

1 The Secretary is responsible for administering the Medicaid program at the federal level.
2 Through her designated agent, the Centers for Medicare and Medicaid Services
3 (“CMS”), the Secretary is responsible for reviewing and approving policy changes that
4 states make to their Medicaid programs.

5 Plaintiff CMTA is a trade association representing the interests of non-emergency
6 medical transportation (“NEMT”) providers in the State of California. Plaintiff GMD
7 Transportation, Inc. (“GMD”) is an NEMT provider participating in the Medi-Cal
8 program, providing approximately 2,500 NEMT rides per month. Plaintiff Lonny
9 Slocum (“Slocum”) is a Medi-Cal beneficiary with significant health difficulties
10 including high blood pressure, congestive heart failure, kidney failure, and chronic
11 obstructive pulmonary disease. Slocum requires dialysis three times per week and is
12 confined to a wheel chair. He uses NEMT services to get to his treatments.

13 On March 25, 2011, California Governor Edmund G. Brown Jr. signed into law
14 Assembly Bill 97 (“AB 97”), the health budget trailer bill for California fiscal year
15 2011–2012. AB 97 enacted significant payment reductions for many classes of services
16 provided under the Medi-Cal program. Most significantly for the purposes of the instant
17 action, AB 97 enacted California Welfare and Institutions Code § 14105.192, which
18 authorizes the Director to reduce the Medi-Cal payment rates for various services,
19 including NEMT, effective June 1, 2011. Pursuant to Welfare and Institutions Code §
20 14105.192(n), the Director is required to seek any federal approvals necessary prior to
21 implementing the rate reduction.

22 DHCS submitted proposed State Plan Amendment (“SPA”) 11-009 to CMS on
23 June 30, 2011, seeking federal approval of the rate reduction and incorporation of that
24 reduction into California’s Medi-Cal State Plan. On September 27, 2011, CMS issued a
25 letter to DHCS requesting additional information concerning the proposed rate
26 reduction. This Request for Additional Information (“RAI”) focused on the impact of
27 the rate reduction on access to services. DHCS responded with an “Access Analysis”
28 and a plan for monitoring access. On October 27, 2011, in a letter from the Associate

1 Regional Administrator of the Division of Medicaid & Children’s Health Operations,
2 CMS provided notice to the Director and DHCS that it had approved the SPA.

3 Plaintiffs allege that CMS’s approval of the SPA was in violation of 42 U.S.C. §
4 1396a(a)(30)(A) (“Section 30(A)”)¹, the Supremacy Clause,² and the Due Process Clause
5 of the 14th Amendment to the U.S. Constitution.³ FAC ¶ 42. Plaintiffs further allege
6 that the Secretary’s approval of the SPA violated the Administrative Procedure Act
7 (“APA”), 5 U.S.C. § 701 *et seq.* because the Secretary failed to consider certain factors
8 including the impact of the rate reduction on access to and quality of NEMT services.
9 *Id.* ¶ 47.

10 On December 8, 2011, plaintiffs filed the present motion seeking a preliminary
11 injunction restraining the Director from implementing the rate reduction. On December
12 22, 2011, the Director and the Secretary filed separate oppositions to plaintiffs’ motion.⁴

14 ¹ Section 30(A) states in pertinent part that a State plan for medical assistance must:
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16 provide such methods and procedures relating to the utilization of, and the payment
17 for, care and services available under the plan . . . to assure that payments are
18 consistent with efficiency, economy, and quality of care and are sufficient to enlist
19 enough providers so that care and services are available under the plan at least to the
20 extent that such care and services are available to the general population in the
21 geographic area.

22 ² U.S. Const. art. VI, cl. 2.

23 ³ U.S. Const. amend. XIV.

