

1 (“CMS”), the Secretary is responsible for reviewing and approving policy changes that
2 states make to their Medicaid programs.

3 Plaintiff CMA is a professional association representing the interests of physicians
4 in California. Plaintiff California Dental Association (“CDA”) is a professional
5 association representing the interests of dentists in California. Plaintiff California
6 Pharmacists Association (“CPhA”) is a professional association representing the
7 interests of California pharmacists.¹ Plaintiff National Association of Chain Drug Stores
8 (“NACDS”) is a national association whose members include 18 national pharmacy
9 chains in California with over 3,100 individual pharmacies throughout the State.
10 Plaintiff California Association of Medical Product Suppliers (“CAMPS”) is a trade
11 organization representing the interests of durable medical equipment (“DME”) suppliers
12 in California.² Plaintiff AIDS Healthcare Foundation (“AHF”) is the largest provider of
13 medical care for AIDS patients in California. Plaintiff American Medical Response
14 West (“AMR”) provides emergency medical transportation (“EMT”) services in
15 California. Plaintiff Jennifer Arnold is an individual whose infant son is a Med-Cal
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18 ¹ The Director argues that the present action is redundant and that Plaintiffs cannot
19 establish irreparable harm as to pharmacy services in light of this Court’s prior ruling in
20 Managed Pharmacy Care v. Sebelius, CV No. 11-09211, (C.D. Cal. Dec. 28, 2011),
21 enjoining enforcement of the rate reduction with respect to pharmacy providers. The Court
22 finds this argument unavailing because the issuance of a preliminary injunction in an
23 overlapping case does not operate to moot a parallel action because the original order is
24 “subject to reopening.” See, e.g., Exxon Mobil Corp. v. Saudi Basic Indus. Corp., 544 U.S.
25 280, 291 n.7 (2005); 13B Wright et al., Federal Practice and Procedure § 3533.2.1, 832 (3d
26 ed. 2008) (“mootness may be denied because the decision is subject to reopening or
27 appeal”). In this case, the Director has already filed an appeal of the preliminary injunction
28 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.

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

1 beneficiary. Plaintiffs Does 1 through 25 are individuals residing in California that
2 receive outpatient services through the Medi-Cal program.

3 On March 25, 2011, California Governor Edmund G. Brown Jr. signed into law
4 Assembly Bill 97 (“AB 97”), the health budget trailer bill for California fiscal year
5 2011–2012. AB 97 enacted significant payment reductions for many classes of services
6 provided under the Medi-Cal program. Most significantly for the purposes of the instant
7 action, AB 97 enacted California Welfare and Institutions Code § 14105.192, which
8 authorizes the Director to reduce the Medi-Cal payment rates for various services,
9 including physician, clinic, dental, pharmaceutical, EMT and DME and medical supply
10 services, effective June 1, 2011. Pursuant to Welfare and Institutions Code §
11 14105.192(n), the Director is required to seek any federal approvals necessary prior to
12 implementing the rate reduction.

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

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1 Plaintiffs allege that CMS' approval of the SPA was in violation of 42 U.S.C. §
2 1396a(a)(30)(A) ("Section 30(A)),³ the Supremacy Clause,⁴ FAC ¶¶ 70–72, and the
3 Due Process Clause of the 14th Amendment to the U.S. Constitution.⁵ Id. ¶¶ 73–79.
4 Plaintiffs further allege that the Secretary's approval of the SPA violated the
5 Administrative Procedure Act ("APA"), 5 U.S.C. § 701 et seq. because the Secretary
6 failed to appropriately consider certain factors including the impact of the rate reduction
7 on access to and quality of medical services. Id. ¶¶ 66–69.

8 On December 30, 2011, plaintiffs filed the instant motion seeking a preliminary
9 injunction restraining the Director from implementing the rate reduction. On January
10 17, 2011, the Director and the Secretary filed separate oppositions to plaintiffs' motion.
11 Plaintiffs replied on January 23, 2011. A hearing was held January 30, 2011. After
12 carefully considering the parties' arguments, the Court find and concludes as follows.

13 **II. LEGAL STANDARD**

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

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21 ³ Section 30(A) states in pertinent part that a State plan for medical assistance must:
22 provide such methods and procedures relating to the utilization of, and the payment
23 for, care and services available under the plan . . . to assure that payments are
24 consistent with efficiency, economy, and quality of care and are sufficient to enlist
25 enough providers so that care and services are available under the plan at least to the
26 extent that such care and services are available to the general population in the
geographic area.

27 ⁴ U.S. Const. art. VI, cl. 2.

28 ⁵ U.S. Const. amend. XIV.

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

11 **III. DISCUSSION**

12 **A. Standing**

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

15 **1. Concrete Injury**

16 The Director argues that plaintiffs have not alleged an “actual and imminent
17 injury” because plaintiffs’ alleged injury relies on a “tenuous thread of assumptions
18 contingent upon possibilities.” Director’s Opp’n at 13.

