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

AMICI BRIEF OF NATIONAL HEALTH LAW PROGRAM, AARP, NATIONAL SENIOR CITIZENS LAW CENTER, PUBLIC INTEREST LAW PROJECT, ASIAN LAW ALLIANCE, CALIFORNIA ADVOCATES FOR NURSING HOME REFORM, WESTERN CENTER ON LAW AND POVERTY, ARIZONA CENTER FOR LAW IN THE PUBLIC INTEREST, DISABILITY RIGHTS LEGAL CENTER, ARIZONA CENTER FOR DISABILITY LAW, NEVADA DISABILITY ADVOCACY & LAW CENTER, DISABILITY LAW CENTER OF ALASKA, DISABILITY RIGHTS IDAHO, HAWAII DISABILITY RIGHTS CENTER, AND DISABILITY RIGHTS CALIFORNIA IN SUPPORT OF THE PENDING PETITIONS FOR REHEARING AND REHEARING *EN BANC*

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STATEMENT IN COMPLIANCE WITH RULE 29(c)(5)

No party or its counsel authored this brief, in whole or in part, or contributed money that was intended to fund preparing or submitting the brief. No person, other than the *Amici Curiae*, their members or their counsel, contributed money that was intended to fund preparing or submitting the brief.

STATEMENT OF INTEREST OF AMICI CURIAE [1]

The National Health Law Program ("NHeLP") advances the health rights of low-income and underserved individuals. For more than forty years, NHeLP has represented thousands of families, children, and people with disabilities in court when state Medicaid programs are not acting in a manner consistent with the Medicaid Act, and it has extensive experience litigating issues relating to inadequate Medi-Cal dental reimbursement and access.

AARP is a non-partisan, non-profit organization dedicated to addressing the needs and interests of people age fifty and older. Through education, advocacy and service, AARP seeks to enhance the quality of life for all by promoting independence, dignity, and purpose. As the country's largest membership organization, AARP advocates for access to affordable healthcare and for controlling costs without compromising quality.

The National Senior Citizens Law Center is a non-profit organization that works to protect Medicaid services for the millions of low-income older adults and persons with disabilities who depend on them. It has repeatedly fought state efforts to cut off or reduce Medicaid benefits since its founding in 1972.

The Public Interest Law Project has worked to provide access to services and public benefits for lower income persons and persons with disabilities

[1] Pursuant to 9th Cir. R. 29-2(a), this brief is submitted with the consent of all parties.

throughout California since 1996. It has litigated over 200 high impact cases and is a recognized expert in the field of public benefits.

The Asian Law Alliance is a non-profit legal organization founded in 1977 with the mission of providing equal access to the justice system to the Asian and Pacific Islander communities in Santa Clara County, California. It has provided community education and legal services on health care including Medi-Cal and the Affordable Care Act.

California Advocates for Nursing Home Reform has been dedicated to improving the care and quality of life for California's long term care consumers since 1983. Through direct advocacy, community education, legislation, and litigation, it educates and supports long term care consumers and advocates regarding the rights and remedies under the law.

The Western Center on Law & Poverty has worked to secure housing, healthcare, and a strong safety net for low-income Californians since 1967. It works to improve and expand health coverage, simplify eligibility and enrollment in Medi-Cal and indigent health care programs, and fights budget cuts to these critical programs.

The Arizona Center for Law in the Public Interest is a non-profit law firm that has been dedicated to representing the people of Arizona on healthcare and

other issues since 1974. It litigates and advocates before administrative agencies, legislative bodies, and the courts.

The Disability Rights Legal Center, a California based public interest law firm, engages in class action litigation on behalf of Medicaid recipients with disabilities.

Arizona Center for Disability Law, Nevada Disability Advocacy & Law Center, Disability Law Center of Alaska, DisAbility Rights Idaho, Hawaii Disability Rights Center, and Disability Rights California are public interest law firms known as "Protection and Advocacy" agencies. They are designated by federal statute to provide legal assistance to individuals with disabilities within their respective states. They also file class actions on behalf of Medicaid recipients.