24 ⁴ The director objects to the admissibility of the declarations submitted by plaintiffs.
25 Dkt. No. 44. However, this Court may consider inadmissible evidence on a motion for
26 preliminary injunction, giving such evidence appropriate weight depending on the
27 competence, personal knowledge, and credibility of the declarants. 11 Charles A. Wright,
28 Arthur K. Miller, & Mary K. Kane, Federal Practice and Procedure § 2949 at 216–17 (2d
ed. 1995); *see also Johnson v. Courturier*, 572 F. 3d 1067, 1083 (9th Cir. 2009); *Houdini,
Inc. v. Goody Baskets LLC*, 166 Fed. Appx. 946, 947 (9th Cir. 2006); *Flynt Distributing
Co., Inc. v. Harvey*, 734 F. 2d 1239 (9th Cir. 1984).

(continued...)

1 Plaintiffs replied on December 29, 2011.⁵ The Court heard oral argument on January 9,
2 2012. After carefully considering the parties’ arguments, the Court finds and concludes
3 as follows.

4 **II. LEGAL STANDARD**

5 A preliminary injunction is an “extraordinary remedy.” Winter v. Natural Res.
6 Def. Council, Inc., 555 U.S. 7, 9 (2008). The Ninth Circuit summarized the Supreme
7 Court’s recent clarification of the standard for granting preliminary injunctions in Winter
8 as follows: “[a] plaintiff seeking a preliminary injunction must establish that he is likely
9 to succeed on the merits, that he is likely to suffer irreparable harm in the absence of
10 preliminary relief, that the balance of equities tips in his favor, and that an injunction is
11 in the public interest.” Am. Trucking Ass’n, Inc. v. City of Los Angeles, 559 F.3d 1046,
12 1052 (9th Cir. 2009); see also Cal. Pharms. Ass’n v. Maxwell-Jolly, 563 F.3d 847, 849
13 (9th Cir. 2009) (“Cal. Pharms. I”). Alternatively, “serious questions going to the
14 merits’ and a hardship balance that tips sharply towards the plaintiff can support
15 issuance of an injunction, so long as the plaintiff also shows a likelihood of irreparable
16 injury and that the injunction is in the public interest.” Alliance for the Wild Rockies v.
17 Cottrell, 632 F.3d 1127, 1132 (9th Cir. 2011); see also Indep. Living Ctr. of So. Cal. v.
18 Maxwell-Jolly, 572 F. 3d 644, 657–58 (9th Cir. 2009) (“ILC II”). A “serious question”
19 is one on which the movant “has a fair chance of success on the merits.” Sierra On-Line,
20 Inc. v. Phoenix Software, Inc., 739 F.2d 1415, 1421 (9th Cir. 1984).

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25 ⁴(...continued)

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27 ⁵ On January 3, 2011, the Court denied plaintiffs’ ex parte application for a
28 temporary restraining order.

1 **III. DISCUSSION**

2 **A. Standing**

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

5 **1. Concrete Injury**

6 The Director argues that plaintiffs have not alleged an “actual and imminent
7 injury” because plaintiffs’ alleged injury relies on a “tenuous thread of assumptions
8 contingent upon possibilities.” Director’s Opp’n at 4.

9 The Court rejects this argument because plaintiffs’ alleged injuries are concrete
10 rather than speculative or conjectural. In order to establish standing to assert a claim, a
11 plaintiff must: (1) demonstrate an injury in fact, which is concrete, distinct and palpable,
12 and actual or imminent; (2) establish a causal connection between the injury and the
13 conduct complained of; and (3) show a substantial likelihood that the requested relief
14 will remedy the alleged injury in fact. See McConnell v. Fed’l Election Comm’n, 540
15 U.S. 93, 225-26 (2003). In this case, plaintiffs allege that if implemented, the challenged
16 rate reduction would inflict concrete financial injury on Medi-Cal participating NEMT
17 providers. See Indep. Living Ctr. of So. Cal. v. Shewry, 543 F. 3d 1050, 1065 (9th Cir.
18 2008) (“ILC I”). ILC I also establishes that Medi-Cal beneficiaries have standing to
19 challenge a Medi-Cal rate reduction when they allege they will be “put at risk of injury
20 by implementation of the . . . payment cuts’ because those cuts will reduce . . . access to
21 quality services.” Id. Accordingly, there can be little doubt that plaintiffs have Article
22 III standing.