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

5 **2. Prudential Standing**

6 The Director argues that plaintiffs’ lack prudential standing to enforce Section
7 30(A) because plaintiffs seek to enforce rights belonging to a third party, CMS.
8 According to the Director, this Section does not confer individual entitlements on any
9 private parties, but instead serves as a “yardstick” by which the federal government may
10 assess a state’s performance under the Medicaid Act. Director’s Opp’n at 14.
11 Moreover, to the extent that plaintiffs’ claims rely on the Supremacy Clause, the
12 Director argues that they run afoul of the bar against considering generalized grievances
13 in that plaintiffs are not attempting to vindicate any right personal to them, but instead
14 invoke the Supremacy Clause as an “all-purpose cause of action to compel a state’s
15 compliance with federal law.” Id. at 15 (citing Valley Forge Christian Coll. v. Amer.
16 United for Sep. of Church and State, 454 U.S. 464, 483 (1982)).

17 The Court finds the Director’s prudential standing arguments unavailing. In
18 assessing prudential standing, a court need not “inquire whether there has been a
19 congressional intent to benefit the would-be plaintiff,” but instead must determine only
20 whether the plaintiff’s interests are among those “arguably . . . to be protected” by the
21 statutory provision. Nat’l Credit Union v. First Nat’l Bank & Trust Co., 552 U.S. 478,
22 489 (1998). This “zone of interest” test “is not meant to be demanding.” Clarke v. Secs.
23 Indus. Ass’n, 479 U.S. 388, 399–400 (1987). To this end, Section 30(A) establishes
24 standards by which payments to providers are set. Accordingly, Medi-Cal beneficiaries
25 and providers are undoubtedly within the zone of interests protected by Section 30(A).
26 Further, the Court finds that contrary to the Director’s assertion, plaintiffs are not
27 alleging a “generalized grievance.” This is so because plaintiffs have alleged that the
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1 associational plaintiffs' members and Medi-Cal beneficiaries will be directly harmed by
2 the implementation of the rate reduction.

3 **3. Associational Standing**

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

13 The Director's associational standing arguments also fail. An association has
14 standing to sue on behalf of its members if (1) they would have standing to sue in their
15 own right; (2) the interests it seeks to protect are germane to the organization's purpose;
16 and (3) participation by the individual members is not necessary to resolve the claim.
17 Hunt v. Wash. State Apple Advertising Comm'n, 432 U.S. 333, 343 (1997). The Ninth
18 Circuit has recognized that when an association is pursuing an action for only
19 declaratory and injunctive relief on behalf of its members, participation in the action by
20 individual members is not required. See Associated Gen'l Contractors of Am. v.
21 Metropolitan Water Dist. of So. Cal., 159 F. 3d 1178, 1181 (9th Cir. 1998). Here,
22 plaintiffs are not seeking monetary relief, so participation of individual Medi-Cal
23 providers is not required. Next, other courts have held that because individual medical
24 providers would have third-party standing to represent the interests of their patients,
25 associations representing those providers can also represent the interests of patients.
26 See, e.g., Penn. Psychiatric Soc'y v. Green Spring Health Svcs., Inc., 280 F. 3d 278,
27 288–94 (3d Cir. 2002); New Jersey Protection & Advocacy v. New Jersey Dep't of
28 Educ., 563 F. Supp. 2d 474, 481–84 (D.N.J 2008). Accordingly, in this case, the

1 associational plaintiffs’ members would have standing to represent the interests of their
2 Medi-Cal patients and therefore the associational plaintiffs have standing to do the same.
3 More fundamentally, even if the associational plaintiffs did not have standing to
4 represent Medi-Cal beneficiaries, it would not alter the Court’s ability to reach the merits
5 of the controversy because an individual Medi-Cal beneficiary whose standing is not
6 challenged is a plaintiff in this case.

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

9 **B. Likelihood of Success on the Merits**

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

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

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

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

3 **a. CMS’ Companion Letter**

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

8 42 C.F.R. § 430.10 requires that a State plan be a comprehensive written statement
9 containing all information necessary for CMS to determine whether the plan can be
10 approved. CMS’ companion letter to the letter approving SPA 11-009 acknowledged
11 that CMS “reviews SPAs in the context of the overall state Plan for consistency with the
12 requirements of section 1902(a) of the Social Security Act.” The letter states:

13 Section 1902(a)(30)(A) of the Social Security Act (the Act) requires the
14 procedures related to payments include a comprehensive description of the
15 methods and standards used to set payment rates. Attachment 4.19-B illustrates
16 how non-institutional providers will be reimbursed and must contain
17 comprehensive State plan language. . . . In addition, since the State plan is the
18 basis for Federal financial participation, it is important that payment
19 methodologies documented in the State plan are understandable and auditable.
20 Absent the descriptions of these criteria, CMS will not be able to determine that
21 the State plan language meets the requirements set forth in 42 CFR 447.252(b), 42
22 CFR 447.10, and Section 1902(a)(30)(A) of the Act.

