IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

MANAGED PHARMACY CARE, *et al.*, Plaintiffs/Appellees/Cross-Appellants, **v.** **KATHLEEN SEBELIUS, *et al.*,** Defendants/Appellants/Cross-Appellees.	Nos. 12-55067 and 12-55332 2:11-cv-09211-CAS (MANx) Central District of California, Los Angeles
CALIFORNIA HOSPITAL ASS'N, *et al.*, Plaintiffs/Appellees/Cross-Appellants, **v.** **TOBY DOUGLAS**, ***et al.***, Defendants/Appellants/Cross-Appellees.	Nos. 12-55068, 12-55331 and 12-55535 2:11-cv-09078-CAS (MANx) Central District of California, Los Angeles
CALIFORNIA MEDICAL TRANSPORTATION ASS'N, INC., *et al.*, Plaintiffs/Appellees/Cross-Appellants, **v.** **TOBY DOUGLAS**, ***et al.***, Defendants/Appellants/Cross-Appellees.	Nos. 12-55103, 12-55334 and 12-55554 2:11-cv-09830-CAS (MANx) Central District of California, Los Angeles
CALIFORNIA MEDICAL ASS'N, *et al.*, Plaintiffs/Appellees/Cross-Appellants, **v.** **TOBY DOUGLAS**, ***et al.***, Defendants/Appellants/Cross-Appellees.	Nos. 12-55315, 12-55335 and 12-55550 2:11-cv-09688-CAS (MANx) Central District of California, Los Angeles

AMICUS BRIEF OF ALASKA STATE HOSPITAL AND NURSING HOME ASSOCIATION, AMERICAN HOSPITAL ASSOCIATION, ARIZONA HOSPITAL AND HEALTHCARE ASSOCIATION, HEALTHCARE ASSOCIATION OF HAWAII, IDAHO HOSPITAL ASSOCIATION, MONTANA HOSPITAL ASSOCIATION, NEVADA HOSPITAL ASSOCIATION, OREGON ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS AND WASHINGTON STATE HOSPITAL ASSOCIATION IN SUPPORT OF PETITION FOR REHEARING AND REHEARING EN BANC OF APPELLEES/PETITIONERS CALIFORNIA MEDICAL ASS'N, ET AL.

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Under Federal Rule of Appellate Procedure 26.1, the Alaska State Hospital and Nursing Home Association, American Hospital Association, Arizona Hospital and Healthcare Association, Healthcare Association of Hawaii, Idaho Hospital Association, Montana Hospital Association, Nevada Hospital Association, Oregon Association of Hospitals and Health Systems and Washington State Hospital Association (hereafter referred to as the "Hospital Associations"), each states that it has no parent companies, subsidiaries (including wholly-owned subsidiaries), or affiliates that have issued shares to the public.

Date: February 7, 2013

s/ Mark H. Gallant
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No party's counsel authored this brief in whole or in part. No party, party's counsel, or person – other than the amicus curiae – contributed money intended to fund the preparation or submission of this brief.

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I. IDENTITY AND STATEMENT OF INTEREST OF AMICUS CURIAE HOSPITAL ASSOCIATIONS

The Panel has acknowledged the public importance of the issues presented by this case. Joint Petition For Rehearing Appendix 1 ("App. 1"), p. 17. These issues are profoundly significant to both those who provide, and those who receive services through Medicaid.

Amici's members furnish significant volumes of services to Medicaid patients. The American Hospital Association ("AHA") represents nearly 5,000 hospitals, health care systems, and networks, plus 37,000 individual members. Nationally, Medicaid patients account for approximately 16% of the total costs of hospitals. The State Amici's members provide hospital and skilled nursing services in every State within the Ninth Circuit. Medicaid patients make up approximately 9.71 % to 26 % of hospital inpatients as measured by admission and/or discharge data in the States represented by the Amici. Given the volume of services they provide to Medicaid recipients, the financial viability of Amici's members – to which the public's "access" to quality health care services is inextricably linked – is significantly impacted by the adequacy of Medicaid rates.

