

APPENDIX

**APPENDIX
TABLE OF CONTENTS**

	Page
APPENDIX A: Opinion of the United States Court of Appeals for the District of Columbia Circuit, dated April 4, 2025	1a
APPENDIX B: Memorandum Opinion of the United States District Court for the District of Columbia, dated February 14, 2023.....	31a
APPENDIX C: Order of the United States District Court for the District of Columbia, dated February 14, 2023.....	55a
APPENDIX D: Order of the United States Court of Appeals for the District of Columbia Circuit denying rehearing of May 19, 2025 petition for panel rehearing, dated July 17, 2025	57a
APPENDIX E: Order of the United States Court of Appeals for the District of Columbia Circuit denying petition for rehearing en banc, dated July 17, 2025	59a
APPENDIX F: Relevant Statutes and Regulations:	
42 U.S.C. § 1396a(a)(16)	61a
42 U.S.C. § 1396b(a)(1)	61a
42 U.S.C. § 1396b(w)(4)(B)	62a
42 U.S.C. § 1396bb(1)(B)(iv)	62a
42 U.S.C. § 1396d(a).....	63a
Cal. Welf. & Inst. Code § 14169.50	64a
Cal. Welf. & Inst. Code § 14169.54(a)	65a

Cal. Welf. & Inst. Code § 14169.55(a)	66a
42 C.F.R. § 431.52.....	66a
42 C.F.R. § 436.403(a).....	67a
42 C.F.R. § 447.272(b)(1).....	68a
42 C.F.R. § 447.321(b)(1).....	68a

1a

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 23-5055

ASANTE, ET AL.,

Appellants,

v.

ROBERT F. KENNEDY, JR.,
IN HIS OFFICIAL CAPACITY, SECRETARY, DEPARTMENT
OF HEALTH AND HUMAN SERVICES, ET AL.,
Appellees.

Argued February 9, 2024
Decided April 4, 2025

Appeal from the United States District Court
for the District of Columbia
(No. 1:20-cv-00601)

* * *

Before: SRINIVASAN, *Chief Judge*, KATSAS and
CHILDS, *Circuit Judges*.

Opinion of the Court filed by *Chief Judge*
SRINIVASAN.

Dissenting opinion filed by *Circuit Judge* KATSAS.

SRINIVASAN, *Chief Judge*: California collects a fee
from in-state hospitals and then uses a portion of the
revenues, along with matching federal Medicaid funds,
to provide subsidies to California hospitals that serve

the State’s Medicaid beneficiaries. A group of out-of-state hospitals located near the California border filed this suit seeking access to the subsidy payments. While those out-of-state hospitals sometimes serve California Medicaid beneficiaries who come across the border, they do not pay the fee assessed against in-state hospitals to generate revenues for the subsidy program.

The out-of-state hospitals argue that their exclusion from the subsidy payments discriminates against out-of-state entities in violation of the dormant Commerce Clause and the Equal Protection Clause. They also contend that federal Medicaid regulations require paying them the subsidy. The district court rejected those arguments. We affirm.

I.

A.

Medicaid is a cooperative federal-state program that funds medical care for low-income persons. *See* 42 U.S.C. § 1396 *et seq.* State participation in Medicaid is voluntary, but a State that opts to participate must comply with conditions imposed by federal law if it wishes to maintain access to federal Medicaid funding. *NB ex rel. Peacock v. District of Columbia*, 794 F.3d 31, 35 (D.C. Cir. 2015); *Gallardo ex rel. Vassallo v. Marsteller*, 596 U.S. 420, 424 (2022).

To participate in Medicaid, a State must establish a State Medicaid plan that adheres to the Medicaid Act and Department of Health and Human Services (HHS) regulations. *Dep’t of Med. Assistance Servs. v. U.S. Dep’t of Health & Hum. Servs.*, 967 F.3d 853, 854–55 (D.C. Cir. 2020). The Centers for Medicare and Medicaid Services (CMS), an agency within HHS, administers the Medicaid program and approves a State’s Medicaid plan. *Id.*; 42 C.F.R. § 430.12(c); *see* 42 U.S.C. § 1396a(a)–(b).

When a State amends its Medicaid plan, it must obtain CMS's approval that the plan still complies with federal law. 42 C.F.R. § 430.12(c).

