreover, the Secretary contends that DHCS also evaluated access at “the statewide level,” which would have been sufficient for CMS’s approval. *Id.* (citing *Methodist Hosps. v. Sullivan*, 91 F.3d 1026, 1029 (7th Cir. 1996) (“‘Geographic area’ could mean many things.”)). As to plaintiffs’ contention that DHCS improperly relied on data regarding historic utilization and available capacity, the Secretary responds that historical data can reasonably be used to identify trends, and that by definition there is no data about actual future access. *Id.* at 22. In response to plaintiffs’ assertion that DHCS failed to consider the aging Medi-Cal population, the Secretary notes that DHCS’s monitoring plan specifically uses the percentage change in Medi-Cal enrollment to evaluate access. *Id.* n. 11. As to plaintiffs’ contention that DHCS improperly assumed facilities could operate at full capacity, the Secretary responds that DHCS did not assume that a facility can have every available bed filled, but rather identified vacancy rates and determined only that sufficient capacity existed based on those rates. *Id.* at 23.

The Court finds that plaintiffs have shown a likelihood of success on the merits of their claim that CMS’s approval based on its acceptance of DHCS’s

access analysis was arbitrary and capricious.¹² In this regard, the Court rejects the Secretary's argument that DP/NFs are interchangeable with SNFs. While the law may treat DP/NFs and SNFs as fungible, the record demonstrates that as a matter of fact, they are far from interchangeable. Accordingly, any conclusion by the Secretary and DHCS that freestanding SNFs could absorb patients from DP/NFs is belied by the record, making it likely that the Secretary's decision to approve SPA 11-010 was arbitrary and capricious. Similarly, the Court finds it likely that the Secretary's acceptance of DHCS's geographic peer group analysis will also be found to be arbitrary and capricious. This is so because DHCS's peer groups apparently have nothing to do with geographic proximity and include hospitals from disparate regions of the state. For example, Peer Group 3 includes both Plumas and Siskiyou Counties in northern and northeastern part of the State and Ventura County in the south. It is unreasonable to expect that any capacity in Ventura County could offset DP/NF closures in Plumas and Siskiyou Counties. As a result, the peer groups provide minimal useful information about the availability of skilled nursing services in any particular region of California. Finally, the Court finds it likely that the Secretary's acceptance of the monitoring plan

¹² The Court notes that counsel for the Secretary conceded at oral argument that if the State's access analysis were inherently flawed, the Secretary's decision to approve the SPA may be found arbitrary and capricious. Transcript of Oral Argument at 36: 13-15.

as adequately ensuring access to quality care will also be found arbitrary and capricious. This is so because the monitoring plan merely creates a potential response after an access problem has been identified. To the extent reduced rates cause DP/NFs to close their doors, increased rates will not necessarily result in the reopening of those facilities. More fundamentally, during the period between the detection of an access problem and its potential remedy through increased reimbursements, Medi-Cal beneficiaries will necessarily suffer from reduced access to skilled nursing services.¹³

c. Quality of Care

Plaintiffs next argue that the record demonstrates “no consideration” at all by DHCS or CMS of the impact of the rate reduction on quality of care. Mot. at 16. In this regard, plaintiffs maintain that closure of DP/NFs, reductions in their bed capacity or willingness to accept Medi-Cal patients, and reduction or elimination of specialized services, means that patients requiring more complex services will not be

¹³ Furthermore, whether the Secretary’s acceptance of the access analysis and monitoring plan as sufficiently ensuring access to skilled nursing services will be found to be arbitrary and capricious at least presents a “serious question going to the merits.” Because the Court finds that the balance of hardships tips strongly in plaintiffs’ favor, a preliminary injunction is appropriate on this basis as well. See *Alliance for the Wild Rockies*, 632 F.3d at 1132; *ILC II*, 572 F. 3d at 657-58; *Sierra On-Line, Inc.*, 739 F.2d at 1421.

able to obtain appropriate care or will have to wait longer to obtain such services. Further, plaintiffs contend that the record shows that DP/NF patients have shorter lengths of stay, are readmitted to acute care settings less frequently, and have better outcomes than patients in freestanding facilities. Mot. at 16-17.

The Secretary responds that in the RAI, CMS specifically asked the State to address concerns about the impact on quality of care. Secretary's Opp'n at 18. Furthermore, the Secretary contends that the State's monitoring plan repeatedly makes clear that it does not simply address access to any care, but rather that it addresses access to high quality care. *Id.* The Secretary notes also that the monitoring plan acknowledges that "[p]rovisions in both Federal and State [law] mandate that administrators ensure access to high quality healthcare for its Medi-Cal beneficiaries." *Id.* (quoting Dkt. No 18-3 at 8).

The Court finds that plaintiffs have shown a high probability of success on the claim that CMS's acceptance of the State's monitoring plan as sufficiently ensuring quality of care was arbitrary and capricious. First, as described above with respect to access, the Court finds it likely that at best the monitoring plan creates a potential response after a quality deficiency has been identified. That is, while the monitoring plan may alert the State that reimbursement rates must be increased to improve the quality of skilled nursing services, at that point beneficiaries will necessarily have already suffered injury. Next, the Court finds it likely that the monitoring plan's reliance on

external assurances of quality will also be found to be flawed. In *Orthopaedic Hospital*, 103 F.3d at 1497, the Ninth Circuit rejected the view that under Section 30(A), it was reasonable to rely on independent provisions in federal and state law that ensure quality of care. Specifically, the court explained that “[t]he Department, itself, must satisfy the requirement that the payments themselves be consistent with quality care.” *Id.* For the reasons state [sic] above, the Secretary’s contrary interpretation in this case is not owed *Chevron* deference because the approval of a State Plan Amendment does not include the “hallmarks of ‘fairness and deliberation’” to which deference is owed. *See Alaska*, 424 F.3d at 939 (quoting *Mead*, 533 U.S. at 226-27).¹⁴

2. Plaintiffs’ Section 30(A) Claim Against the Director

The Director argues that plaintiffs are unlikely to succeed on the merits of their Section 30(A) claim because they have no basis for asserting a private right of action under Section 30(A). Director’s Opp’n at 18. The Director further contends that even if