The importance of "assur[ing] that [Medicaid] payments are consistent with efficiency, economy and quality of care," 42 U.S.C. § 1396a(a)(30)(A) (hereinafter "Section (30)(A)"), was heightened by the recent enactment of the Patient Protection and Affordable Care Act ("ACA"),[1] which both prevents reductions to, and dramatically expands Medicaid eligibility, while simultaneously reducing government subsidies for hospitals that treat disproportionate numbers of low-income patients. The economic impact of Medicaid rate reductions also is

[1] Pub. L. No. 111-148 at §§ 2001–2304.

compounded by the fact many hospitals represented by the Amici operate on slender margins.[2] AHA data reflect that over 28% of hospitals nationally have negative operating margins. Additionally, future review of Medicaid rate reductions by the Center for Medicare & Medicaid Services ("CMS") in the States represented by the Amici will be governed by the Circuit's disposition of the captioned appeals. Accordingly the Amici's concern about the Panel's decision transcends this particular dispute over California's Medi-Cal program.

II. INTRODUCTION

Because maintenance of effort and enhanced Medicaid eligibility has been mandated by Congress, payments to providers become natural targets when States face budgetary pressures. And CMS has been proactive in reminding States of their ability to adjust provider payments as a way to make ends meet and routinely approving rate reductions.[3] As a consequence, checks and balances by the judiciary against arbitrary, purely budget-driven rate Medicaid reductions is essential for ensuring Medicaid payments are at least minimally adequate.

In Orthopaedic Hospital v. Belshe, 103 F.3d 1491, 1496 (1997), cert denied, 522 U.S. 1044 (1998), this Court held that a State cannot satisfy Section (30)(A) without considering whether proposed Medicaid payments "bear a reasonable relationship to efficient and economical [providers'] costs of providing quality

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[2] For example, 47% of Montana hospitals and 30% of Oregon hospitals operate on negative margins.

[3] See Letter of February 3, 2011 from HHS Secretary Sebelius to the Governors of the United States (http://www.hhs.gov/news/press/2011pres/01/20110203c.html); Letter of February 15, 2011 from same to Arizona Governor Janice Brewer (http://www.azahcccs.gov/shared/Downloads/News/SebeliusLetter_JaniceBrewer.pdf).

services." While Sanchez v. Johnson, 416 F.3d 1051 (9th Cir. 2005), found that Section (30)(A) is not enforceable under the civil rights act, this Circuit has reaffirmed in Indep. Living Ctr. of S. California v. Maxwell-Jolly, 572 F.3d 644, 652 (9th Cir. 2009), *vacated and remanded sub nom.* Douglas v. Indep. Living Ctr. of S. California, Inc., 132 S. Ct. 1204 (U.S. 2012) that legislatively mandated, across-the-board rate reductions adopted without due consideration of the factors prescribed by Section (30)(A) conflict with federal law, and may be enjoined under the Supremacy Clause.

The Panel's decision extinguishes settled Ninth Circuit law by extending virtually controlling Chevron-level[4] deference to CMS approvals of State Plan Amendments ("SPAs"). Affording such deference to routine SPA approvals poses a significant threat to the financial viability of hospitals and amounts to abdicating meaningful judicial oversight of Medicaid rate reductions. Unless the Panel's decision is reconsidered, States within this Circuit will be able to blithely legislate Medicaid rate cuts with CMS imprimatur and with no meaningful judicial oversight, placing hospitals represented by the Amici at great financial risk and reducing access to care for Medicaid beneficiaries.

III. ARGUMENT

The Panel reversed this Circuit's standing precedents and rejected the meticulous analysis of the district court as a result of attributing Chevron-level deference to CMS's approvals of the California SPAs at issue. This case warrants review by the full Circuit both because the Panel's decision nullifies solidly

[4] See Chevron U.S.A., Inc. v. Nat'l Resources Defense Council, Inc., 467 U.S. 837 (1984).

reasoned, and longstanding Ninth Circuit precedent, and makes significant public policy based on highly questionable legal assumptions.