23 According to plaintiffs, the companion letter “provides CMS’ own admission”
24 that when CMS approved SPA 11-009, the resulting State Plan did not comply with
25 various federal Medicaid requirements. Mot. at 10–11. Plaintiffs argue that CMS’
26 inquiry “indicates that at the time CMS approved SPA 11-009, CMS did not know what
27 California’s current reimbursement rates actually were.” Id. at 11. Therefore, plaintiffs
28 argue that CMS could not determine whether the resulting rates complied with Section

1 30(A), and that such “internally contradictory agency reasoning” renders the approval of
2 SPA 11-009 “arbitrary and capricious.” Id. (citing Ariz. Cattle Growers’ Ass’n v. U.S.
3 Fish and Wildlife, 273 F.3d 1229, 1236 (9th Cir. 2001)).

4 In opposition, the Secretary argues that CMS issued the companion letter to begin
5 a separate process to resolve “peripheral issues” with the State Plan, and not to address
6 problems with SPA 11-009. Thus, the Secretary contends that the companion letter does
7 not reflect any inconsistency in CMS’ position, but instead merely shows that CMS
8 determined that tangential technical matters should not delay the approval of an
9 acceptable SPA. Secretary’s Opp’n at 12–13.

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

24 **b. Cost Studies**

25 Plaintiffs contend that CMS’ approval of SPA 11-009 was arbitrary and capricious
26 because CMS failed to consider whether DHCS relied on credible cost studies and
27 developed rates reasonably related to provider costs as the Ninth Circuit has held is
28 required under Section 30(A). Mot. at 11 (citing Orthopaedic Hosp. v. Belshe, 103 F. 3d

1 1491, 1492, 1496, 1500 (9th Cir. 1997) cert. denied, Belshe v. Orthopaedic Hosp., 522
2 U.S. 1044 (1998)).

3 In opposition, the Secretary contends that CMS' contrary interpretation of Section
4 30(A), upon which it based its approval of SPA 11-009, is entitled to Chevron deference
5 notwithstanding the Ninth Circuit's decision in Orthopaedic Hospital that a state must
6 consider "responsible cost studies."

7 Although Section 30(A) leaves room for interpretation,⁶ the Court does not
8 believe the agency's interpretation is owed Chevron deference with respect to the
9 approval at issue in this case. In this respect, the Court finds significant that the
10 Secretary's approval of SPA 11-009 did not involve a formal adjudication accompanied
11 by the procedural safeguards justifying Chevron deference. Instead, the Secretary's
12 issued her interpretation of Section 30(A) in a letter to DHCS. This kind of
13 interpretation is of the very type for which the Supreme Court has declined to extend
14 Chevron deference. See e.g., Christensen v. Harris County, 529 U.S. 576, 586–88
15 (2000) (holding that informal agency interpretations of a statute such as those contained
16 in an opinion letter, policy statement, agency manuals, or enforcement guidelines, are
17 not entitled to Chevron-style deference). Alaska Dept. of Health and Social Servs. v.
18 CMS, 424 F. 3d 931 (9th Cir. 2005), upon which the Secretary relies, is inapposite. In
19 Alaska, the Ninth Circuit deferred to the Secretary's interpretation of Section 30(A) and
20 upheld the denial of a State Plan Amendment. In finding that the CMS Administrator's
21 final determination "carr[ie]d] the force of law" necessary for Chevron deference, the
22 court highlighted "the formal administrative process afforded the State," with
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25 ⁶ The Court notes that Section 30(A) does not explicitly mention provider costs or
26 cost studies and that three other circuit courts have determined that CMS need not consider
27 provider costs in deciding whether or not to approve a State Plan Amendment. See Rite
28 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).

1 “opportunities to petition for reconsideration, brief its legal arguments, be heard at a
2 formal hearing, receive reasoned decisions at multiple levels of review and submit
3 exceptions to those decision.” Alaska, 424 F. 3d at 939. None of these procedural
4 safeguards was incorporated in the SPA approval process at issue in this case, in which
5 there was no hearing, no record, no opportunity for interested parties to present
6 evidence, and no formal decision in which the Secretary set forth her reasoning.⁷
7 Accordingly, the Secretary’s approval of SPA 11-009 did not include the “hallmarks of
8 ‘fairness and deliberation,’” to which Chevron deference is owed. See Alaska, 424 F. 3d
9 at 939 (quoting Mead, 533 U.S. at 226–27).⁸

11 ⁷ 42 U.S.C. § 1316(a), which governs CMS’ consideration of State Plan
12 Amendments, does not require any type of hearing when the Secretary approves a State
13 Plan Amendment. 42 U.S.C. § 1316(a)(1). In contrast, where the Secretary rejects a
14 State’s proposed Amendment, the State is entitled to petition the Secretary for
15 reconsideration of the issue, and the Secretary is required to hold a hearing. 42 U.S.C. §
16 1316(a)(2). For this reason, Chevron deference is more appropriate for the disapproval of
17 a State Plan Amendment.

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

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

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

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27 ⁸(...continued)
28 itself. See id., 131 S. Ct at 880.