Collectively, *amici* support Medicaid as a means for improving access to health care for those without private insurance and believe that Medicaid funding must be sufficient to enable beneficiaries to secure access to an adequate number and variety of providers. *Amici* are gravely concerned that the Panel's decision will directly compromise access to quality care for millions of current and future Medi-Cal beneficiaries, and—if allowed to stand— places at risk the health and well-being of Medicaid beneficiaries throughout the Ninth Circuit.

The reason for *amici*'s concern is simple: Medicaid beneficiaries' access to providers depends on whether payment rates exceed provider costs. If a provider's costs exceed the Medicaid reimbursement rate, the provider will simply opt out of accepting Medicaid patients. In *Orthopaedic Hospital v. Belshe*, 103 F.3d 1491 (9th Cir. 1997), this Court held that States cannot lawfully set rates without considering providers' costs. Yet, that is exactly what California did here—and the Panel approved it only by sweeping away 16 years of contrary Ninth Circuit precedent. The Panel divined an "implicit" interpretation in an approval of a State Plan Amendment ("SPA") that contained no such interpretation, and then played a *Chevron* trump card that contravenes this Court's *en banc* decision last year in *Price v. Stevedoring Services of America, Inc.*, 697 F.3d 820 (9th Cir. 2012).

The Panel's decision merits *en banc* review—and reversal. As the petitions for rehearing and rehearing *en banc* detail, it creates an intra-circuit conflict as to the role of costs in setting Medicaid rates and upends settled principles that apply to all administrative review cases. This case also, as detailed below, involves a "question of exceptional importance." Fed. R. App. P. 35(a).

ARGUMENT

I. MORE THAN 7.5 MILLION MEDI-CAL BENEFICIARIES DEPEND ON MEDICAID RATES EXCEEDING PROVIDER COSTS TO ENSURE THE STATUTORY MANDATE OF ACCESS TO MEDICAL SERVICES TO THE SAME EXTENT THOSE SERVICES ARE AVAILABLE TO THE GENERAL POPULATION.

The Panel reversed and vacated a preliminary injunction that prevented California from implementing a 10% across-the-board cut in Medi-Cal provider payment rates without considering how the cut would affect the quality of care and access to care that Congress mandates for Medicaid participants. That decision is wrong for at least the following reasons: (a) it conflicts with prior decisions of this Circuit because it gives *Chevron* deference to an "implicit interpretation" by the Secretary of the Department of Health and Human Services ("Secretary") that was issued through the informal approval process for Medicaid SPAs, and (b) it fails to conduct the thorough review of the administrative record that this Court's precedents require, instead simply rubberstamping the agency's position. *See generally* California Medical Association, *et al.*'s Joint Petition for Rehearing and Rehearing *En Banc*.

These issues are of exceptional importance. More than 7.5 million Californians currently depend on Medicaid for health and dental care,[2] which totals

[2] *See* State of California, California Dep't of Health Care Serv., *Medi-Cal Program Enrollment Totals for Fiscal Year 2010-11* (July 2011), *available at*

more than 20% of the state's population and includes one out of every three children in California.[3] The number of Californians who qualify for Medi-Cal is expected to grow significantly in the year ahead under the Affordable Care Act. The 10% cut in provider payment rates at issue will dramatically decrease these millions of individuals' ability to access quality health and dental care.

The Panel's (incorrect) decision thus plainly implicates the "robust public interest in safeguarding access to health care for those eligible for Medicaid," *Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly*, 572 F.3d 644, 659 (9th Cir. 2009), for both the millions of California Medicaid beneficiaries and the additional millions of Medicaid beneficiaries elsewhere in the Ninth Circuit—all of whom depend on the courts to ensure that a State hews to the obligations contained in the Medicaid Act.

Medicaid beneficiaries include low-income children and their caretakers, seniors, and people with disabilities who lack access to the private health insurance system. Most of the low-income individuals and families covered by Medicaid have jobs, but lack access to health insurance through their employers or cannot

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http://www.dhcs.ca.gov/dataandstats/statistics/Documents/2_1_Reporting_Year_FY2010-11.pdf.