¹⁴ Furthermore, whether the Secretary’s acceptance of the monitoring plan as sufficiently ensuring quality will be found to be arbitrary and capricious at least presents a “serious question going to the merits.” Because the Court finds that the balance of hardships tips strongly in plaintiffs’ favor, a preliminary injunction is warranted on this basis as well. *See Alliance for the Wild Rockies*, 632 F.3d at 1132; *ILC II*, 572 F.3d at 657-58; *Sierra On-Line, Inc.*, 739 F.2d at 1421.

plaintiffs have a private right of action, they cannot demonstrate that AB 97 violates, and is thus preempted by, Section 30(A). In support of this argument, the Director points to CMS's approval of SPA 11-010, which the Director contends is owed deference, and the concession of CHA's counsel at oral argument before the Supreme Court that if CMS were to approve an SPA, medicaid providers and recipients would not prevail in litigation. *Id.* at 19 (citing Tr. Oral Arg. at 53, *Douglas v. Indep. Living Ctr.*, No. 09-958).

At this juncture, the Director's argument that plaintiffs lack a private right of action to enforce Section 30(A) fails. While plaintiffs lack a private right of action under 42 U.S.C. § 1983, *see Develop. Servs. Network v. Douglas*, No. 11-55851 slip op. at 20533 (9th Cir. Nov. 30, 2011), Ninth Circuit case law establishes that Section 30(A) is enforceable by private parties under the Supremacy Clause. *See ILC I*, 543 F.3d at 1050-52; *ILC II*, 572 F.3d at 644; *Cal. Pharms. I*, 563 F.3d at 850-51. Although this issue is presently before the Supreme Court, unless and until this precedent is overruled, it controls here. *See Hart v. Massanari*, 266 F.3d 1155, 1171 (9th Cir. 2001). For the reasons articulated in Section B(1) *supra*, the Court finds that plaintiffs are likely to succeed on their claim that DHCS's failure to consider responsible cost studies, failure to adequately consider the effect of the rate reduction on access, and failure to appropriately consider the effect of the rate reduction on quality of care may be found to have violated

Section 30(A).¹⁵ As discussed above, the Court finds that these issues at least present “serious questions as to the merits” of plaintiffs’ claim, and that the balance of hardships tips strongly in plaintiffs’ favor. *See Alliance for the Wild Rockies*, 632 F.3d at 1132; *ILC II*, 572 F.3d at 657-58; *Sierra On-Line, Inc.*, 739 F.2d at 1421.

3. Plaintiffs’ Section (a)(8) Claim

Plaintiffs contend that the rate reduction violates Section (a)(8) because it will result in significant delays in the time that Medi-Cal beneficiaries will be able to access skilled nursing care.¹⁶ In support of this argument, plaintiffs cite *Sobky v. Smoley*, 855 F. Supp. 1123, 1149 (E.D. Cal. 1994) (“ . . . the insufficient funding by the State . . . has caused providers . . . to place eligible individuals on waiting lists for

¹⁵ The Court reaches this conclusion in spite of the statement before the Supreme Court in *Douglas v. Indep. Living Ctr.* by CHA’s counsel that litigation was unlikely to succeed if CMS approved a SPA. That statement was made in another case, on an issue that had not been briefed prior to argument. In addition, because the individual-beneficiary plaintiffs in this case were not involved in any way with *Douglas v. Indep. Living Ctr.* a statement by counsel for another party in those proceedings should not be deemed to be a concession by the individual-beneficiary plaintiffs here.

¹⁶ Section (a)(8) states that a State plan for medical assistance must “provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals.”

treatment. This is precisely the sort of state procedure the reasonable promptness provision is designed to prevent.”).

The Court finds that plaintiffs’ Section (a)(8) claim is unlikely to succeed on the merits because Section (a)(8)’s “reasonable promptness” provision requires the expeditious processing of applications and payment rather than the provision of medical services. In reaching this conclusion, the Court notes that although the Ninth Circuit has not ruled on the issue, the Fifth, Sixth, Seventh, and Tenth Circuits have all rejected the argument that Section (a)(8) guarantees prompt medical care and services to Medicaid recipients. *Equal Access for El Paso, Inc. v. Hawkins*, 562 F. 3d 724, 727 (5th Cir. 2009); *Westside Mothers v. Olszewski*, 454 F. 3d 532, 540 (6th Cir. 2006); *Bruggeman v. Blagojevich*, 324 F. 3d 906, 910 (7th Cir. 2003); *Oklahoma Chap. of the Amer. Acad. of Pediatrics v. Fogarty*, 472 F. 3d 1208, 1214 (10th Cir. 2007). Accordingly, the Court declines to follow the *Sobky* court’s reasoning because it appears to be based on a flawed interpretation of the term “medical assistance.” See *Brown v. Tenn Dep’t of Fin. & Admin.*, 561 F. 3d 542, 544 (6th Cir. 2009) (rejecting finding in *Sobky* that term “medical assistance” meant medical services); *Susan J. v. Riley*, 616 F. Supp. 2d 1219,

1241 n. 24 (M.D. Ala. 2009) (declining to follow *Sobky* and finding it “not persuasive”).¹⁷

4. Plaintiffs’ Section (a)(19) Claim

Plaintiffs argue that the rate reduction violates Section (a)(19), which mandates that Medicaid policies promote the “best interests” of beneficiaries. According to plaintiffs, by justifying the reduction in part on the grounds that, even if some DP/NFs are forced to close, access will not decrease because patients can simply transfer to freestanding nursing facilities, DHCS does not act in the best interest of beneficiaries because this ignores the trauma beneficiaries will suffer as a result of such transfer. Mot at 19, n. 3.

The Court finds that plaintiffs’ Section (a)(19) claim is unlikely to succeed on the merits. This is so because Section (a)(19)’s “best interest” provision is too vague to create any objective benchmark for measuring whether the State has met its obligations. *See Maynard v. Bonta*, 2003 U.S. Dist. LEXIS 16201, at *97-*100 (C.D. Cal. 2003). Instead, the Section merely imposes a generalized duty on the states and

¹⁷ 42 C.F.R. § 435.911, the regulation implementing Section (a)(8), imposes specific deadlines for processing eligibility applications, providing further support for this interpretation. *See Bruggerman*, 324 F.3d at 910 (noting that the regulation indicates that Section (a)(8) requires “prompt determination of eligibility and prompt provision of funds to eligible individuals” and not prompt treatment).

expresses in general terms the overall goals of the program. *Id.*; *Harris v. James*, 127 F.3d 993, 1010 (11th Cir. 1997).