1 administrative formality was required and none was afforded, the circumstances of this
2 case call into question whether Chevron deference is appropriate.⁹

3 Having determined that Chevron deference is inappropriate, the Court now turns
4 to whether the Secretary's interpretation that cost studies are not required under Section
5 30(A) is "entitled to respect" under Skidmore v. Swift & Co., 323 U.S. 134, 140 (1944).

6 The Court answers this question in the negative. Skidmore instructs that "[t]he
7 weight accorded to an administrative judgment in a particular case will depend upon the
8 thoroughness evident in its consideration, the validity of its reasoning, its consistency
9 with earlier and later pronouncements, and all of those factors which give it power to
10 persuade, if lacking power to control." 333 U.S. at 140. Skidmore respect is not owed
11 for two reasons. First, in apparent conflict with the Secretary's position in this case, in
12 Alaska, the Secretary asked the Ninth Circuit to uphold her disapproval of a State Plan
13 Amendment because Alaska failed to analyze provider costs. Specifically, the Secretary
14 argued:

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

19 Alaska, Resp. Br., 2004 WL 3155124, at 32 (citing Orthopaedic Hospital, 103 F. 3d at
20 1499).¹⁰ In addition to this inconsistency in agency position, the Secretary's proffered
21 interpretation directly contradicts the law in the Ninth Circuit. See Orthopaedic

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

28 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).

1 Hospital, 103 F. 3d at 1497. Thus, while the Court recognizes that in appropriate
2 circumstances, an agency may change its position on the construction of a statute, the
3 Court finds that in light of the circumstances of this case, the Secretary’s conclusory
4 interpretation that Section 30(A) does not require consideration of cost studies is of
5 limited “power to persuade,” and is therefore not entitled to respect under Skidmore.

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

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

16 **c. Access to Quality Services**

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

20 Plaintiffs contend that contrary to the Secretary’s approval letter, the content of
21 the administrative record before the Secretary did not “demonstrate a baseline of
22 beneficiary access that . . . is consistent with Section 30(A).” Mot. at 13. According to
23 plaintiffs, the Director’s access analyses failed to include a meaningful comparison of
24 the Medi-Cal population to the general population, any analysis of access on a local
25 geographic level, any analysis based on the actual healthcare needs of the Medi-Cal
26 population, or any attempt to project the rate reduction’s impact on access to quality
27 services. Id. at 14.

1 In opposition, the Secretary argues that CMS properly considered all Section
2 30(A) factors. According to the Secretary, CMS reasonably concluded based on the
3 evidence before it that the rate reduction would not harm beneficiary access to services.
4 Secretary's Opp'n at 15. Additionally, the Secretary argues that the monitoring plan
5 submitted by the State makes clear that it is addressing access to high quality care.¹¹ Id.
6 at 13. Further, the Secretary asserts that independent provisions of federal and state law
7 ensure high quality of care. Id.

8 The Court finds that plaintiffs have shown a substantial likelihood of success on
9 the merits of their claim that CMS' acceptance of DHCS' access analyses and
10 monitoring plan was arbitrary and capricious. In this regard, the Court finds significant
11 that DHCS' access analyses failed to include projections of what impact the rate
12 reduction would have on beneficiary access or comparisons of Medi-Cal payment rates
13 to Medicare payment rates, average commercial payment rates or provider costs.¹²
14 Furthermore, DHCS' analyses lack any meaningful geographic comparisons.¹³ This is
15 so because DHCS reviewed access by "geographic peer groups," which apparently have
16 nothing to do with geographic proximity and include providers from disparate regions of
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18 ¹¹ Under the State's plan, DHCS will monitor a set of "early warning" measures,
19 including change in Medi-Cal enrollment, provider participation rates, and calls to the
20 Medi-Cal help line. Any indication of a reduction in beneficiaries' access to services
21 would trigger a prompt response from DHCS, and if DHCS concludes that an access
22 problem results from a reduction in payment, DHCS will "immediately take action to
23 change the payment levels. DHCS is required to abide by the monitoring plan as a
24 condition of CMS' approval of SPA 11-009.

25 ¹² The Court notes that in a proposed rulemaking, CMS proposed that an access
26 review should include comparisons of Medicaid payments to either Medicare payment
27 rates, the average commercial payment rates, or the applicable Medicaid allowable costs.
28 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.

1 the State. Next, the Court finds it likely that the Secretary’s acceptance of the
2 monitoring plan as adequately ensuring access to quality services will also be found to
3 be arbitrary and capricious. This is so because the monitoring plan merely creates a
4 potential response after an access problem has been identified. To the extent reduced
5 rates cause providers to close their doors, increased rates will not necessarily result in the
6 reopening of those facilities. More fundamentally, during the period between the
7 detection of an access problem and its potential remedy through increased
8 reimbursements, Medi-Cal beneficiaries will necessarily suffer from reduced access to
9 services. Finally, the Ninth Circuit has found it unreasonable to rely on independent
10 provisions of federal and state law to ensure quality of care, precisely what the
11 monitoring plan purports to do here. See Orthopaedic Hospital, 103 F. 3d at 1497 (“The
12 Department, itself, must satisfy the requirement that the payments themselves be
13 consistent with quality care.”).¹⁴