[3] *See* California HealthCare Found., *California Health Care Almanac Medi-Cal Facts and Figures*, 4 (Sept. 2009), *available at* http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/M/PDF%20MediCalFactsAndFigures2009.pdf.

afford the premiums. Most also cannot obtain individual health insurance, either because they cannot afford it or because they are excluded based on health status.[4] Access to care matters, because Medicaid beneficiaries collectively are in markedly worse health than people with private insurance.[5]

The Medicaid Act requires each state to have an approved plan explaining how it will operate its Medicaid program to meet the program's requirements.[6] Any significant changes to this plan require the approval of an SPA, which is filed with one of ten Regional Offices of the Centers for Medicare & Medicaid Services ("CMS"). Among those requirements are ensuring that the State provides adequate access and quality of care for beneficiaries.[7]

To meet that objective, the Medicaid Act and its implementing regulations require that health services be available to program beneficiaries at least to the extent that those services are available to the general population living in the same geographic area. 42 U.S.C. §1396a(a)(30)(A) ("Section 30(A)"). The Medicaid Act's equal access provision, Section 30(A), states in pertinent part that a State

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4 Kaiser Family Found., *Medicaid: A Primer*, 5 (Jan. 2009), *available at* http://www.kff.org/medicaid/upload/7334-03.pdf.

5 *Id.*

6 *See* Robin Rudowitz & Andy Schneider, *Kaiser Commission on Medicaid and the Uninsured, The Nuts and Bolts of Making Medicaid Policy Changes: An Overview and a Look at the Deficit Reduction Act* (Aug. 2006), *available at* http://www.kff.org/medicaid/upload/7550.pdf.

7 *See* Kaiser Family Found., *Medicaid: A Primer*, *supra* n.4.

must "*assure that payments* are consistent with efficiency, economy, and quality of care and are sufficient to *enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area*." *Id.* (emphases added). Thus, the statute's key payment-related requirements are tied to access and quality of care.[8] Hospitals, health centers, and providers that care for low-income and high-risk populations depend heavily on adequate Medicaid reimbursement.[9]

California, like all participating states, is legally obligated to administer its Medicaid program in compliance with Section 30(A). Moreover, CMS is legally obligated to ensure that all SPAs comply with Section 30(A). Notwithstanding these obligations, in 2011, the California Legislature passed legislation that was incorporated into an SPA imposing a 10% reduction in reimbursement rates for many Medi-Cal providers, including physicians and dentists, and CMS approved the SPA. The Panel's erroneous decision vacated the District Court's order preventing this rate cut, notwithstanding the fact that if it goes into effect, "Medi-Cal providers will reduce or eliminate their services in response to the implementation of the rate reduction, suggesting that at least some beneficiaries

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[8] Evaluating access requires comparing Medicaid recipients' access with the access of privately insured individuals in the same geographic area. *Clark v. Kizer*, 758 F. Supp. 572, 576 (E.D. Cal. 1990), *aff'd in part vacated in part sub nom.*, *Clark v. Coye*, 967 F.2d 585 (9th Cir. 1992).

[9] Kaiser Family Found., *Medicaid: A Primer*, *supra* n.4, at 1.

would suffer reduced access to services." *California Med. Ass'n v. Douglas*, 848 F. Supp. 2d 1117, 1138 (C.D. Cal. 2012).

This finding should not come as a surprise: there is no question that Medicaid payment policies impact the amount, type, and quality of care that Medi-Cal beneficiaries receive.[10] Given the challenges that this population already faces in accessing care—a direct consequence of the fact that "California stands out [for] . . . its very low Medicaid payment levels," Supp. E.R. at 1942—the additional rate cut will worsen the already inadequate access to care for Medi-Cal beneficiaries compared to that of the general population. The Panel's decision thus fails to uphold the Medicaid Act's equal access provision and raises issues of exceptional importance, warranting *en banc* review.

II. THE PANEL'S DECISION WILL RESULT IN YET FURTHER REDUCED ACCESS TO HEALTH CARE FOR CALIFORNIA'S MOST VULNERABLE POPULATIONS.