5. Plaintiffs' Takings Clause Claim

The "Takings Clause" of the Fifth Amendment provides that private property shall not "be taken for public use, without just compensation." U.S. Const. amend. V. "In order to state a claim under the Takings Clause, a plaintiff must first demonstrate that he possesses a 'property interest' that is constitutionally protected." *Turnacliiff v. Westly*, 546 F.3d 1113, 1118-19 (9th Cir. 2008) (internal citations omitted).

Plaintiffs contend that due to California's statutes that restrict the ability of nursing facilities to withdraw from Medi-Cal and cease operations,¹⁸ the Director's failure to pay hospitals adequate rates for DP/NF services constitutes an unlawful taking of their property without just compensation. Mot. at 17. Specifically, plaintiffs contend that any skilled nursing facility that wants to close or withdraw from Medi-Cal must continue to treat Medi-Cal patients

¹⁸ Cal. Welf. & Inst. Code § 14022.4(3)(d) requires that no NP/NF facility may withdraw from the Medi-Cal program until "all patients residing in the facility at the time the facility filed [a] notice of intent to withdraw from the Medi-Cal program no longer reside in the facility."

Under Cal. Health and Safety Code § 1336.2, facilities that intend to close must transfer their residents to other facilities before they can cease operations.

until they are: (1) transferred to another facility; (2) appropriately discharged; or (3) lose entitlements to Medi-Cal benefits. *Id.*

In opposition, the Director argues that it is well-settled in the Ninth Circuit that health care providers “do not possess a property interest in continued participation in Medicare, Medicaid, or the federally-funded state health care programs.” Director’s Opp’n at 7 (quoting *Erickson v. U.S. ex rel. Dept. of Health and Human Services*, 67 F.3d 858, 862 (9th Cir. 1995)). In this respect, the Director argues that CHA has failed to establish a protected property interest because its member hospitals voluntarily participate in the Medi-Cal program. *Id.* at 7-8 (citing *Burditt v. U.S. Dept. of Health and Human Services*, 934 F.2d 1362, 1376 (5th Cir. 1991) (quoting *Whitney v. Heckler*, 780 F.2d 963, 972 (11th Cir. 1986)). According to the Director, CHA’s member hospitals “accepted the various restrictions to their services, including the statutory requirements to continue treating Medi-Cal beneficiaries until they are placed in suitable alternative facilities,” such that there is no valid property interest subject to a Takings Clause claim. *Id.* at 10.

The Court finds that plaintiffs have established a likelihood of success on their Takings Clause claim. In reaching this conclusion, the Court finds that the cases the Director cites for the principle that a Takings Clause claim is not viable when an entity voluntarily participates in a regulated field are inapposite. *See, e.g., Garelick v. Sullivan*, 987 F.2d 913, 917 (2d

Cir. 1993); *Minn. Ass'n of Health Facilities, Inc. v. Minn. Dep't of Public Welfare*, 742 F. 2d 442, 446 (8th Cir. 1984); *Franklin Mem'l Hosp. v. Harvey*, 575 F. 3d 121, 129 (1st Cir. 2009); *Burditt v. U.S. Dep't of Health and Human Services*, 934 F. 2d 1362 (5th Cir. 1991). For example, while the court in *Franklin Mem'l Hosp.*, 575 F. 3d at 129, held that a state statute requiring hospitals to provide free medical services to low-income patients was not an unconstitutional taking because the hospital's participation in the state Medicaid program was voluntary, here the hospitals' continued participation in Medi-Cal is compulsory at least until such time as alternate arrangements are made for patients receiving skilled nursing services. And while it is true that the hospitals in this case accepted the restrictions to their services when they voluntarily elected to participate in Medi-Cal, they did so before the State enacted AB 97. See *Georgia Nursing Home Ass'n v. State of Georgia*, 1997 WL 820966, *3 (N.D. Ga. Oct. 29, 1997) (noting that plaintiffs "may have a valid claim" if a Georgia statute required them to continue treating Medicaid patients once they opt out of the Medicaid program).¹⁹

¹⁹ At oral argument, counsel for the Director cited *L.A. Haven Hospice, Inc. v. Leavitt*, 2009 U.S. Dist. LEXIS 125308, *3 n.2 (C.D. Cal. July 13, 2009), *aff'd in part and vacated on other grounds*, 638 F. 3d 644 (9th Cir. 2011), for the proposition that providers have no takings claim where their participation in Medi-Cal is voluntary. However, that case, like those cases cited in the Director's opposition, is inapposite because here, the

(Continued on following page)

C. Risk of Irreparable Injury

Plaintiffs contend that the rate reduction will cause irreparable harm in a number of ways. Plaintiffs first argue that beneficiaries will be injured because access to skilled nursing will be impaired. According to plaintiffs, due to the rate reduction, many hospitals are planning to eliminate services, reduce hours and lay off employees, with some facilities having already taken such steps. *See, e.g.*, Declaration of C. Duane Duaner ¶¶ 6-8; Declaration of Andrew Jahn, ¶¶ 5-8; Declaration of David A. Neopolitan ¶¶ 6, 10; Declaration of James J. Raggio, ¶¶ 9, 14; Declaration of Thomas Hayes, ¶¶ 9, 12; Declaration of Marieellen Faria, ¶¶ 4, 6. Plaintiffs argue that these measures will adversely impact the availability of skilled nursing, as well as other categories of medical services, in a number of communities, many of which are already medically underserved. *See* Dauner Decl., ¶¶ 6-8; Jahn Decl., ¶¶ 5-8; Neopolitan Decl., ¶¶ 6, 10; Raggio Decl., ¶¶ 9, 14; Hayes Decl., ¶¶ 9, 12; Faria Decl., ¶¶ 4, 6. Plaintiffs further contend that the fact that multiple DP/NFs will close in response to the rate reduction requiring the transfer of patients causing “significant trauma and disruption” to many Medi-Cal beneficiaries, most of whom are physically or mentally frail. *See e.g.*, Declaration of E.H.D., ¶¶ 6-8; Declaration of D.F., ¶¶ 6-8; Declaration of D.X.P.,

hospitals’ continued participation in Medi-Cal after the implementation of the rate reduction is at least temporarily compelled by state law.