A. The SPAs To Which The Panel Deferred Conflict With the Law of this Circuit

Section (30)(A) requires States to "assure" access to care and services for Medicaid patients that is at least equivalent to that available to the general population through adequate "payment for care and services." In Orthopedic Hosp. v. Belshe, this Circuit soundly construed the operative language of Section (30)(A) as obligating States to assess the relationship of payment rates to the costs of providing services of appropriate quality *prior to* adopting Medicaid rate reductions. As the Court emphasized, a State agency "cannot know that it is setting rates that are consistent with efficiency, economy quality of care and access without [first] considering the costs of providing such services." Orthopedic Hosp., 103 F.3d at 1496. The vitality of the Court's interpretation of Section (30)(A) was steadfastly reaffirmed in California Pharmacists Ass'n v. Maxwell-Jolly, 596 F.3d 1098 (9th Cir. 2010), *vacated on other grounds sub nom* Douglas v. ILC, 132 S.Ct. 1204 (2012).

There is no real dispute that the SPAs at issue, and to which the Panel deferred, squarely conflict with the law of the Circuit. For example, the letter approving SPA 11-009, States that "[w]e conducted our review of your submittal with particular attention to the statutory requirements at section 1902(a)(30)(A)," and concludes that California was able "to provide metrics which adequately demonstrated beneficiary access [to care]." App. 1, p. 21. Those bullet-point "metrics" – such as "[t]otal number of provider by types and geographic location" – make no pretense of comparing the relationship of the proposed rates to the

necessary costs of efficient providers and no mention of the relationship of payments to services of appropriate "quality" – factors this Circuit has deemed essential since Orthopedic Hosp.

B. An SPA Approval is Not a "Statutory Interpretation" That Qualifies for Chevron-Level Deference

The Panel set aside this Circuit's standing interpretation of Section (30)(A) (which it obliquely criticized as being inconsistent with decisions of "sister circuits")[5] by treating the approval of California's SPAs as an "interpretation" of Section (30)(A) by the agency charged with its implementation entitled to controlling deference under Chevron. Based on that premise, the Panel held that CMS' approvals of SPA 11-009 and SPA 11-010 supplanted the law of this Circuit under National Cable & Telecommunications Ass'n v. Brand X Internet Services, 545 U.S. 967 (2005) ("Brand X"). This approach is troubling.

In Brand X, the Supreme Court announced that a formal agency interpretation of an ambiguous statute can override an inconsistent judicial interpretation of a same statute adopted before the agency had spoken. The notion that an agency interpretation might "trump the values served by *stare decisis* and judicial interpretative supremacy," however, was a "remarkable bottom line." Richard Murphy, The Brand X Constitution, 2007 B.Y.U. L. REV. 1247, 1295 (2007).[6]" So remarkable was this result that Justice Scalia considered it "probably unconstitutional." Brand X, 545 U.S. at 1017 (Scalia, A., dissenting). "In light of Brand X, the weight given to an agency rule or interpretation is more

[5] App. 1, p. 35-36.
[6] See also AARP v. EEOC, 390 F. Supp. 2d 437, 442 (E.D. Pa. 2005) (Brand X "dramatically altered the roles of courts and agencies under Chevron").

significant. If an agency's interpretation has the ability to carry the force of law, it is necessary to ensure … that the procedures used to arrive at that rule or interpretation are just, fair, and reasonable. If an agency interpretation or rule has the ability to trump court precedent, however, the standard must be something even greater."[7] Brand X was improvidently invoked in this case.

To begin with, the two-step Chevron analysis applies *only* to agency *interpretations* of statutes. And Chevron deference cannot nullify judicial precedent unless an agency "adequately explains its reasoning." In re: MDL-1824 Tri-State Water Rights Litigation, 644 F.3d 1160, 1194 n. 29 (11th Cir. 2011). In Brand X, judicial precedent was displaced by a formal regulatory interpretation adopted through a rigorous notice and comment rulemaking proceeding. The SPAs in this case don't come close to justifying rejection of this Court's repeated, well-reasoned interpretations of the Section (30)(A).

An SPA is not an *interpretation* of the law at all, but rather, an *agency action* in the nature of grant approval under Title XIX (entitled "Grants to States for Medical Assistance Programs"). This court has squarely recognized that an agency's "interpretation" of a statute is considered in light of Chevron and its progeny," while, "[i]n contrast, an agency's actions exercised under its statutory authority are generally subject to arbitrary and capricious review." United States v. W.R. Grace & Co., 429 F.3d 1224, 1236 (9th Cir. 2005).[8] While the SPA

[7] Darren H. Weiss, Note, X Misses The Spot: Fernandez v. Keisler And The (Mis)Appropriation Of Brand X By The Board Of Immigration Appeals, 17 Geo. Mason L. Rev. 889, 902-903 (2010).