Rather than analyze up-front the impact of an across-the-board reimbursement cut, California instead proposed that it would monitor for access problems later. That ostrich-like approach ignores repeated decisions from this Court recognizing that Medi-Cal rate cuts force heath care providers to limit the number of new Medi-Cal patients they accept or stop treating them entirely. *See*,

[10] *See* Deborah Bachrach, Center for Healthcare Strategies, Inc., *Medicaid Payment Reform: What Policymakers Need to Know about Federal Law* 2 (Nov. 2010), *available at* http://www.chcs.org/usr_doc/CHCS_Payment_Reform_FINAL.pdf .

e.g., *Indep. Living Ctr.*, 572 F.3d at 656-67. It also ignores the cumulative and resounding evidence that provider participation in California is already inadequate, even without the proposed cut. The Panel's decision sidesteps this issue entirely and, if not reversed, will cause irreparable harm to California's Medi-Cal beneficiaries by exacerbating their already limited access to quality health care.

A. California's Most Vulnerable Populations Currently Lack Access to Physicians and Dentists Due to Low Provider Participation in Medi-Cal.

Physician Services: Even before this proposed rate cut, California had the absolute *lowest* Medicaid spending per enrollee in the nation.[11] Medi-Cal also has one of the lowest physician reimbursement rates in the country—ranked as the forty-seventh *lowest* in the United States.[12]

Because payment rates are closely linked with the willingness of physicians to serve Medi-Cal beneficiaries,[13] and because Medi-Cal reimbursement rates are insufficient to cover the costs of treatment, few doctors in California are willing to

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[11] Henry J. Kaiser Family Found., *Medicaid Payments Per Enrollee* (2009), *available at* http://www.statehealthfacts.org/comparetable.jsp?typ=4&ind=183&sortc=5&o=a.

[12] Steven Zuckerman, *et al.*, California HealthCare Found., *Medi-Cal Physician and Dentist Fees: A Comparison to Other Medicaid Programs and Medicare* 23 (Apr. 2009), *available at* http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/M/PDF%20MediCalFeeComparison.pdf.

[13] Supp. E.R. 1891.

treat Medi-Cal patients.[14] This is particularly pronounced with respect to medical specialists. *See, e.g.*, David Skaggs, *et al.*, *Access to Orthopedic Care for Children With Medicaid Versus Private Insurance in California*, 107 Pediatrics 1405, 1406 (2001) (study concluding that "on average, the overhead cost to an orthopedic surgeon to treat a patient with Medi-Cal is more than the reimbursement"). Physician specialists, including pediatric surgeons, gynecologists and obstetricians, and dentists, all have reported that the actual cost of providing care is well above what Medi-Cal reimburses for their services.[15]

As a result, California suffers from a critically low provider-to-beneficiary ratio: there are only 46 primary care providers for every 100,000 beneficiaries in the state, well below the commonly cited minimum guideline of 60 to 80 providers per 100,000 people.[16] Simply put, the fact is that the supply of physicians

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[14] *See, e.g.*, Edward C. Wang, *et al.*, *Inequality of Access to Surgical Specialty Healthcare: Why Children With Government-Funded Insurance Have Less Access Than Those with Private Insurance in Southern California*, 114 Pediatrics e584, e584 (2004).

[15] *See id.* at 1406 (finding that cost of treatment by pediatric orthopedic surgeon exceeded Medi-Cal reimbursement); Evan Halper, *Further Fee Cuts Force a Medi-Cal Exodus: Doctors are Rejecting New Patients*, L.A. Times (Mar. 24, 2008), *available at* http://articles.latimes.com/2008/mar/24/local/me-medical24 (reporting Medi-Cal reimbursement for tonsillectomies is insufficient to cover surgical costs).