¶¶ 6-8; Declaration of E.M., ¶¶ 5-8. Lastly, plaintiffs argue that CHA's member hospitals will be irreparably harmed by the rate reduction because they are barred from recovering any unlawfully withheld Medicaid payments from the State in federal court by virtue of the Eleventh Amendment. Mot. at 24 (citing *Cal. Pharms. I*, 563 F. 3d at 851-52). See also Declaration of Mary M. Forrest, ¶ 6 (projecting annual losses of \$6.2 million due to rate reduction); Declaration of Daniel Ruth, ¶ 6 (projecting annual losses of \$11 million).

In opposition, both the Secretary and the Director rely on the mitigating impact of the monitoring plan that California has adopted. Secretary's Opp'n at 24; Director's Opp'n at 25. Both defendants cite *Midgett v. Tri-County Metro. Transp. Dist. of Or.*, 254 F. 3d 846, 850 (9th Cir. 2001) (holding that a defendant's procedures for monitoring compliance in the ADA context "show that Plaintiff does not face a threat of immediate irreparable harm without an injunction"), and argue that given the procedural safeguards of the monitoring plan, plaintiffs cannot prove irreparable harm as a result of the rate reduction. Additionally, the Director argues that the injury to providers is not a proper basis for an injunction because providers are merely "indirect beneficiaries" of the program. Director's Opp'n at 23. Finally, the Director contends that the claims of irreparable harm to beneficiaries are based entirely on hearsay and conjecture that their current providers will stop

treating them and that, in such event, they will not receive equal or better care at another facility. *Id.*

The Court finds that plaintiffs have met their burden of showing irreparable harm in the absence of an injunction. In reaching this conclusion, the Court rejects defendants' contention that California's monitoring plan will necessarily prevent beneficiaries from being harmed. As discussed above, the Court believes that the monitoring plan at best presents a potential remedy *after* an access or quality problem has been detected. Even if the monitoring plan could ensure that beneficiary access to services would not be reduced on the aggregate, the Ninth Circuit has held that as long as there is evidence showing that at least some Medi-Cal beneficiaries might lose services as a result of a rate reduction, irreparable harm is adequately demonstrated. *Cal. Pharms. Ass'n v. Maxwell-Jolly*, 596 F.3d 1098, 1114 (9th Cir. 2010) ("*Cal. Pharms. II*"). Here, plaintiffs have proffered substantial evidence that numerous DP/NF providers will reduce their capacity or shutter their doors in response to the implementation of the rate reduction, suggesting that at least some beneficiaries would suffer reduced access to services. Even if this were not the case, it is reasonable to infer that for many people requiring skilled nursing services, transfer to other facilities could itself inflict serious injury. Furthermore, because CHA's member hospitals would be barred from recovering any reimbursement short fall in an action at law due to California's Eleventh Amendment immunity, the Court finds plaintiffs have

shown adequate irreparable injury to support an injunction on this basis as well. *See Cal. Pharms. I*, 563 F. 3d at 850-52.²⁰

D. Balance of Hardships and Public Interest

Plaintiffs argue that the balance of equities and the public interest weigh in favor of entering an injunction. In this regard, plaintiffs contend that the only interest the Secretary and Director can point to is the State's budget difficulties. Mot. at 25 (citing *ILC II*, 572 F. 3d at 659; *Cal. Pharms. I*, 563 F. 3d at 852-853; *Cal. Pharms. II*, 596 F. 3d at 1114-15 for the proposition that a state's financial problems do not excuse continued violations of federal law with respect to Medicaid policy decisions). Moreover, plaintiffs assert that where "there is a conflict between financial concerns and preventable human suffering . . . , the balance of hardships tips decidedly in favor of the latter." *Id.* (quoting *Golden Gate Restaurant Ass'n v. City and County of San Francisco*, 512 F. 3d 1112, 1126 (9th Cir. 2008)).

In opposition, the Secretary and Director each argue that injunctive relief would have a serious

²⁰ In this respect, the Director's argument that monetary loss to providers cannot be a basis for an injunction is unavailing. The Ninth Circuit has repeatedly rejected this precise argument. *See, e.g., Cal. Pharms. I*, 563 F. 3d at 850-51; *ILC II*, 572 F.3d at 658; *Cal. Pharms. II*, 596 F. 3d at 1113-14.

impact on the continuing financial health of the State of California. Secretary's Opp'n at 25; Director's Opp'n at 26. The Director also maintains that the public will suffer harm if an injunction issues because any injunction that prevents the implementation of a state statute [sic] inflicts injury on the State. Director's Opp'n at 25 (citing *Coalition for Economic Equity v. Wilson*, 122 F. 3d 718, 719 (9th Cir. 1997)).

Although keenly aware of the State's fiscal difficulties, the Court believes that the balance of the equities and the public interest strongly favor the issuance of an injunction. In reaching this conclusion, the Court notes that the Ninth Circuit has held that the injury to a state caused by the injunction of one of its statutes does not outweigh the public's interest in ensuring that state agencies comply with the law and protect beneficiaries' access to services. *ILC II*, 573 F. 3d at 658; *Cal. Pharms. II*, 596 F. 3d at 1114-15. Similarly, the State's fiscal crisis does not outweigh the serious irreparable injury plaintiffs would suffer absent the issuance of an injunction. *See ILC II*, 573 F. 3d at 658-59 ("State budgetary considerations do not . . . in social welfare cases, constitute a critical public interest that would be injured by the grant of preliminary relief. In contrast, there is a robust public interest in safeguarding access to health care for those eligible for Medicaid."); *Cal. Pharms. II*, 596 F. 3d at 1114-15.

IV. CONCLUSION

In accordance with the foregoing, the Court hereby GRANTS plaintiffs' motion for a preliminary injunction.