23 **2. Prudential Standing**

24 The Director argues that plaintiffs’ lack prudential standing to enforce Section
25 30(A) because plaintiffs seek to enforce rights belonging to a third party, CMS.
26 According to the Director, this Section does not confer individual entitlements on any
27 private parties, but instead serves as a “yardstick” by which the federal government may
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1 assess a state’s performance under the Medicaid Act. Director’s Opp’n at 5. Moreover,
2 to the extent that plaintiffs’ claims rely on the Supremacy Clause, the Director argues
3 that they run afoul of the bar against considering generalized grievances in that plaintiffs
4 are not attempting to vindicate any right personal to them, but instead invoke the
5 Supremacy Clause as an “all-purpose cause of action to compel a state’s compliance
6 with federal law.” Id. at 6 (citing Valley Forge Christian Coll. v. Amer. United for Sep.
7 of Church and State, 454 U.S. 464, 483 (1982)).

8 The Court finds the Director’s prudential standing arguments unavailing. In
9 assessing prudential standing, a court need not “inquire whether there has been a
10 congressional intent to benefit the would-be plaintiff,” but instead must determine only
11 whether the plaintiff’s interests are among those “arguably . . . to be protected” by the
12 statutory provision. Nat’l Credit Union v. First Nat’l Bank & Trust Co., 552 U.S. 478,
13 489 (1998). This “zone of interest” test “is not meant to be demanding.” Clarke v. Secs.
14 Indus. Ass’n, 479 U.S. 388, 399–400 (1987). To this end, Section 30(A) establishes
15 standards by which payments to providers are set. Accordingly, Medi-Cal beneficiaries
16 and providers are undoubtedly within the zone of interests protected by Section 30(A).
17 Further, the Court finds that contrary to the Director’s assertion, plaintiffs are not
18 alleging a “generalized grievance.” This is so because plaintiffs have alleged that
19 CMTA’s members and the individual-beneficiary plaintiff will be directly harmed by the
20 implementation of the rate reduction.

21 3. Associational Standing

22 The Director maintains that CMTA cannot establish associational standing on
23 behalf of NEMT providers because any injury suffered by a provider will be particular to
24 that provider. Director’s Opp’n at 7–8. The Director further contends that CMTA does
25 not have standing on behalf of Medi-Cal beneficiaries because CMTA represents the
26 interests of NEMT providers, rather than the patients of those providers, because CMTA
27 fails to allege how representing Medi-Cal recipients’ interests is germane to CMTA’s
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1 purpose, and because whether an individual beneficiary has a legitimate claim will
2 require individualized determinations. Id. at 5–6.

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

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

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

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

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

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

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

22 **a. Cost Studies**

23 Plaintiffs first contend that CMS's approval of SPA 11-009 was arbitrary and
24 capricious because CMS failed to consider whether DHCS relied on credible cost studies
25 and developed rates reasonably related to provider costs as the Ninth Circuit has held is
26 required under Section 30(A). Mot. at 13-14 (citing Orthopaedic Hosp. v. Belshe, 103
27 F. 3d 1491, 1492, 1496, 1500 (9th Cir. 1997) cert. denied, Belshe v. Orthopaedic Hosp.,
28 522 U.S. 1044 (1998)).