[8] In W.R. Grace, the EPA's approved cleanup activities in response to an asbestos-related threat based on the agency's interpretation of the removal/remedial distinction in CERCLA through a series of "action memos." Id. at 1224. The court found that (1) the EPA properly applied CERCLA in characterizing the

process requires CMS to apply Section (30)(A) in a specific context, an SPA approval letter is an administrative action that bears little resemblance to an "interpretation" of statutory provisions. The SPA approvals at hand are utterly conclusory, stating only and without explication that California's proposed "metrics," taken together with a proposed post-payment reduction "monitoring Plan," were "consistent with the requirement of section 1902(a)(30)(A)."

By analogy, in Beno v. Shalala, 30 F.3d 1057 (9th Cir. 1994), this Court reviewed the Secretary's approval of a Medicaid waiver and demonstration grant under Section 1115 of the Act. A Section 1115 Waiver is a common alternative to a traditional State Plan under which funding is "regarded as" medical assistance expenditures under a Title XIX State Plan, 42 U.S.C. § 1315(a)(2)(A).[9] The Court did not treat the Secretary's Waiver approval – which is a far more searching and comprehensive exercise than an SPA approval – as a statutory "interpretation" entitled to Chevron deference. Instead, Beno reviewed the Waiver approval for compliance with the plain terms of the statute under the "arbitrary and capricious" standard of the APA (under which standards the SPAs at hand come up short). The only thing the Beno Court regarded as an "interpretation" was the Secretary's legal arguments about the statutory provisions on appeal – to which the Court refused to defer under Chevron as "statutory interpretations … adopted for purposes of litigation." Id. at 1071.

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cleanup as a removal, rather than a remedial action, and (2) the EPA's action approving the cleanup was not arbitrary and capricious. Id.

[9] See generally Spry v. Thompson, 487 F.3d 1272 (9th Cir. 2007).

C. An SPA Approval Plainly Lacks the Requisite Formality to Qualify for Chevron Deference

1. As a safeguard against precipitously ceding judicial authority to agency officials, the Supreme Court has stressed repeatedly that Chevron deference does not attach to "informal" agency interpretations. See, e.g. United States v. Mead, 533 U.S. 218 (2001); Christensen v. Harris County, 529 U.S. 576 (2000). Even if it were treated, incorrectly, as a "statutory interpretation," an SPA approval would not satisfy this standard. To garner Chevron deference an agency decision must not only represent a formal interpretation of an ambiguous statute within the agency's delegated discretion, it also "must be supported by reasoned decision making" and be "adequately explained." Fox v. Clinton, 684 F.3d 67, 74-76 (D.C. Cir. 2012).[10] Under this standard, an SPA is not even due the same respect as a letter ruling, which at least includes a reasoned statutory interpretation.

SPA approvals contain sparse, if any, explanations of statutory terms. Requests for SPA amendments are submitted on a two-page form comprised of checklists. Indeed, SPAs are "deemed approved" if not acted upon within 90 days. 42 C.F.R. § 430.16(b)(i). As evidenced by the record in this case, even affirmative SPA approvals (which the Panel euphemistically termed "succinct") take the form of conclusory letters containing nothing in the nature of a reasoned explanation of operative statutory terms. There is no analysis of Section (30)(A), let alone any

[10] See also id. at 77-78 (agency manuals and letters setting forth an agency's "conclusory assertions of law" are owed no deference); AFGE, AFL-CIO Local 2152 v. Principi, 464 F.3d 1049, 1057 (9th Cir. 2006) (finding no Chevron deference is due an interpretation of law contained in an opinion letter rather than "as the result of a formal proceeding.").

discussion of the ostensible flaws in California's approach articulated in prior decisions of this Circuit. Simply put, an approval letter cannot fairly be described as an "interpretation" of the statute – formal or otherwise. It is merely a conclusory summary of the agency's "action," and therefore unworthy of being gilded with Chevron deference.