IT IS HEREBY ORDERED as follows:

Defendant Toby Douglas, Director of the California Department of Health Care Services, his employees, his agents, and others acting in concert with him shall be, and hereby are, enjoined and restrained from violating federal law by implementing or otherwise applying the reduction on Medi-Cal reimbursement for skilled nursing services rendered by distinct part hospital units on or after June 1, 2011, pursuant to Assembly Bill 97 enacted by the California Legislature in March 2011, as codified at California Welfare and Institutions Code § 14105.192(j), or to any other degree reducing current Medi-Cal rates for skilled nursing services rendered by distinct part hospital units.

IT IS HEREBY FURTHER ORDERED that, consistent with the foregoing, the October 27, 2011 decision by Defendant Kathleen Sebelius, Secretary of the Department of the United States Department of Health and Human Services, approving the

Medi-Cal reimbursement reduction codified at Welfare and Institutions Code § 14105.192(j), is hereby stayed.

Dated: December 28, 2011 /s/ Christina A. Snyder
CHRISTINA A. SNYDER
UNITED STATES
DISTRICT JUDGE

APPENDIX D

**UNITED STATES CODE
TITLE 42—THE PUBLIC HEALTH
AND WELFARE**

CHAPTER 7—SOCIAL SECURITY

**SUBCHAPTER XI—GENERAL PROVISIONS,
PEER REVIEW, AND ADMINISTRATIVE
SIMPLIFICATION**

PART A—GENERAL PROVISIONS

**§ 1316. Administrative and judicial review of
public assistance determinations**

**(a) Determination of conformity with re-
quirements for approval; petition for re-
consideration; hearing; time limitations;
review by court of appeals**

(1) Whenever a State plan is submitted to the Secretary by a State for approval under subchapter I, X, XIV, XVI, or XIX of this chapter, he shall, not later than 90 days after the date the plan is submitted to him, make a determination as to whether it conforms to the requirements for approval under such subchapter. The 90-day period provided herein may be extended by written agreement of the Secretary and the affected State.

(2) Any State dissatisfied with a determination of the Secretary under paragraph (1) of this subsection with respect to any plan may, within 60 days after it has been notified of such determination, file a petition with the Secretary for reconsideration of the

issue of whether such plan conforms to the requirements for approval under such subchapter. Within 30 days after receipt of such a petition, the Secretary shall notify the State of the time and place at which a hearing will be held for the purpose of reconsidering such issue. Such hearing shall be held not less than 20 days nor more than 60 days after the date notice of such hearing is furnished to such State, unless the Secretary and such State agree in writing to holding the hearing at another time. The Secretary shall affirm, modify, or reverse his original determination within 60 days of the conclusion of the hearing.

(3) Any State which is dissatisfied with a final determination made by the Secretary on such a reconsideration or a final determination of the Secretary under section 304, 1204, 1354, 1384, or 1396c of this title may, within 60 days after it has been notified of such determination, file with the United States court of appeals for the circuit in which such State is located a petition for review of such determination. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary. The Secretary thereupon shall file in the court the record of the proceedings on which he based his determination as provided in section 2112 of title 28.

(4) The findings of fact by the Secretary, if supported by substantial evidence, shall be conclusive; but the court, for good cause shown, may remand the case to the Secretary to take further evidence, and the Secretary may thereupon make new or modified findings of fact and may modify his

previous action, and shall certify to the court the transcript and record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence.

(5) The court shall have jurisdiction to affirm the action of the Secretary or to set it aside, in whole or in part. The judgment of the court shall be subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28.

(b) Amendment of plans

For the purposes of subsection (a) of this section, any amendment of a State plan approved under subchapter I, X, XIV, XVI, or XIX of this chapter, may, at the option of the State, be treated as the submission of a new State plan.

(c) Restitution when Secretary reverses his determination

Action pursuant to an initial determination of the Secretary described in subsection (a) of this section shall not be stayed pending reconsideration, but in the event that the Secretary subsequently determines that his initial determination was incorrect he shall certify restitution forthwith in a lump sum of any funds incorrectly withheld or otherwise denied.

(d) Disallowance of items covered under other subchapters

Whenever the Secretary determines that any item or class of items on account of which Federal

financial participation is claimed under subchapter I, X, XIV, XVI, shall be disallowed for such participation, the State shall be entitled to and upon request shall receive a reconsideration of the disallowance.

(e) Disallowance of items covered under subchapter XIX

(1) Whenever the Secretary determines that any item or class of items on account of which Federal financial participation is claimed under subchapter XIX shall be disallowed for such participation, the State shall be entitled to and upon request shall receive a reconsideration of the disallowance, provided that such request is made during the 60-day period that begins on the date the State receives notice of the disallowance.

(2)(A) A State may appeal a disallowance of a claim for federal financial participation under subchapter XIX by the Secretary, or an unfavorable reconsideration of a disallowance, during the 60-day period that begins on the date the State receives notice of the disallowance or of the unfavorable reconsideration, in whole or in part, to the Departmental Appeals Board, established in the Department of Health and Human Services (in this paragraph referred to as the "Board"), by filing a notice of appeal with the Board.

(B) The Board shall consider a State's appeal of a disallowance of such a claim (or of an unfavorable reconsideration of a disallowance) on the basis of such documentation as the State may submit and as the

Board may require to support the final decision of the Board. In deciding whether to uphold a disallowance of such a claim or any portion thereof, the Board shall be bound by all applicable laws and regulations and shall conduct a thorough review of the issues, taking into account all relevant evidence. The Board's decision of an appeal under subparagraph (A) shall be the final decision of the Secretary and shall be subject to reconsideration by the Board only upon motion of either party filed during the 60-day period that begins on the date of the Board's decision or to judicial review in accordance with subparagraph (C).

(C) A State may obtain judicial review of a decision of the Board by filing an action in any United States District Court located within the appealing State (or, if several States jointly appeal the disallowance of claims for Federal financial participation under section 1396b of this title, in any United States District Court that is located within any State that is a party to the appeal) or the United States District Court for the District of Columbia. Such an action may only be filed—

(i) if no motion for reconsideration was filed within the 60-day period specified in subparagraph (B), during such 60-day period; or

(ii) if such a motion was filed within such period, during the 60-day period that begins on the date of the Board's decision on such motion.