[16] California HealthCare Found., *California Health Care Almanac Medi-Cal Facts and Figures*, *supra* n.3, at 52. This guideline was established by HHS' Council on Graduate Medical Education.

available to Medi-Cal patients is significantly less than that available to the general population.[17]

Consistent with these findings, Medi-Cal beneficiaries have limited access to physicians in the office setting.[18] In fact, access to office-based physicians is already so limited that some recipients wait months for an appointment.[19] Studies in California show that low Medi-Cal participation rates among medical and surgical specialists have resulted in poor specialty care access for Medi-Cal beneficiaries.[20] One consequence of decreased access to doctors' offices is a steady increase in emergency room visits by Medi-Cal beneficiaries.[21]

Dental Services: In the same vein, reports document that Medicaid beneficiaries have difficulty accessing dental care, in part due to extremely low provider participation rates. Consequently, Medi-Cal beneficiaries have unequal

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[17] Andrew B. Bindman, *et al.*, California HealthCare Found., *Physician Participation in Medi-Cal, 2008*, 14 (July 2010), *available at* http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/P/PDF%20PhysicianParticipationMediCal2008.pdf.

[18] *See* Supp. E.R. 4773, 4776-77.

[19] *See, e.g.*, Halper, *supra* n.15. Reports have specifically "documented the inequality of access to subspecialty healthcare" for patients with Medi-Cal. *See, e.g.*, Andrew H. Hwang, *et al.*, *Access to Urological Care for Children in California: Medicaid Versus Private Insurance*, 66 Urology 170, 171 (2005) (citing Andrew B. Bindman, *et al.*, *Physician Participation in Medi-Cal, 2001*, 1-50 (May 2003)).

[20] California HealthCare Found., *California Health Care Almanac Medi-Cal Facts and Figures*, *supra* n.3, at 53.

[21] Supp. E.R. 1891.

access to dental care as compared to privately-insured individuals, contrary to the mandate of Section 30(A). A recent study concluded that only about one-quarter of general dentists in California participate in Medi-Cal.[22] Moreover, even among the limited pool of dentists who participate, many place limits on the number of Medicaid patients they will treat.[23]

Low reimbursement rates are commonly cited as a reason for low dentist participation in Medi-Cal. Indeed, this is not a new problem in California: as far back as 1990, a federal district court found that Medi-Cal's inadequately low dental reimbursement rates impeded beneficiary access to care in violation of federal law. *Clark v. Kizer*, 758 F. Supp. 572, 578 (E.D. Cal. 1990), *aff'd in part vacated in part sub nom., Clark v. Coye*, 967 F.2d 585 (9th Cir. 1992).[24] Further, a recent study of California dentists concludes that dentists' acceptance of Medi-Cal

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[22] Barbara Aved Assoc., *Without Change It's The Same Old Drill: Improving Access to Denti-Cal Services for California Children Through Dentist Participation*, 5 (Oct. 2012), *available at* http://centerforhealthreporting.org/sites/default/files/denti-cal_final_report_nov_2_2012.pdf.

[23] GAO, Report GAO-11-96, *Oral Health: Efforts Underway to Improve Children's Access to Dental Services, but Sustained Attention Needed to Address Ongoing Concerns*, 12 (Nov. 2010), *available at* http://www.gao.gov/new.items/d1196.pdf.

[24] The district court found dental reimbursement rates were "woefully inadequate," indicating that beneficiaries' access to dental care was not equal to that of the general populations'. *Clark*, 758 F. Supp. at 577. Dental rates were subsequently ordered to be set at 80% of the average charge by participating providers. *Clark v. Coye*, 8 F.3d 26, 1993 WL 394846, at *1 (9th Cir. 1993).

patients would increase if Medi-Cal rates increase, but if rates were to decrease, the opposite would be expected to occur.[25]

Cutting Medi-Cal rates by an additional 10% for purely budgetary reasons—which the Panel endorsed—will cause many more physicians and dentists to stop accepting Medi-Cal patients and exacerbate the already dangerously limited access to physicians and dentists outlined above.[26] The prospect of yet more provider withdrawal from Medi-Cal, combined with the millions of new beneficiaries joining the system in the year ahead, threatens irreparable harm to current and future Medi-Cal beneficiaries and presents an issue of exceptional importance.

B. Fewer Medi-Cal Physicians and Dentists Means that Low-Income Individuals Will Suffer From Reduced Access to Medical Care and Negative Health Outcomes.