2. SPA approvals not only lack the formality and detail necessary to trump Circuit law but are not sufficiently authoritative to be regarded as the "agency's" interpretation. The "precedential value of an [agency's interpretation] is *the* essential factor in determining whether Chevron deference is appropriate." Alvarado v. Gonzales, 449 F.3d 915, 922 (9th Cir. 2006) (denying Chevron deference to interpretations of individual immigration judges).[11] SPA approvals are devoid of precedential value.

Under 42 C.F.R. § 430.15, SPAs typically are approved at the CMS Regional Office level (as was SPA 11-009), and govern only the specific application at hand. SPAs are approved routinely. Indeed, the prime focus of CMS review is to ensure against creative financing mechanisms that impermissibly shift costs to the federal government.[12] Moreover, CMS reviews SPAs with a light

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[11] Accord Mead, 533 U.S. at 229-30 (the "binding character" of a Custom's letter "stops short of third parties" and is thus "beyond the Chevron pale" because it "lacks the force of law"); Hall v. EPA, 273 F.3d 1146, 1155-56 (9th Cir. 2001) ("interpretations of the Act in . . . non-precedential documents are not entitled to Chevron deference").

[12] Literally hundreds of SPAs are processed and approved every year, which tend to be "rubber-stamped" by CMS. See Joint Petition for Rehearing, p. 8, fn. 8. See also http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Plan-Amendments/Medicaid-State-Plan-Amendments.html; CRS Report for Congress: *Medicaid Regulation of Governmental Providers* (March 25, 2008); U.S. Governmental Accountability Office, *Medicaid: States' Efforts to Maximize*

touch, owing to both a lack of resources and heavy reliance on the "assurances" of the States – as attested in the Amicus Brief filed in the Supreme Court by several former high level CMS officials and HHS Secretaries.[13] SPA approvals thus lack the "precedential" import this Circuit regards as "essential" to Chevron deference.[14]

D. A Summary SPA Approval Is Materially Distinguishable From and Not Entitled to the Deference Due an SPA Disapproval by the Secretary

The Panel relied heavily on the fact that this Court afforded Chevron deference to the "disapproval" of an SPA in Alaska Dept. of Health and Social Servs. v. CMS, 424 F.3d 931 (9th Cir. 2005) ("Alaska"). That approach is ill-founded. An SPA *disapproval* is entitled to far greater respect than an SPA *approval* because it includes a detailed, reasoned interpretation that is both adopted through formal adjudicative process and represents the authoritative view of the Secretary.

In contrast with a conclusory SPA approval letter, an SPA disapproval requires publication of a Federal Register Notice, which explains the basis for the agency's adverse action and describes why an SPA is found not to satisfy one or

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Federal Reimbursement Highlight Need for Improved Federal Oversight, GAO-05-836T; U.S. Dept. HHS, OIG, *Review of Medicaid Enhanced Payments to Local Public Providers and Use of Intergovernmental Transfers*, A-03-00-0021G.

[13] Brief of Former HHS Officials and Amicus Curiae in Support of Respondents in Douglas v. Independent Living Ctr. of S. Cal., 2011 WL3706105 (US) at p. *5, *10 (noting that Title XIX historically has been enforced through legal actions by providers and beneficiaries, and that CMS and HHS devote minimal staff and resources to SPA reviews).

[14] In contrast, only the CMS Administrator has authority to "give notice of [a] disapproval of [an SPA]," which takes the form of a detailed formal decision "of the Secretary." 42 C.F.R. § 430.18(b)(2).

more requirements of the Act. See 42 C.F.R. §§ 430.60, 430.70. It also is subject to "reconsideration of a final determination of the Secretary" through a formal public hearing process in which the proposed disapproval may be affirmed, modified or reversed based on the evidence and arguments presented, and which culminates in the issuance of a detailed "decision" by the CMS Administrator which, in turn, is treated as "the final decision of the Secretary." 42 U.S.C. § 1316(a)(3); 42 C.F.R. §§ 430.102(c), 430.18(c).