SUBCHAPTER XIX—GRANTS TO STATES FOR
MEDICAL ASSISTANCE PROGRAMS

§ 1386a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

* * *

(30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area; and

(B) provide, under the program described in subparagraph (A), that—

(i) each admission to a hospital, intermediate care facility for the mentally retarded, or hospital for mental diseases is reviewed or screened in accordance with criteria established by medical and other professional personnel who are not themselves directly responsible for the care of the patient involved, and who do not have a significant financial interest in any such institution and

are not, except in the case of a hospital, employed by the institution providing the care involved, and

(ii) the information developed from such review or screening, along with the data obtained from prior reviews of the necessity for admission and continued stay of patients by such professional personnel, shall be used as the basis for establishing the size and composition of the sample of admissions to be subject to review and evaluation by such personnel, and any such sample may be of any size up to 100 percent of all admissions and must be of sufficient size to serve the purpose of (I) identifying the patterns of care being provided and the changes occurring over time in such patterns so that the need for modification may be ascertained, and (II) subjecting admissions to early or more extensive review where information indicates that such consideration is warranted to a hospital, intermediate care facility for the mentally retarded, or hospital for mental diseases;

* * *

APPENDIX E

**CODE OF FEDERAL REGULATIONS
TITLE 42—PUBLIC HEALTH**

**CHAPTER IV—CENTERS FOR MEDICARE &
MEDICAID SERVICES, DEPARTMENT OF
HEALTH AND HUMAN SERVICES**

**SUBCHAPTER C—MEDICAL
ASSISTANCE PROGRAMS**

**PART 430—GRANTS TO STATES FOR
MEDICAL ASSISTANCE PROGRAMS**

Subpart B—State Plans

**§ 430.15 Basis and authority for action on State
plan material.**

(a) *Basis for action.* (1) Determinations as to whether State plans (including plan amendments and administrative practice under the plans) originally meet or continue to meet the requirements for approval are based on relevant Federal statutes and regulations.

(2) Guidelines are furnished to assist in the interpretation of the regulations.

(b) *Approval authority.* The Regional Administrator exercises delegated authority to approve the State plan and plan amendments on the basis of policy statements and precedents previously approved by the Administrator.

(c) *Disapproval authority.* (1) The Administrator retains authority for determining that proposed plan

material is not approvable or that previously approved material no longer meets the requirements for approval.

(2) The Administrator does not make a final determination of disapproval without first consulting the Secretary.

§ 430.16 Timing and notice of action on State plan material.

(a) *Timing.* (1) A State plan or plan amendment will be considered approved unless CMS, within 90 days after receipt of the plan or plan amendment in the regional office, sends the State—

(i) Written notice of disapproval; or

(ii) Written notice of any additional information it needs in order to make a final determination.

(2) If CMS requests additional information, the 90-day period for CMS action on the plan or plan amendment begins on the day it receives that information.

(b) *Notice of final determination.* (1) The Regional Administrator or the Administrator notifies the Medicaid agency of the approval of a State plan or plan amendment.

(2) Only the Administrator gives notice of disapproval of a State plan or plan amendment.

§430.18 Administrative review of action on State plan material.

(a) *Request for reconsideration.* Any State dissatisfied with the Administrator's action on plan material under § 430.15 may, within 60 days after receipt of the notice provided under § 430.16(b), request that the Administrator reconsider the issue of whether the plan or plan amendment conforms to the requirements for approval.

(b) *Notice and timing of hearing.* (1) Within 30 days after receipt of the request, the Administrator notifies the State of the time and place of the hearing.

(2) The hearing takes place not less than 30 days nor more than 60 days after the date of the notice, unless the State and the Administrator agree in writing on an earlier or later date.

(c) *Hearing procedures.* The hearing procedures are set forth in subpart D of this part.

(d) *Decision.* A decision affirming, modifying, or reversing the Administrator's original determination is made in accordance with § 430.102.

(e) *Effect of hearing decision.* (1) Denial of Federal funds, if required by the Administrator's original determination, will not be delayed pending a hearing decision.

(2) However, if the Administrator determines that his or her original decision was incorrect, CMS

pays the State a lump sum equal to any funds incorrectly denied.

APPENDIX F

WELFARE AND INSTITUTIONS CODE

DIVISION 9. PUBLIC SOCIAL SERVICES

PART 3. AID AND MEDICAL ASSISTANCE

CHAPTER 7. Basic Health Care

ARTICLE 3. Administration

14105.192

(a) The Legislature finds and declares the following:

(1) Costs within the Medi-Cal program continue to grow due to the rising cost of providing health care throughout the state and also due to increases in enrollment, which are more pronounced during difficult economic times.

(2) In order to minimize the need for drastically cutting enrollment standards or benefits during times of economic crisis, it is crucial to find areas within the program where reimbursement levels are higher than required under the standard provided in Section 1902(a)(30)(A) of the federal Social Security Act and can be reduced in accordance with federal law.

(3) The Medi-Cal program delivers its services and benefits to Medi-Cal beneficiaries through a wide variety of health care providers, some of which deliver care via managed care or other contract models while others do so through fee-for-service arrangements.

(4) The setting of rates within the Medi-Cal program is complex and is subject to close supervision by the United States Department of Health and Human Services.

(5) As the single state agency for Medicaid in California, the department has unique expertise that can inform decisions that set or adjust reimbursement methodologies and levels consistent with the requirements of federal law.

(b) Therefore, it is the intent of the Legislature for the department to analyze and identify where reimbursement levels can be reduced consistent with the standard provided in Section 1902(a)(30)(A) of the federal Social Security Act and consistent with federal and state law and policies, including any exemptions contained in the provisions of the act that added this section, provided that the reductions in reimbursement shall not exceed 10 percent on an aggregate basis for all providers, services and products.

(c) Notwithstanding any other provision of law, the director shall adjust provider payments, as specified in this section.

(d)(1) Except as otherwise provided in this section, payments shall be reduced by 10 percent for Medi-Cal fee-for-service benefits for dates of service on and after June 1, 2011.

(2) For managed health care plans that contract with the department pursuant to this chapter or Chapter 8 (commencing with Section 14200), except

contracts with Senior Care Action Network and AIDS Healthcare Foundation, payments shall be reduced by the actuarial equivalent amount of the payment reductions specified in this section pursuant to contract amendments or change orders effective on July 1, 2011, or thereafter.