Amici wish to highlight two grave outcomes for Medi-Cal beneficiaries that will flow from the inadequate reimbursement and resulting unequal access to physician and dental services that the Panel's decision sanctions: (1) restricted access to essential preventive care services; and (2) unacceptable wait times for care.

Restricted Access to Preventive Care Services: It is widely recognized that Medicaid beneficiaries generally have worse health status than their non-Medicaid

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[25] Barbara Aved Assoc., *supra* n.22.

[26] *See, e.g.*, Halper, *supra* n.15.

counterparts and thus a greater need for physicians than the general public.[27] As a result, reducing this population's access to care will lead to dire consequences.[28] These individuals, particularly older and disabled patients, are more likely to die from conditions that could be prevented or cured with adequate health coverage.[29] In fact, lack of access to preventive care across the population as a whole is the third leading cause of death for adults age 55-64 (behind only heart disease and cancer)[30] and the sixth leading cause of death among adults ages 25 to 64 (ahead of HIV/AIDS and diabetes).[31]

Moreover, a recent Institute of Medicine ("IOM") report highlights the connection between lack of access to dental care and health disparities: for

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[27] Supp. E.R. 1886.

[28] Jack Hadley, Kaiser Comm'n on Medicaid and the Uninsured, *Sicker and Poorer: the Consequences of Being Uninsured*, 45-46 (May 2002), *available at* http://www.kff.org/uninsured/upload/Full-Report.pdf.

[29] *Id.* at 16-34; Jack Hadley & John Holahan, Kaiser Comm'n on Medicaid and the Uninsured, *The Cost of Not Covering the Uninsured*, 3-5 (June 2003), *available at* http://www.kff.org/uninsured/upload/Cost-of-Not-Covering-the-Uninsured-Project-Highlights.pdf.

[30] Stan Dorn, Urban Institute, *Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality*, 4 (Jan. 2008), *available at* http://www.urban.org/UploadedPDF/411588_uninsured_dying.pdf.

[31] Karen Davis, The Commonwealth Fund, *Time for Change: the Hidden Cost of a Fragmented Health Insurance System*, 2 (Mar. 10, 2003), *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Testimony/2003/Mar/Time%20for%20Change%20%20The%20Hidden%20Cost%20of%20a%20Fragmented%20Health%20Insurance%20System/davis_senatecommitteetestimony_622%20pdf.pdf.

example, tooth decay—a largely preventable chronic disease—disproportionately impacts vulnerable and underserved populations such as children and low-income individuals.[32] The IOM makes clear that "oral health is inextricably linked to overall health,"[33] and explains that there are "far reaching" health consequences that result from poor access to dental care, documenting the clear link between oral health and respiratory disease, cardiovascular disease, and diabetes.[34]

Wait Times: Delayed access to health care also causes severe negative health outcomes. Studies have shown that patients of facilities with average wait times of 31 days or more had significantly higher odds of mortality than patients who attended medical facilities with wait times under 31 days.[35] Moreover, delayed access to care may result in permanent harm or prolonged pain that could have been prevented with more prompt care, especially for children.

As California researchers have discovered, there are vast differences between the medical care available to children on Medi-Cal and the care available

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[32] Institute of Medicine, *Improving Access to Oral Health Care for Vulnerable and Underserved Populations*, 1, 19, 47 (2011), *available at* http://www.iom.edu/Reports/2011/Improving-Access-to-Oral-Health-Care-for-Vulnerable-and-Underserved-Populations.aspx.

[33] *Id.* at 41.

[34] *Id.* at 19.