Chevron deference was applied in Alaska not simply because the Secretary's disapproval of the SPA was binding on the State and flowed from a delegation of congressional authority, but because it was the product of "a relatively formal administrative proceeding" in which there was an on-record "deliberation" that included "reasoned decisions at multiple levels of review." Alaska at 939. Stated otherwise, Chevron deference was accorded not to the act of disapproving the SPA, but to the formal process and detailed decisions that attended that action. There simply is no comparison to a non-public, and entirely conclusory, SPA approval letter."[15]

[15] The lower court's refusal in this case to defer to the SPA approvals here was consistent with other decisions that have examined the SPA process. See, e.g., Indep. Acceptance Co. v. California, 204 F.3d of 1247, 1252 (9th Cir. 2000) (noting that "the Secretary reviews only the reasonableness of the assurances"); Michigan Hosp. Ass'n. v. Dept of Social Servs., 738 F. Supp. 1080, 1085 (W.D. Mich. 1990) (recognizing "minimal review by the [Secretary]"); Illinois Health Care Ass'n v. Suter, 719 F. Supp. 1419, 1423 (N.D. Ill. 1989) (Congress intended Secretary's role as "one that does not emesh him in the details of the State's compliance with the Act"). CMS underscored in the proposed Section (30)(A) rules that it continues to rely "upon State assurances" and that review under even the more robust standards of the proposed (30)(A) regulations "will generally be limited to the issues of whether the State collected relevant data." 76 Fed. Reg. 26342, 26349 (col. 1 and col. 3) (May 6, 2011). This is all the more disconcerting

E. The Pendency of Proposed Section (30)(A) Rules Undermines Any Suggestion that the SPA Approvals are Due Chevron Deference

Attributing Chevron deference to the instant SPA approvals is all the more inappropriate given the fact that the Secretary's formal "interpretation" of Section (30)(A) remains the subject of pending proposed Regulations. Nearly two years ago the Secretary promulgated rules to implement Section (30)(A). These generated nearly 200 public comments which are still being considered.[16]

In some respects, the Proposed Rules differ markedly from the "implicit" interpretation of Section (30)(A) the Panel divined from the two SPA approvals. For example, the Proposed Rules mandate an "access review" that includes an advance assessment of "Medicaid payments." See § 447.203(b)(2)(B), 76 Fed. Reg. 26342, 26361 (col. 2). This assessment "must include" an estimate of Medicaid rates as a percentile of "estimated average customary charges"; and an estimate of Medicaid payments as a percentile of Medicare rates, average commercial payment rates or Medicaid allowable costs for the services; and an estimate of the composite decrease in the above "resulting from any proposed revisions in payment rates." Additionally, the Proposed Rules prohibit rate reductions prior to a "public process" in which comments concerning the sufficiency of *proposed* rate reductions are publicly vetted and reviewed. Id. at 26361-62.

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given CMS' recognition that "only a few States indicated that they relied upon actual data" about the impact of rate reductions on quality of care before implementing provider rate cuts. 76 Fed. Reg. 26342, 26348 (col. 3).

[16] 76 Fed. Reg. 26342 (May 6, 2011). (A complete list of the comments may be found at http://www.regulations.gov/#!docketBrowser;rpp=25;po=0;D=CMS-2011-0062.)

Under the Secretary's published proposed *regulatory* "interpretation" of Section (30)(A), the SPAs at issue in this case would be void on their face. It is completely incongruous to "defer" to the implicit "interpretation" of Section (3)(A) in the SPA to the extent that it materially *conflicts* with critical elements of the more comprehensively articulated "interpretation" in the Proposed Rules. Conversely, the Proposed Rules align with the SPA approvals at issue to the extent they do not exclusively mandate comparing Medicaid rates to allowable costs and rely heavily on after-the-fact monitoring as the basis for assuring proposed rate cuts satisfy statutory access requirements. But these elements of the Proposed Rules are not entitled to Chevron deference – or to any legal force or effect – because the regulations, which have been under consideration since May 2011, following an avalanche of comments, are not yet "final."[17] It is completely illogical to accord controlling deference to the "implicit" logic of the SPAs when the Proposed Rules – despite being published under the name of the Secretary and including exponentially more detail than the SPAs – cannot qualify for Chevron deference because they are not yet "final."