(3) Payments shall be reduced by 10 percent for non-Medi-Cal programs described in Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, and Section 14105.18, for dates of service on and after June 1, 2011. This paragraph shall not apply to inpatient hospital services provided in a hospital that is paid under contract pursuant to Article 2.6 (commencing with Section 14081).

(4)(A) Notwithstanding any other provision of law, the director may adjust the payments specified in paragraphs (1) and (3) of this subdivision with respect to one or more categories of Medi-Cal providers, or for one or more products or services rendered, or any combination thereof, so long as the resulting reductions to any category of Medi-Cal providers, in the aggregate, total no more than 10 percent.

(B) The adjustments authorized in subparagraph (A) shall be implemented only if the director determines that, for each affected product, service or provider category, the payments resulting from the adjustment comply with subdivision (m).

(e) Notwithstanding any other provision of this section, payments to hospitals that are not under

contract with the State Department of Health Care Services pursuant to Article 2.6 (commencing with Section 14081) for inpatient hospital services provided to Medi-Cal beneficiaries and that are subject to Section 14166.245 shall be governed by that section.

(f) Notwithstanding any other provision of this section, the following shall apply:

(1) Payments to providers that are paid pursuant to Article 3.8 (commencing with Section 14126) shall be governed by that article.

(2)(A) Subject to subparagraph (B), for dates of service on and after June 1, 2011, Medi-Cal reimbursement rates for intermediate care facilities for the developmentally disabled licensed pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code, and facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14132.20, as determined by the applicable methodology for setting reimbursement rates for these facilities, shall not exceed the reimbursement rates that were applicable to providers in the 2008-09 rate year.

(B)(i) If Section 14105.07 is added to the Welfare and Institutions Code during the 2011-12 Regular Session of the Legislature, subparagraph (A) shall become inoperative.

(ii) If Section 14105.07 is added to the Welfare and Institutions Code during the 2011-12 Regular

Session of the Legislature, then for dates of service on and after June 1, 2011, payments to intermediate care facilities for the developmentally disabled licensed pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code, and facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14132.20, shall be governed by the applicable methodology for setting reimbursement rates for these facilities and by Section 14105.07.

(g) The department may enter into contracts with a vendor for the purposes of implementing this section on a bid or nonbid basis. In order to achieve maximum cost savings, the Legislature declares that an expedited process for contracts under this subdivision is necessary. Therefore, contracts entered into to implement this section and all contract amendments and change orders shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 Division 2 of the Public Contract Code.

(h) To the extent applicable, the services, facilities, and payments listed in this subdivision shall be exempt from the payment reductions specified in subdivision (d) as follows:

(1) Acute hospital inpatient services that are paid under contracts pursuant to Article 2.6 (commencing with Section 14081).

(2) Federally qualified health center services, including those facilities deemed to have federally

qualified health center status pursuant to a waiver pursuant to subsection (a) of Section 1115 of the federal Social Security Act (42 U.S.C. Sec. 1315(a)).

(3) Rural health clinic services.

(4) Payments to facilities owned or operated by the State Department of Mental Health or the State Department of Developmental Services.

(5) Hospice services.

(6) Contract services, as designated by the director pursuant to subdivision (k).

(7) Payments to providers to the extent that the payments are funded by means of a certified public expenditure or an intergovernmental transfer pursuant to Section 433.51 of Title 42 of the Code of Federal Regulations. This paragraph shall apply to payments described in paragraph (3) of subdivision (d) only to the extent that they are also exempt from reduction pursuant to subdivision (1).

(8) Services pursuant to local assistance contracts and interagency agreements to the extent the funding is not included in the funds appropriated to the department in the annual Budget Act.

(9) Breast and cervical cancer treatment provided pursuant to Section 14007.71 and as described in paragraph (3) of subdivision (a) of Section 14105.18 or Article 1.5 (commencing with Section 104160) of Chapter 2 of Part 1 of Division 103 of the Health and Safety Code.

(10) The Family Planning, Access, Care, and Treatment (Family PACT) Program pursuant to subdivision (aa) of Section 14132.

(i) Subject to the exception for services listed in subdivision (h), the payment reductions required by subdivision (d) shall apply to the benefits rendered by any provider who may be authorized to bill for the service, including, but not limited to, physicians, podiatrists, nurse practitioners, certified nurse-midwives, nurse anesthetists, and organized outpatient clinics.

(j) Notwithstanding any other provision of law, for dates of service on and after June 1, 2011, Medi-Cal reimbursement rates applicable to the following classes of providers shall not exceed the reimbursement rates that were applicable to those classes of providers in the 2008-09 rate year, as described in subdivision (f) of Section 14105.191, reduced by 10 percent:

(1) Intermediate care facilities, excluding those facilities identified in paragraph (2) of subdivision (f). For purposes of this section, “intermediate care facility” has the same meaning as defined in Section 51118 of Title 22 of the California Code of Regulations.

(2) Skilled nursing facilities that are distinct parts of general acute care hospitals. For purposes of this section, “distinct part” has the same meaning as defined in Section 72041 of Title 22 of the California Code of Regulations.

(3) Rural swing-bed facilities.

(4) Subacute care units that are, or are parts of, distinct parts of general acute care hospitals. For purposes of this subparagraph, “subacute care unit” has the same meaning as defined in Section 51215.5 of Title 22 of the California Code of Regulations.

(5) Pediatric subacute care units that are, or are parts of, distinct parts of general acute care hospitals. For purposes of this subparagraph, “pediatric subacute care unit” has the same meaning as defined in Section 51215.8 of Title 22 of the California Code of Regulations.

(6) Adult day health care centers.

(7) Freestanding pediatric subacute care units, as defined in Section 51215.8 of Title 22 of the California Code of Regulations.

(k) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement and administer this section by means of provider bulletins or similar instructions, without taking regulatory action.

(l) The reductions described in this section shall apply only to payments for services when the General Fund share of the payment is paid with funds directly appropriated to the department in the annual Budget Act and shall not apply to payments for services paid with funds appropriated to other departments or agencies.

(m) Notwithstanding any other provision of this section, the payment reductions and adjustments provided for in subdivision (d) shall be implemented only if the director determines that the payments that result from the application of this section will comply with applicable federal Medicaid requirements and that federal financial participation will be available.