1 In opposition, the Secretary contends that CMS’s contrary interpretation of
2 Section 30(A), upon which it based its approval of SPA 11-009, is entitled to Chevron
3 deference notwithstanding the Ninth Circuit’s decision in Orthopaedic Hospital that a
4 state must consider “responsible cost studies.” According to the Secretary, she has
5 consistently taken the position that Section 30(A) does not require states to base
6 payment rates on the costs incurred by providers even though this interpretation has not
7 yet been incorporated into a final rule. Secretary’s Opp’n at 8. The Secretary cites Nat’l
8 Cable & Telecom. Ass’n v. Brand X Internet Servs. (“Brand X”), for the principle that
9 “[a] court’s prior judicial construction of a statute trumps an agency construction
10 otherwise entitled to Chevron deference only if the prior court decision holds that its
11 construction follows from the unambiguous terms of the statute and thus leaves no room
12 for agency discretion.” Id. at 9 (quoting Brand X, 545 U.S. 967, 982 (2005)). Because
13 the Ninth Circuit has not held that its interpretation follows from the unambiguous terms
14 of the statute, the Secretary contends that her interpretation of the statute controls
15 because it was made within the context of an adjudication that would normally be
16 afforded Chevron deference. Id. The Secretary further argues that the Ninth Circuit has
17 held that the Secretary’s interpretation of Section 30(A), which formed the basis of the
18 disapproval of a State Plan Amendment, is entitled to Chevron deference. Id. at 10
19 (citing Alaska Dept. of Health and Social Servs. v. CMS, 424 F. 3d 931 (9th Cir. 2005)
20 (“Alaska”). The Secretary contends that any distinction between the approval and the
21 disapproval of a SPA is irrelevant to whether Congress delegated interpretative authority
22 to the agency, thus mandating Chevron deference. Id. The Secretary notes also that the
23 Court of Appeals for the District of Columbia Circuit has determined that the Secretary’s
24 interpretation of the Medicaid statute made in connection with the approval of an SPA is
25 entitled to Chevron deference. Id. at 11 (citing PhRMA v. Thompson, 362 F.3d 817, 822
26 (D.C. Cir. 2004)).

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1 Although the Court agrees with the Secretary that Section 30(A) leaves room for
2 interpretation,⁶ the Court does not believe the agency’s interpretation is owed Chevron
3 deference with respect to the approval at issue in this case. In this respect, the Court
4 finds significant that the Secretary’s approval of SPA 11-009 did not involve a formal
5 adjudication accompanied by the procedural safeguards justifying Chevron deference.
6 Instead, the Secretary’s issued her interpretation of Section 30(A) in a letter to DHCS.
7 This kind of interpretation is of the very type for which the Supreme Court has declined
8 to extend Chevron deference. See e.g., Christensen v. Harris County, 529 U.S. 576,
9 586–88 (2000) (holding that informal agency interpretations of a statute such as those
10 contained in an opinion letter, policy statement, agency manuals, or enforcement
11 guidelines, are not entitled to Chevron-style deference). The Secretary’s reliance on
12 Alaska misplaced. In Alaska, the Ninth Circuit deferred to the Secretary’s interpretation
13 of Section 30(A) and upheld the denial of a State Plan Amendment. In finding that the
14 CMS Administrator’s final determination “carr[ied] the force of law” necessary for
15 Chevron deference, the court highlighted “the formal administrative process afforded the
16 State,” with “opportunities to petition for reconsideration, brief its legal arguments, be
17 heard at a formal hearing, receive reasoned decisions at multiple levels of review and
18 submit exceptions to those decision.” Alaska, 424 F. 3d at 939. None of these
19 procedural safeguards was incorporated in the SPA approval process at issue in this case,
20 in which there was no hearing, no record, no opportunity for interested parties to present
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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 evidence, and no formal decision in which the Secretary set forth her reasoning.⁷
2 Accordingly, the Secretary’s approval of SPA 11-009 did not include the “hallmarks of
3 ‘fairness and deliberation,’” to which Chevron deference is owed. See Alaska, 424 F. 3d
4 at 939 (quoting Mead, 533 U.S. at 226–27).⁸

5 The Court does not believe that the Court of Appeals for the District of Columbia
6 Circuit’s determination in PhRMA, 362 F.3d at 822, compels a contrary result in this
7 case. Here, the decision of the Associate Regional Administrator of the Division of
8 Medicaid & Children's Health Operations approving the SPA, as set forth in the October
9 27 approval letter, is conclusory in nature. It does not provide any reasons on its face as

11 ⁷ 42 U.S.C. § 1316(a), which governs CMS’s 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.