14 **i. Physician and Clinic Services**

15 According to plaintiffs, despite overwhelming evidence that Medi-Cal rates prior
16 to the rate reduction did not ensure sufficient access to care, the Director erroneously
17 determined that a ten percent reduction would not adversely affect beneficiary access.
18 Mot. at 16. Plaintiffs point to several purported defects in the Director’s methodology
19 including that: (1) the Director “consistently and grossly overrepresents” the number of
20 physicians in California and the number participating in Medi-Cal; (2) the Director
21 consistently fails to adjust his counts of physicians to his counts of beneficiaries when
22 calculating beneficiary to physician ratios; (3) the Director’s utilization data is
23 inadequate because it does not account for the level of patient need; and (4) the
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25
26 ¹⁴ For the reasons stated above, the Secretary’s contrary interpretation in this case
27 is not owed Chevron deference because the approval of a State Plan Amendment does not
28 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)

1 utilization data is inadequate because it does not account for the type of provider serving
2 the beneficiary or the location of service.¹⁵ Id. at 16.

3 In opposition, the Secretary argues that CMS considered all information before it,
4 and determined that the proposed rate cuts would not harm access. Secretary's Opp'n at
5 18. Further, the Secretary maintains that much of the input from providers was "very
6 general" and did not provide specific examples or data on beneficiary impact. Id. The
7 Secretary also contends that CMS considered the various studies and research literature
8 included in the record, and concluded that these did not undermine the State's
9 conclusion that the State's conclusion would not harm beneficiary access. Id. (citing Fan
10 Decl. ¶ 5). The Secretary highlights that the studies upon which plaintiffs rely do not
11 account for the fact that Medi-Cal beneficiaries rely heavily upon federally qualified
12 health centers ("FQHCs") and rural health clinics ("RHCs"), which were not subject to
13 the rate reduction. Id. at 19. Finally, the Secretary argues that there was no information
14 in the record indicating that the data provided by the State was erroneous, but instead
15 that the State relied on data that CMS considers reliable. Id.

16 The Court agrees with plaintiffs that the specific methodology by which the
17 Director analyzed beneficiary access to physician and clinic services was likely
18 fundamentally flawed. In this respect, the Court finds two factors particularly
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21 ¹⁵ In support of their argument that the Director's analyses were fatally flawed,
22 plaintiffs submit the declarations of two purported experts, Drs. Grumbach and Zuckerman.
23 The Secretary argues that the experts' declarations were not before the agency and
24 therefore should not be considered by the Court. Secretary's Opp'n at 16. This argument
25 is not persuasive. A court may accept evidence outside the administrative record "to permit
26 explanation or clarification of technical terms or subject matter involved in the agency
27 action under review" or "for background information." Public Power Council v. Johnson,
28 674 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.

1 concerning. First, the Director based his conclusion that Medi-Cal beneficiaries
2 continued to have access to services on data related to how many physicians submitted at
3 least one claim per year to Medical. The fact that a given number of physicians have
4 submitted at least one claim per year to Medi-Cal does not necessarily reflect that those
5 physicians see Medi-Cal patients on a regular basis. Next, the Court is troubled by
6 DHCS' reliance on FQHCs and RHCs to serve beneficiaries. Even if Medi-Cal
7 beneficiaries heavily utilize FQHCs and RHCs, it does not constitute comparable access
8 to care within the meaning of Section 30(A) to effectively limit Medi-Cal beneficiaries
9 to such facilities.

10 **ii. Dental Services**

11 Plaintiffs maintain that CMS and other governmental agencies have for years
12 identified a lack of access to dental services for Medi-Cal beneficiaries. Mot. at 17.
13 According to plaintiffs, in response to continuing access problems, in 2001, CMS issued
14 a letter to all State Medicaid Directors in which it stated that "significant shortfalls in
15 beneficiary receipt of dental services, together with evidence that Medicaid
16 reimbursement rates fall below the 50th percentile of providers' fees in the marketplace,
17 create a presumption of noncompliance" with Section 30(A). Id. (citing Crall Decl. Ex.
18 11). Since that time, plaintiffs assert that CMS has targeted California as one of 16
19 states with low dental utilization rates, and a 2010 Government Accounting Office report
20 stated that California had the seventh lowest dental utilization rate in the United States.
21 Id. (citing Crall Decl. Ex. 2; Crall Decl. Ex. 4). In this context, plaintiffs argue that it
22 was arbitrary and capricious for CMS to approve SPA 11-009 as to pediatric dental
23 services. Further, plaintiffs assert that the Director relied on erroneous data relating to
24 dental utilization rates. In support of this argument, plaintiffs points to that the
25 utilization statistics reported by the Director in his analysis are between 13.8 and 17
26 percentage points higher than what the Director annually reports to CMS and what other
27 research reports. Id. at 18 (citing Cannizzo Decl. Ex. 5-9). Further, plaintiffs note that
28 the Director's count of dentists participating in Medi-Cal for 2008 outnumbered those

1 reported by the Centers for Disease Control without explanation. Id. (citing Cannizzo
2 Decl. Ex. 10).