[35] Julia C. Prentice & Steven D. Pizer, *Delayed Access to Health Care and Mortality*, 42.2 Health Serv. Res. 644-662 (Apr. 2007).

to similarly-situated children with private insurance.[36] These researchers found that, when contacted about a hypothetical child with a broken arm, only 2% of randomly selected orthopedic surgeons would schedule an appointment within a week for a child on Medi-Cal, whereas 100% would do so for a child on private insurance.[37] Of the orthopedic offices that would not see the Medi-Cal child, 87% could not even recommend another orthopedic office that would accept Medi-Cal.[38]

Inadequate reimbursement rates discourage providers from participating in Medi-Cal and result in worse access to care and longer wait times for Medi-Cal beneficiaries than the general public, contrary to the mandate of Section (30)(A).[39] Ultimately, the Panel's decision will diminish already inadequate access to health care for vulnerable individuals who depend on Medicaid in California and elsewhere in the Ninth Circuit, given the Panel's view of its almost non-existent role in reviewing SPA approvals for compliance with federal law.

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36 *See* Skaggs, *supra* p. 11, at 1405.

37 *Id.*

38 *Id.*

39 *See* Zuckerman, *et al*., California HealthCare Found., *Medi-Cal Physician and Dentist Fees*, *supra* n.12, at 2.

III. THE PANEL'S DECISION CONFLICTS WITH NINTH CIRCUIT LAW GOVERNING APA REVIEW AND *CHEVRON* DEFERENCE.

The Panel's decision upends the longstanding principle that review of an administrative record is to be "thorough, probing, and in-depth," *Stop H-3 Ass'n v. Dole*, 740 F.2d 1442, 1449 (9th Cir. 1984), and it contradicts the *en banc* Court's recent ruling that an agency does not get a free pass to *Chevron* deference simply by asserting that statutory interpretation is at issue, *Price*, 697 F.3d at 827. By insisting that APA review should be cursory and that courts can discover—and defer to—"implicit" statutory interpretations, the Panel's ruling is at odds with established Ninth Circuit and Supreme Court precedent.

If not reversed, the Panel's re-writing of APA review standards could foreclose searching judicial review of *any* programmatic changes in any of the Ninth Circuit's state Medicaid programs. It will not only directly affect Medi-Cal beneficiaries who will lose access to care because of this particular rate cut, but also involves the sort of broad repercussions that merit *en banc* consideration.

Similarly, the Panel's willingness to grant *Chevron* deference to a statutory interpretation never mentioned in the administrative record flouts the obligation agencies have to articulate their position, and the reasons for it, at the agency stage. As *Price* explained, "deferring to agencies' litigating positions interpreting statutes they are charged with administering would create a danger that agencies would

avoid promulgating regulations altogether."[40] 697 F.3d at 830 (reversing prior precedent regarding *Chevron* deference that was irreconcilable with *United States v. Mead Corp.*, 533 U.S. 218 (2001)); *Mead*, 533 U.S. at 226-27 (agency's statutory interpretation qualifies for *Chevron* deference only "when it appears that Congress delegated authority to the agency generally to make rules carrying the force of law, and that the agency interpretation claiming deference was promulgated in the exercise of that authority").

This bears emphasizing: an implicit interpretation hidden in one of the hundreds of SPA approvals issued annually by CMS's ten Regional Offices is not the type of agency decision entitled to *Chevron* deference. Like the agency action not entitled to *Chevron* deference in *Mead*, SPA approvals bind only the parties to the ruling, do not involve notice-and-comment rulemaking, and issue in large numbers annually from various agency offices. 533 U.S. at 231-34.

In protecting their rights, *amici* depend on the fact that APA review is thorough and probing and that agencies do not get *Chevron* deference on all matters of statutory interpretation. *En banc* review of these issues is warranted.

CONCLUSION

For the foregoing reasons, *amici* respectfully request that this Court grant further review.

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[40] Indeed, after initiating a rulemaking in 2011 as to Section 30(A), CMS has never finalized it. *See* 76 Fed. Reg. 26342-01 (May 6, 2011).

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CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 32(a)(7)(C), I hereby certify that this brief was produced in Times New Roman 14 point typeface using Microsoft Word and contains 4,141 words.

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CERTIFICATE OF SERVICE

I hereby certify that I filed the foregoing with the Clerk for the Court of the United States Court of Appeals for the Ninth Circuit by using the Appellate CM/ECF system on February 7, 2013. Participants in this case are registered CM/ECF users, and service will be accomplished through that system.

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