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

1 to why provider costs should not be considered in determining whether the SPA's rate
2 reduction will result in lower quality of care or decreased access to services. Given the
3 logical and empirical relationship between reimbursement rates and the willingness of
4 providers to make services available that the Ninth Circuit found was the case in
5 Orthopaedic Hospital, the absence of a reasoned decision to not require cost studies to
6 justify the SPA makes the decision to approve the SPA less appropriate for Chevron
7 deference. Further, the record reflects that CMS states even though it “does not
8 currently interpret [Section 30(A)] of the Act to require cost studies in order to
9 demonstrate compliance,” CMS is “currently reviewing and refining, in a rulemaking
10 proceeding, guidance on how states can adequately document access to services,”
11 suggesting that a formal notice and comment rulemaking process, accompanied by the
12 procedural safeguards of such a proceeding, is contemplated by CMS. See Dkt. No. 23-
13 2, at 1; June 17, 2011 Letter from CMS to DHCS. Besides the fact that no explanation is
14 given for not requiring cost studies other than the statement that CMS “believe[s] the
15 appropriate focus in on access,” this statement by CMS suggests that its position
16 regarding cost studies is not necessarily settled. Thus, although the court noted in
17 PhRMA, that Chevron deference may be warranted even when no administrative
18 formality was required and none was afforded, the circumstances of this case call into
19 question whether Chevron deference is appropriate.⁹

20 Having determined that Chevron deference is inappropriate, the Court now turns
21 to whether the Secretary’s interpretation that cost studies are not required under Section
22 30(A) is “entitled to respect” under Skidmore v. Swift & Co., 323 U.S. 134, 140 (1944).

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25 ⁹ Further, in PhRMA, not only did the record support the reasonableness of the
26 Secretary's decision that the SPA at issue would make it less likely that needy persons
27 would become eligible for Medicaid, thereby impacting Medicaid services, the court noted
28 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.

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

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

14 Alaska, Resp. Br., 2004 WL 3155124, at 32 (citing Orthopaedic Hospital, 103 F. 3d at
15 1499).¹⁰ In addition to this inconsistency in agency position, the Secretary’s proffered
16 interpretation directly contradicts the law in the Ninth Circuit. See Orthopaedic
17 Hospital, 103 F. 3d at 1497. Thus, while the Court recognizes that in appropriate
18 circumstances, an agency may change its position on the construction of a statute, the
19 Court finds that in light of the circumstances of this case, the Secretary’s conclusory
20 interpretation that Section 30(A) does not require consideration of cost studies is of
21 limited “power to persuade,” and is therefore not entitled to respect under Skidmore.

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

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

7 **b. Access to and Quality of Care**

8 Plaintiffs also contend that the Secretary’s approval of SPA-009 was arbitrary and
9 capricious because DHCS failed to consider facts that bear on the impact of the rate
10 reduction on access to and quality services. In particular, plaintiffs contend that DHCS’
11 analysis was flawed because it failed to consider that in the past several years, many
12 NEMT providers have shut down their operations due to low Medi-Cal reimbursement
13 rates; and because it significantly overstated the number of NEMT providers by
14 inappropriately including *emergency* medical transportation (“EMT”) providers. Mot. at
15 11.

16 In opposition, the Secretary argues that CMS reached a “considered conclusion”
17 that SPA 11-009 does not violate Section 30(A) after a three-year process in which the
18 State submitted a “thorough analysis” of the rate reduction’s impact on access and a plan
19 to measure and monitor access to services. Secretary’s Opp’n at 15–16.¹¹ In support of
20 her argument that reliance on DHCS’s access analysis was justified, the Secretary points
21 to DHCS’s consideration of Medi-Cal enrollment and Medi-Cal utilization over a three-
22 year period as well as trends in provider participation. Id. at 16. As to plaintiffs’

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24 ¹¹ Under the State’s plan, DHCS will monitor a set of “early warning” measures,
25 including change in Medi-Cal enrollment, provider participation rates, and calls to the
26 Medi-Cal help line. Dkt. No 10-11, at 63–64. Any indication of a reduction in
27 beneficiaries’ access to NEMT services would trigger a prompt response from DHCS, and
28 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 the monitoring plan as a condition of CMS’s approval of SPA 11-009.