F. Review is Warranted Because the Putative Interpretation to Which the Panel Deferred is Manifestly Incorrect

Once it is recognized that the subject SPAs are not formal statutory interpretations entitled to Chevron deference, it is obvious that they were properly

[17] See Commodity Future Trading Comm'n. v. Schor, 478 U.S. 833, 845 (1986) ("it goes without saying that a proposed regulation does not represent an agency's considered interpretation of a statute and that an agency is entitled to consider alternative interpretations before settling on the view it considers not sound."). See also Sweet v. Sheahan, 235 F.3d 80, 87 (2d Cir. 2000) ("proposed regulations … have no legal effect"); Wuillamey v. Werblin, 364 F.Supp. 237, 243 (D.N.J. 1973) (same).

enjoined by the district court as noncompliant with the law of the Circuit. The State's reliance on post-hoc monitoring of patient access to services as the central mechanism for ensuring the adequacy of "payments" was, moreover, not just facially inconsistent with the Act and this Circuit's precedent, but is particularly egregious as applied to hospitals.

First, the "metrics" California relied on to predict "access" include no hard comparison of the rates to provider costs, Medicare rates, or market rates, as would be required under the Proposed Rules. Nor was the "quality" of care considered. Yet, as this Court recognized in Orthopedic Hosp, 103 F.3d at 1496, Section (30)(A) refers repeatedly to *payment* (i.e., "payment for, care and services" and "payments . . . consistent with efficiency, economy, and quality of care and . . . sufficient to enlist enough providers"). And where Congress has directly addressed "access" issues under Medicaid, it has done so by prescribing payment floors.[18]

Second, the central focus on whether Medicaid patients are "being seen" by providers to measure the adequacy of "payments" under Section (30)(A) is completely irrational as applied to hospitals. In the Proposed Rules, CMS focused on patient "utilization" of services to the virtual exclusion of the adequacy of payments based on the report of the Medicaid and CHIP Payment and Access

[18] To address shortages of primary care services, Congress mandated Medicaid payment rates in 2013 and 2014 at levels not lower than those paid under Medicare. ACA, as amended by the Health Care Education Reconciliation Act, P.L. 111-152, § 1202. Similarly, in the Omnibus Budget Reconciliation Act of 1989, P.L. 101-239, Congress mandated payment for obstetrical and pediatric services based on 90 percent of the amounts paid by private insurers as the means of assuring access under Medicaid to those services.

Commission.[19] But MACPAC cautioned that this approach is viable only for assuring access to physician services[20] while simultaneously underscoring that "inadequate payment was the most common reason for providers not to accept Medicaid patients." Id. at 132. Moreover, hospitals are required by federal law[21] to screen everyone who presents at an emergency department and provide treatment to stabilize emergency medical conditions, including inpatient care, if necessary, regardless of the patient's source of coverage or ability to pay. See Orthopedic Hosp., 103 F.3d at 1498. In states represented by the Amici, over 50% to as many as 90% of hospital admissions tend to originate in the emergency department. Since hospitals cannot "opt out of providing emergency care for Medicaid patients," utilization-based metrics are virtually meaningless for determining if "payments for [hospital] care and services" are minimally adequate to sustain the provision of "quality of care," since Medicaid patients will continue to receive treatment until hospitals "close their emergency departments." Id.

IV. CONCLUSION

For the reasons stated, the Court should grant rehearing en banc.

Respectfully Submitted,

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[19] 76 Fed. Reg. 26342, 26343-26344.
[20] MACPAC March 2011 Report, p. 127(http://www.macpac.gov/reports).
[21] See 42 U.S.C. § 1395dd.

CERTIFICATE OF COMPLIANCE WITH TYPE-VOLUME LIMITATION

This brief complies with the type-volume limitation of Fed. R. App. P. 29-2(c)(2) because it contains 4,191 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii), and totals 15 pages.

Date: February 7, 2013

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CERTIFICATE OF COMPLIANCE WITH
FEDERAL RULE OF APPELLATE PROCEDURE 29(a)

In compliance with Fed. R. App. P. 29(a), this brief has been filed with the written consent of all parties involved.

Date: February 7, 2013

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CERTIFICATE OF SERVICE

I certify that a copy of the foregoing brief was filed with the Court via the CM/ECF system and further certify that a copy was served on all parties or their counsel of record through the CM/ECF system.

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