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

16 The Court believes plaintiffs’ arguments are persuasive. In reaching this
17 conclusion, the Court finds significant that CMS’ State Medicaid Director Letter
18 established that a low beneficiary utilization rate along with reimbursement rates that fall
19 below 50 percent of providers’ fees in the marketplace “create a presumption of
20 noncompliance” with Section 30(A). Crall Decl. Ex. 11. Because neither CMS nor
21 DHCS provide any evidence that Medi-Cal’s reimbursement rates are above 50 percent
22 of providers’ fees and California’s utilization rate is among the lowest in the country,
23 that presumption should apply here. Further, the Court also finds concerning that CMS
24 acknowledges that only 53 of 58 counties have a Medi-Cal enrolled dentist, and that
25 even in those counties, CMS apparently had no information before it to suggest that
26 beneficiaries had comparable access to dentists as the general population.

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28 ///

1 **iii. Pharmacy Services**

2 Plaintiffs argue that the record before CMS demonstrated that the Director could
3 not lawfully implement the rate reduction with respect to pharmacy services. Mot. at 18.
4 In this respect, plaintiffs maintain that CPhA provided evidence to CMS demonstrating
5 that the rate reduction would result in pharmacies being paid less than their costs for
6 most drugs and in turn to decreased beneficiary access as a result of pharmacies refusing
7 to provide services to Medi-Cal patients. Id. Plaintiffs assert that the Director’s analysis
8 included “several deficiencies” including that it relied on pharmacy utilization, which
9 plaintiffs maintain is not an accurate indicator of access. Id. Finally, plaintiffs contend
10 that “[b]ecause the Director failed to conduct a competent access study,” on December
11 16, 2011, he was “forced to acknowledge” that for certain drugs, providers, or
12 geographic areas, the ten percent reduction may impede access to selected Medi-Cal
13 drug benefits and “possibly result in a violation of federal Medicaid law.” Id. (quoting
14 DHCS Proposal to Adjust Provider Payment Reductions for Selected Medi-Cal Drug
15 Product Payments).

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

23 The Court finds that there are two particular areas of concern regarding CMS’
24 analysis of the rate reduction’s impact on access to pharmacy services. First, the
25 Secretary’s argument regarding how pharmacies are reimbursed appears to rest on a
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27 ¹⁶ AWP was found to be an inflated price metric in In re Pharm. Indus. Average
28 Wholesale Price Litig., 230 F.R.D. 61, 67–60 (D. Mass. 2005).

1 misunderstanding of Medi-Cal pharmacy reimbursement. In this respect, Medi-Cal does
2 not reimburse pharmacies the full amount of a drug's AWP. Instead, reimbursement is
3 calculated by subtracting 17 percent from AWP. Cal. Welf. & Inst. Code
4 § 14105.45(b)(3). Accordingly, California already accounts for the fact that AWP has
5 been found to be an inflated price metric. Second, the Court does not believe utilization
6 data is an accurate indicator of access in the pharmacy context because it reflects only
7 whether a pharmacy services Medi-Cal beneficiaries. It fails to capture whether a
8 pharmacy refuses to dispense a particular drug as a result of inadequate reimbursement.

9 **iv. EMT Services**

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

16 **v. DME and Supply Services**

17 Plaintiffs contend that based on the evidence in the record, CMS' approval of SPA
18 11-009 with respect to DME was arbitrary and capricious. Mot. at 20. According to
19 plaintiffs, CMS should have known that a ten percent rate reduction could not be
20 implemented without reducing the services provided to Medi-Cal beneficiaries because
21 DME providers only average a five percent pretax profit margin. *Id.* at 21. Further,
22 plaintiffs argue that there was no analysis with respect to medical suppliers and that
23 CMS "had no basis" upon which to conclude that access would be preserved after the
24 implementation of the rate reduction. *Id.*

25 The Secretary responds that the Director's access analysis indicates that utilization
26 of DME services remained constant over a three-year period despite earlier cuts, with
27 fluctuations upward, and that the number of available suppliers has increased as
28 enrollment has expanded. Opp'n at 24. The Secretary argues that plaintiffs' assertion

1 that a ten percent rate reduction would necessarily result in reduction of access relies on
2 the faulty assumption that providers are incapable of adapting to new rates. Id. at 25.
3 Further, the Secretary maintains that it was reasonable for CMS to credit the Director’s
4 analysis over “self-serving” survey responses from DME suppliers.¹⁷

5 The Court does not believe the CMS’ analysis of the rate reduction contained
6 specific flaws particular to DME services. However, because the Court believes the
7 Director’s analysis did not properly consider provider costs and failed to include a
8 projection of the rate reduction’s impact on access to DME services, the Court finds that
9 plaintiffs have shown that they are likely to prevail on their claim that CMS’ approval of
10 SPA 11-009 with respect to DME supply services was arbitrary and capricious.