1 argument that the number of NEMT providers is considerably lower than the access
2 study reflects, the Secretary asserts that plaintiffs ignore the fact that California’s state
3 plan for medical transportation contemplates that EMT providers may also furnish
4 NEMT.¹² As to plaintiffs’ charge that CMS’s analysis ignored the impact of the rate
5 reduction on quality of services, the Secretary argues that the State’s monitoring plan
6 repeatedly makes clear that it does not simply address access to any care, but rather that
7 it addresses access to high quality care. Id. at 19. The Secretary notes also that the
8 monitoring plan acknowledges that “[p]rovisions in both Federal and State [law]
9 mandate that administrators ensure access to high quality healthcare for its Medi-Cal
10 beneficiaries.” Id.

11 The Court finds that plaintiffs have shown a likelihood of success on the merits of
12 their claim that CMS’s approval based on its acceptance of DHCS’s access analysis and
13 monitoring plan was arbitrary and capricious. In this regard, the Court rejects the
14 argument that EMT providers are interchangeable with NEMT providers for the

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16 ¹² In addition, the Secretary notes that Section 30(A) only requires state plans to
17 provide payments sufficient to enlist enough providers so that care and services are
18 available at least to the extent that such care and services are available to the general
19 population. Id. at 17. The Secretary argues that NEMT is not a service available to the
20 general population, and that the access analysis therefore indicates that Medi-Cal
21 beneficiaries have “far greater access” to NEMT than required by Section 30(A). Id. at 18.
22 However, the Court believes that this argument relies on an overly narrow reading of
23 Section 30(A). That is, Section 30(A) requires sufficient payments to enlist enough
24 providers so that both care and services are available to medical beneficiaries at least to the
25 extent that such care and services are available to the general population. Therefore, even
26 if NEMT services are not available to the general population as counsel for the Secretary
27 argued at oral argument, Section 30(A) may still be violated if the state plan fails to
28 provide payments sufficient to enlist enough providers so that *care* would be available to
Medical beneficiaries to the same extent that such care is available to the general
population. In this case, were payments insufficient to enlist enough NEMT providers to
transport Medical beneficiaries to treatments available to the general population, Medical
beneficiaries would not receive the level of care mandated by Section 30(A). Further, the
Court notes that its previous injunction of a similar rate reduction for NEMT services was
affirmed by the Ninth Circuit. See ILC II, 572 F. 3d 644.

1 purposes of determining the rate reduction’s impact on access. While California’s
2 medical transportation plan contemplates that emergency medical transportation
3 providers may furnish NEMT services, the access analysis fails to consider the extent to
4 which they will actually do so after the implementation of the challenged rate reduction.
5 Furthermore, the Court believes it was likely unreasonable for the Secretary to accept
6 DHCS’s “utilization” rate, which considered the number of NEMT rides given by Medi-
7 Cal participating providers. While the utilization rate may be useful for understanding
8 historical trends in NEMT usage, it fails to consider the rate reduction’s prospective
9 impact on NEMT availability, and is therefore of limited relevance. Next, the Court
10 finds it likely that the Secretary’s acceptance of the monitoring plan as adequately
11 ensuring access to care will also be found arbitrary and capricious. First, the monitoring
12 plan merely creates a potential response after an access or quality problem has been
13 identified. To the extent reduced rates cause NEMT providers to cease their operations,
14 increased rates will not necessarily result in the restarting of those businesses. More
15 fundamentally, during the period between the detection of an access or quality problem
16 and its potential remedy through increased reimbursements, Medi-Cal beneficiaries will
17 necessarily suffer from reduced access to quality NEMT services. Finally, the Ninth
18 Circuit has found it unreasonable to rely on independent provisions of federal and state
19 law to ensure quality of care, precisely what the monitoring plan purports to do here.
20 See Orthopaedic Hospital, 103 F. 3d at 1497 (“The Department, itself, must satisfy the
21 requirement that the payments themselves be consistent with quality care.”).¹³