(1) In determining whether federal financial participation is available, the director shall determine whether the payments comply with applicable federal Medicaid requirements, including those set forth in Section 1396a(a)(30)(A) of Title 42 of the United States Code.

(2) To the extent that the director determines that the payments do not comply with the federal Medicaid requirements or that federal financial participation is not available with respect to any payment that is reduced pursuant to this section, the director retains the discretion to not implement the particular payment reduction or adjustment and may adjust the payment as necessary to comply with federal Medicaid requirements.

(n) The department shall seek any necessary federal approvals for the implementation of this section.

(o)(1) The payment reductions and adjustments set forth in this section shall not be implemented until federal approval is obtained.

(2) To the extent that federal approval is obtained for one or more of the payment reductions and adjustments in this section and Section 14105.07, the payment reductions and adjustments set forth in Section 14105.191 shall cease to be implemented for the same services provided by the same class of providers. In the event of a conflict between this section and Section 14105.191, other than the provisions setting forth a payment reduction or adjustment, this section shall govern.

(3) When federal approval is obtained, the payments resulting from the application of this section shall be implemented retroactively to June 1, 2011, or on any other date or dates as may be applicable.

(4) The director may clarify the application of this subdivision by means of provider bulletins or similar instructions, pursuant to subdivision (k).

(p) Adjustments to pharmacy drug product payment pursuant to this section shall no longer apply when the department determines that the average acquisition cost methodology pursuant to Section 14105.45 has been fully implemented and the department's pharmacy budget reduction targets, consistent with payment reduction levels pursuant to this section, have been met.

APPENDIX G

[SEAL]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region IX

Division of Medicaid & Children's Health Operations
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

OCT 27 2011

Toby Douglas, Director
California Department of Health Care Services
1501 Capitol Avenue
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Mr. Douglas:

Enclosed is an approved copy of California State plan amendment (SPA) 11-009. This SPA proposes to reduce the reimbursement rates for certain non-institutional services furnished under the approved State plan by 10%, effective June 1, 2011.

We conducted our review of your submittal with particular attention to the statutory requirements at section 1902(a)(30) of the Social Security Act (Act). Because I find that this amendment complies with all applicable requirements, Medicaid State plan amendment 11-009 is approved effective June 1, 2011. We are enclosing the HCFA-179 and the amended plan pages.

As part of the analysis of this amendment, the State was able to provide metrics which adequately demonstrated beneficiary access to care in accordance with section 1902(a)(30)(A) of the Act. In general, these metrics included data which provide:

- Total number of providers by type and geographic location and participating Medi-Cal providers by type and geographic area
- Total number of Medi-Cal beneficiaries by eligibility type
- Utilization of services by eligibility type over time
- Analysis of benchmark service utilization where available

Data concerning these metrics were submitted for State Fiscal Years (SFY) 2008, 2009 and 2010. These metrics demonstrated a baseline level of beneficiary access that we find is consistent with the requirements of section 1902(a)(30)(A) of the Act prior to the implementation of SPA 11-009. As well as determining beneficiary access for SFY 2010, the State also submitted a monitoring plan as part of SPA 08-009B1 (also being approved today) that would apply to the services at issue in this SPA by which beneficiary access will be monitored on a service-by-service basis. The State will monitor predetermined metrics on a quarterly or annual basis in order to ensure that beneficiary access is comparable to services available to the general population in the geographic area.

In light of the data CMS reviewed, the monitoring plan, and our consideration of stakeholder input, we have determined that the above mentioned amendment complies with section 1902(a)(30)(A) of the Act.

If you have any questions, please contact me directly at 415-744-3552 or via email at Gloria.Nagle@cms.hhs.gov.

Sincerely,

/s/ Gloria Nagle

Gloria Nagle, Ph.D., MPA
Associate Regional Administrator
Division of Medicaid & Children's
Health Operations

cc: Vickie Orlich, California Department of
Health Care Services
Linda Machado, California Department of
Health Care Services
Kathryn Waje, California Department of
Health Care Services
Christopher Thompson, Centers for Medicare
and Medicaid Services

APPENDIX H

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850 [LOGO]

Center for Medicaid and CHIP Services

OCT 27 2011

Toby Douglas
Director of Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Mr. Douglas:

Enclosed is an approved copy of California State plan amendment (SPA) 11-010. This SPA proposes to reduce the reimbursement rates for the following long term care facilities by 10%, effective June 1, 2011:

- Nursing Facilities—Level A
- Distinct Part Nursing Facilities—Level B

We conducted our review of your submittal with particular attention to the statutory requirements at sections 1902(a)(13), and 1902(a)(30), of the Social Security Act (Act) and the implementing Federal regulations at 42 CFR 447 Subpart C. Because I find that this amendment complies with all applicable requirements, Medicaid State plan amendment 11-010 is approved effective June 1, 2011. We are enclosing the HCFA-179 and the amended plan pages.

As part of the analysis of this amendment, the State was able to provide metrics which adequately demonstrated beneficiary access. In general, these metrics included data which provided:

- Total number of providers by type and geographic location and participating Medi-Cal providers by type and geographic area
- Total number of Med-Cal Beneficiaries by eligibility type
- Utilization of services by eligibility type over time
- Analysis of benchmark service utilization where available

Data concerning these metrics were submitted for State Fiscal Years (SFY) 2008, 2009 and 2010. These metrics demonstrated a baseline level of beneficiary access that we find is consistent with the requirements of section 1902(a)(30)(A) of the Act prior to the implementation of SPA 11-010. As well as determining beneficiary access for SFY 2010, the State also submitted a monitoring plan as part of SPA 08-009B1 (also being approved today) that would apply to the services at issue in this SPA by which beneficiary access will be monitored on a service-by-service basis. The State will monitor predetermined metrics on a quarterly or annual basis in order to ensure that beneficiary access is comparable to services available to the general population in the geographic area.

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In light of the data CMS reviewed, the monitoring plan, and our consideration of stakeholder input, we have determined that the above mentioned amendment complies with section 1902(a)(30)(A) of the Act.

If you have any questions, please have your staff contact Mark Wong at (415) 744-3561.

Sincerely,

/s/ Cindy Mann
Cindy Mann
Director