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

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

19 The Director argues that plaintiffs are unlikely to succeed on the merits of their
20 Section 30(A) claim because they have no basis for asserting a private right of action
21 under Section 30(A). Director’s Opp’n at 22. The Director further contends that even if
22 plaintiffs have a private right of action, they cannot demonstrate that AB 97 violates, and
23

24 ¹⁷ The Secretary notes that “medical supply services” are not included in the
25 definition of DME, but are instead listed as a subcategory of “home health services.”
26 Secretary’s Opp’n at 24 n. 16 (citing 42 U.S.C. § 1395x(m)(4), (n)). Therefore, according
27 to the Secretary, because the State declined to implement the rate reduction for home health
28 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.

1 is thus preempted by, Section 30(A). In support of this argument, the Director points to
2 CMS' approval of SPA 11-009, which the Director contends is owed deference. Id. at
3 18–20.

4 At this juncture, the Director's argument that plaintiffs lack a private right of
5 action to enforce Section 30(A) fails. While plaintiffs lack a private right of action
6 under 42 U.S.C. § 1983, see Develop. Servs. Network v. Douglas, No. 11-55851 slip op.
7 at 20533 (9th Cir. Nov. 30, 2011), Ninth Circuit case law establishes that Section 30(A)
8 is enforceable by private parties under the Supremacy Clause. See ILC I, 543 F. 3d at
9 1050-52; ILC II, 572 F. 3d at 644; Cal. Pharms. I, 563 F. 3d at 850–51. Although this
10 issue is presently before the Supreme Court, unless and until this precedent is overruled,
11 it controls here. See Hart v. Massanari, 266 F. 3d 1155, 1171 (9th Cir. 2001). For the
12 reasons articulated in Section B(1) supra, the Court finds that plaintiffs are likely to
13 succeed on their claim that DHCS' failure to consider responsible cost studies and
14 failure to adequately consider the effect of the rate reduction on access to and quality of
15 care may be found to have violated Section 30(A). As noted above, the Court finds that
16 these issues at least present "serious questions as to the merits" of plaintiffs' claim, and
17 that the balance of hardships tips strongly in plaintiffs' favor. See Alliance for the Wild
18 Rockies, 632 F.3d at 1132; ILC II, 572 F. 3d at 657–58; Sierra On-Line, Inc., 739 F.2d
19 at 1421.

20 3. Plaintiffs' Takings Clause Claim

21 Plaintiffs assert that the rate reduction violates the Takings Clause of the Fifth
22 Amendment of the U.S. Constitution as incorporated against the states through the
23 Fourteenth Amendment of the U.S. Constitution. FAC ¶¶ 73–79. Plaintiffs argue that
24 due to state laws that require EMT providers and emergency room physicians to provide
25 emergency medical services regardless of a patient's ability to pay, the Director's failure
26 to adequately reimburse these providers for their services constitutes an unlawful taking
27 of their property without just compensation. Mot. at 22.

28 ///

1 The “Takings Clause” of the Fifth Amendment provides that private property shall
2 not “be taken for public use, without just compensation.” U.S. Const. amend. V. “In
3 order to state a claim under the Takings Clause, a plaintiff must first demonstrate that he
4 possesses a ‘property interest’ that is constitutionally protected.” Turnacliff v. Westly,
5 546 F. 3d 1113, 1118–19 (9th Cir. 2008) (internal citations omitted).

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

19 **C. Risk of Irreparable Injury**

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

26 In opposition, the Director first argues that injury to individual providers is not a
27 proper basis for injunctive relieve. Director’s Opp’n at 3. In any event, the Director
28 argues that the declarations of individual providers upon which plaintiffs rely confirm

1 that the rate reduction will not cause irreparable harm because these declarants assert
2 that they have accepted inadequate Medi-Cal reimbursement in the past. Id. at 4–5.
3 Further, the Director argues that CMS’ approval of SPA 11-009 means that beneficiaries
4 will not suffer reduced access to services, and that in any event, the monitoring plan
5 California has adopted mitigates any potential access problem. Id. at 7–9 (citing Midgett
6 v. Tri-County Metro. Transp. Dist. of Or., 254 F. 3d 846, 850 (9th Cir. 2001) (holding
7 that a defendant’s procedures for monitoring compliance in the ADA context “show that
8 Plaintiff does not face a threat of immediate irreparable harm without an injunction”).