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

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

6 The Director argues that plaintiffs are unlikely to succeed on the merits of their
7 Section 30(A) claim because they have no basis for asserting a private right of action
8 under Section 30(A). Director’s Opp’n at 10. The Director further contends that even if
9 plaintiffs have a private right of action, they cannot demonstrate that AB 97 violates, and
10 is thus preempted by, Section 30(A). In support of this argument, the Director points to
11 CMS’s approval of SPA 11-009, which the Director contends is owed deference. Id. at
12 10–12.

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

1 **3. Plaintiffs’ Takings Clause Claim**

2 Plaintiffs assert that the rate reduction violates the Takings Clause of the Fifth
3 Amendment of the U.S. Constitution as incorporated against the states through the
4 Fourteenth Amendment of the U.S. Constitution. FAC ¶ 42; Reply at 13.

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

10 The Court does not believe that plaintiffs have adequately shown a likelihood of
11 success on their Takings Clause claim. Ordinarily, health care providers “do not possess
12 a property interest in continued participation in Medicare, Medicaid, or the federally-
13 funded state health care programs.” Erickson v. U.S. ex rel. Dept. of Health and Human
14 Srvcs., 67 F. 3d 858, 862 (9th Cir. 1995). In this respect, plaintiffs have failed to
15 establish a protected property interest because the NEMT providers voluntarily
16 participate in the Medi-Cal program. Although NEMT providers will receive reduced
17 reimbursements as a result of the rate reduction, they are under no obligation to continue
18 servicing Medi-Cal patients.¹⁴

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21 ¹⁴ At oral argument, plaintiffs’ counsel emphasized the “retroactive” nature of the
22 rate reduction in support of plaintiffs’ claim under the Takings Clause. The Court finds
23 this argument unavailing. Even though the rate reduction might require the return of
24 payments previously made to providers, such an occurrence would not constitute an
25 unconstitutional taking. Rather, assuming overpayments were required to be returned,
26 providers would merely forfeit payments to which they were not entitled in the first place.
27 Further, California enacted AB 97 in March 2011, three months prior to its June 1, 2011
28 effective date, giving notice to providers that the rate reduction could be implemented.
Those providers that continued to furnish NEMT services after June 1, 2011, voluntarily
accepted the risk that reimbursements rates could be reduced if and when SPA 11-009 were
approved.

1 **C. Risk of Irreparable Injury**

2 Plaintiffs contend that the rate reduction will cause irreparable harm in two
3 principal ways. First, plaintiffs argue that NEMT providers will suffer substantial
4 monetary losses as a result of the rate reduction, forcing them to severely curtail their
5 services or close their businesses entirely. Next, plaintiffs argue that the resulting loss of
6 access to NEMT services would require Medi-Cal beneficiaries to enter nursing facilities
7 or hospitals, use hospital emergency rooms more frequently, or face serious health
8 consequences. Mot. at 14–15.

9 In opposition, both the Secretary and the Director rely on the mitigating impact of
10 the monitoring plan that California has adopted. Secretary’s Opp’n at 23–24; Director’s
11 Opp’n at 19. Both defendants cite Midgett v. Tri-County Metro. Transp. Dist. of Or.,
12 254 F. 3d 846, 850 (9th Cir. 2001) (holding that a defendant’s procedures for monitoring
13 compliance in the ADA context “show that Plaintiff does not face a threat of immediate
14 irreparable harm without an injunction”), and argue that given the procedural safeguards
15 of the monitoring plan, plaintiffs cannot prove irreparable harm as a result of the rate
16 reduction. Additionally, the Director argues that the injury to providers is not a proper
17 basis for an injunction because providers are merely “indirect beneficiaries” of the
18 program. Director’s Opp’n at 17. Finally, the Director contends that the claims of
19 irreparable harm to beneficiaries are based entirely on hearsay and conjecture that their
20 current NEMT providers will stop furnishing them services. Id. at 18.

21 The Court finds that plaintiffs have met their burden of showing irreparable harm
22 in the absence of an injunction. In reaching this conclusion, the Court rejects
23 defendants’ contention that California’s monitoring plan will necessarily prevent
24 beneficiaries from being harmed. As discussed above, the Court believes that the
25 monitoring plan at best presents a potential remedy *after* an access or quality problem
26 has been detected. Even if the monitoring plan could ensure that beneficiary access to
27 services would not be reduced on the aggregate, the Ninth Circuit has held that as long
28 as there is evidence showing that at least some Medi-Cal beneficiaries might lose

1 services as a result of a rate reduction, irreparable harm is adequately demonstrated. Cal.
2 Pharms. Ass’n v. Maxwell-Jolly, 596 F. 3d 1098, 1114 (9th Cir. 2010) (“Cal. Pharms.
3 II”). Here, plaintiffs have proffered evidence that NEMT providers will reduce or
4 eliminate their services in response to the implementation of the rate reduction,
5 suggesting that at least some beneficiaries would suffer reduced access to medical
6 transportation services. See Declaration of Marat Sheynkman ¶¶ 5, 17; Declaration of
7 William E. Barnaby and William E. Barnaby III ¶¶ 9; 10.¹⁵ Furthermore, because
8 CMTA’s members would be barred from recovering any reimbursement short fall in an
9 action at law due to California’s Eleventh Amendment immunity, the Court finds
10 plaintiffs have shown adequate irreparable injury to support an injunction on this basis
11 as well. See Cal. Pharms. I, 563 F. 3d at 850–52.¹⁶

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

13 The Secretary and Director each argue that injunctive relief would have a serious
14 impact on the continuing financial health of the State of California. Secretary’s Opp’n at
15 24–25; Director’s Opp’n at 20. The Director also maintains that the public will suffer
16 harm if an injunction issues because any injunction that prevents the implementation of a
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19 ¹⁵ The Court notes that in addition to the declarations submitted in this case,
20 plaintiffs rely on declarations in ILC II in which this Court and the Ninth Circuit found that
21 plaintiffs had adequately shown irreparable harm in the context of a similar rate reduction.
22 See ILC II, 572 F. 3d at 657–58. The Court rejects the Director’s contention that
23 declarations in that case are irrelevant in this case due to DHCS’s access analysis and
24 monitoring plan and the Secretary’s approval thereof. Regardless of the distinguishable
25 features of this case, the declarations previously submitted provide persuasive evidence that
in response to a rate reduction, NEMT providers reduce or eliminate services and that
Medi-Cal beneficiaries are thereby harmed.

26 ¹⁶ 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 state statute inflicts injury on the State. Director’s Opp’n at 19 (citing Coalition for
2 Economic Equity v. Wilson, 122 F. 3d 718, 719 (9th Cir. 1997)).

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

18 **IV. CONCLUSION**

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

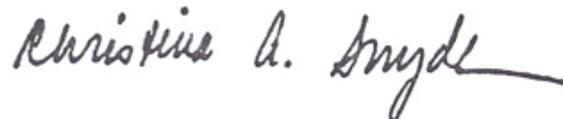
21 IT IS HEREBY ORDERED as follows:

22 Defendant Toby Douglas, Director of the California Department of Health Care
23 Services, his employees, his agents, and others acting in concert with him shall be, and
24 hereby are, enjoined and restrained from violating federal law by implementing or
25 otherwise applying the reduction on Medi-Cal reimbursement for non-emergency
26 medical transportation services on or after June 1, 2011, pursuant to Assembly Bill 97
27 enacted by the California Legislature in March 2011, as codified at California Welfare
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1 and Institutions Code § 14105.192, or to any other degree reducing current Medi-Cal
2 rates for NEMT services.

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

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9 Dated: January 10, 2011



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CHRISTINA A. SNYDER
UNITED STATES DISTRICT JUDGE