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

1 adequate irreparable injury to support an injunction on this basis as well. See Cal.
2 Pharms. I, 563 F. 3d at 850–52.¹⁸

3 **D. Balance of Hardships and Public Interest**

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

10 Although cognizant of the State’s fiscal difficulties, the Court believes that the
11 balance of the equities and the public interest strongly favor the issuance of an
12 injunction. In reaching this conclusion, the Court notes that the Ninth Circuit has held
13 that the injury to a state caused by the injunction of one of its statutes does not outweigh
14 the public’s interest in ensuring that state agencies comply with the law and protect
15 beneficiaries’ access to services. ILC II, 572 F. 3d at 658; Cal. Pharms. II, 596 F. 3d at
16 1114–15. Similarly, the State’s fiscal crisis does not outweigh the serious irreparable
17 injury plaintiffs would suffer absent the issuance of an injunction. See ILC II, 572 F. 3d
18 at 658–59 (“State budgetary considerations do not . . . in social welfare cases, constitute
19 a critical public interest that would be injured by the grant of preliminary relief. In
20 contrast, there is a robust public interest in safeguarding access to health care for those
21 eligible for Medicaid.”); see also Golden Gate Restaurant Ass’n v. City and County of
22 San Francisco, 512 F. 3d 1112, 1126 (9th Cir. 2008) (Where “there is a conflict between
23 financial concerns and preventable human suffering . . . , the balance of hardships tips
24 decidedly in favor of the latter.”).

25
26 ¹⁸ In this respect, the Director’s argument that monetary loss to providers cannot be
27 a basis for an injunction is unavailing. The Ninth Circuit has repeatedly rejected this
28 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.

1 **E. Application of the State’s Eleventh Amendment Immunity**

2 At oral argument, the Director argued that the Court cannot enjoin the Director
3 from implementing the rate reduction because such an injunction would violate
4 California’s Eleventh Amendment immunity. Plaintiffs responded that an injunction
5 restraining implementation of the rate reduction by the Director would not violate the
6 State’s Eleventh Amendment immunity because such relief would be prospective rather
7 than retrospective in effect. Although the Eleventh Amendment bars suits against states
8 in both law and equity, a plaintiff may nonetheless maintain a federal action to compel a
9 state official’s prospective compliance with the plaintiff’s federal rights. Ex Parte
10 Young, 209 U.S. 123, 156 (1908) (“The State has no power to impart to [its officer] any
11 immunity from responsibility to the supreme authority of the United States.”). The
12 Court may issue such an injunction even if the state’s compliance will have an “ancillary
13 effect” on the state treasury. Edelman v. Jordan, 415 U.S. 651, 662–63 (1974).
14 However, this exception applies only to prospective relief; it does not permit retroactive
15 injunctive relief. Id. at 668. The Court finds that to the extent the Director has already
16 reimbursed providers for claims made after June 1, 2011, enjoining the Director from
17 implementing the rate reduction would not violate the State’s Eleventh Amendment
18 immunity. This is so because such an injunction would merely preclude the Director
19 from recovering funds already distributed. However, insofar as the Director has not yet
20 reimbursed providers for services rendered between June 1, 2011, and the date of this
21 order, the Court finds and concludes that an injunction restraining the implementation of
22 the rate reduction would be contrary to the State’s Eleventh Amendment immunity. In
23 this respect, the Court is guided by the Ninth Circuit’s explanation that “whether relief is
24 prospective or retrospective in the Medicaid payment context turns on the date of
25 service, not the date of payment.” ILC II, 572 F.3d 661, n. 19. Under this definition, an
26 injunction precluding the Director from reducing payments for services already rendered
27 would constitute a retrospective award of damages in violation of the Eleventh
28 Amendment.

1 **F. Director’s Motion for a Stay Pending Appeal**

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

16 **IV. CONCLUSION**

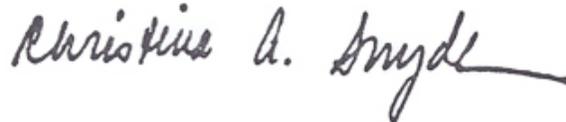
17 In accordance with the foregoing, the Court hereby GRANTS plaintiffs’ motion
18 for a preliminary injunction, and DENIES the Director’s motion for a stay pending
19 appeal.

20 IT IS HEREBY ORDERED as follows:

21 Defendant Toby Douglas, Director of the California Department of Health Care
22 Services, his employees, his agents, and others acting in concert with him with actual
23 notice of this order shall be, and hereby are, enjoined and restrained from violating
24 federal law by implementing or otherwise applying the reduction of Medi-Cal
25 reimbursement for services provided by physicians, clinics, dentists, pharmacists,
26 ambulance providers and providers of medical supplies and durable medical equipment
27 on or after June 1, 2011 for which the Director has already provided reimbursement,
28 pursuant to Assembly Bill 97 enacted by the California Legislature in March 2011, as

1 codified at California Welfare and Institutions Code § 14105.192, or to any other degree
2 reducing current Medi-Cal rates for such services. This injunction does not preclude the
3 Director from applying the rate reduction to services rendered between June 1, 2011, and
4 the date of this order, for which reimbursement has not yet been provided.

5 IT IS HEREBY FURTHER ORDERED that, consistent with the foregoing, the
6 October 27, 2011 decision by Defendant Kathleen Sebelius, Secretary of the Department
7 of the United States Department of Health and Human Services, approving the Medi-Cal
8 reimbursement reduction codified at Welfare and Institutions Code § 14105.192, is
9 hereby stayed.

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11 Dated: January 31, 2012

12 CHRISTINA A. SNYDER
13 UNITED STATES DISTRICT JUDGE
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