Federal Medicaid funding is available to States for expenditures related to the provision of a covered Medicaid service to a Medicaid beneficiary. 42 U.S.C. § 1396b; *see* 42 C.F.R. §§ 435.1002, 435.1007, 435.1009. There are two types of State Medicaid expenditures that bear on this case: (i) base payments, which CMS has defined as payments made to providers “on a per-claim basis for services rendered to a Medicaid beneficiary,” and (ii) supplemental payments, which are payments to providers separate from (and in addition to) the “per-claim” base payments for services rendered to a beneficiary. *See* Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting, 89 Fed. Reg. 40,876, 40,925 (June 21, 2024) (citing 42 U.S.C. § 1396b(bb)); 42 C.F.R. § 438.6(a).

States are not required to fund their share of Medicaid expenditures entirely on their own. Instead, a State may tax providers to generate funds that the federal government will then match. For a tax on providers to be permissible under Medicaid, it must meet certain federal conditions. *See Dana-Farber Cancer Inst. v. Hargan*, 878 F.3d 336, 339 (D.C. Cir. 2017).

B.

California participates in Medicaid through its Medi-Cal program. Cal. Welf. & Inst. Code § 14000 *et seq.* In 2009, California established the Quality Assurance Fee (QAF) as part of its administration of Medi-Cal. The QAF program operates by: (i) assessing a provider tax,

which California calls a quality assurance fee, on nonexempt in-state hospitals; (ii) using those funds to generate matching federal Medicaid funding; and (iii) distributing the collected funds as supplemental payments to qualifying private in-state hospitals. *Id.* §§ 14169.50, 14169.52, 14169.54, 14169.55.

Private acute care hospitals in California generally are required to pay the provider tax and are eligible to receive the QAF supplemental payments. *Id.* §§ 14169.52(a), 14169.54, 14169.55. Certain private hospitals, such as small and rural hospitals, are exempted from having to pay the provider tax but can still receive the QAF supplemental payments. *Id.* §§ 14169.51(l), 14169.52(a), 14169.54, 14169.55.

California does not require any out-of-state hospitals to pay the QAF provider tax. But out-of-state hospitals also do not receive QAF supplemental payments. California law permits the State, “[t]o the extent permitted by federal law and other federal requirements,” to allow out-of-state hospitals to opt into the QAF program. *Id.* § 14169.83. The current Medi-Cal plan, as approved by CMS, however, does not include that option, and so out-of-state hospitals presently cannot opt into the QAF program.

California assesses the QAF provider tax and disburses QAF supplemental payments under a formula that directs more money to hospitals that serve a higher number of Medi-Cal beneficiaries. California calculates each hospital’s provider tax based on the facility’s total days of patient care. The QAF supplemental payments to a hospital, meanwhile, are based on total *Medi-Cal* days, i.e., days serving Medi-Cal beneficiaries. That means a nonexempt hospital serving a sizable number of patients, but a relatively small number of Medi-Cal

beneficiaries, can lose money in the QAF program by paying a large tax but receiving little in the way of QAF supplemental payments. The reverse is also true: a hospital serving a high proportion of Medi-Cal beneficiaries relative to its total patient population is likely to realize a net gain.

The QAF supplemental payments, as their name indicates, are supplemental payments. Unlike base payments, the QAF supplemental payments do not reimburse providers for the costs of providing specific services to specific beneficiaries. Instead, the QAF supplemental payments are in the nature of a periodic bonus for generally providing care to Medicaid beneficiaries, and they are designed to be distinct from base payments. *Id.* §§ 14169.54(a), 14169.55(a). Every two years, California submits for CMS approval its plan specifying how it will distribute QAF supplemental payments.

C.

Following the creation of the QAF program, a group of out-of-state hospitals located near the California border challenged the program in federal court in California. The hospitals claimed an entitlement to receive the QAF supplemental payments, which, as explained, go solely to in-state hospitals. California entered into settlement agreements under which it gave QAF supplemental payments to those out-of-state hospitals. The settlement agreements expired in 2019.

In 2020, CMS approved the QAF program for the next two-year cycle. A group of out-of-state hospitals located near the California border sought judicial review of CMS's approval in the district court for the District of Columbia. The out-of-state hospitals argued that their exclusion from the QAF supplemental payments

violates the Commerce Clause, the Equal Protection Clause, and federal Medicaid regulations. The district court granted summary judgment in favor of CMS. *Asante v. Azar*, 656 F. Supp. 3d 185, 190 (D.D.C. 2023). The hospitals now appeal.

II.

The plaintiff out-of-state hospitals renew their arguments that their exclusion from the QAF supplemental payments violates the Commerce Clause, the Equal Protection Clause, and federal Medicaid regulations. We review the district court's decision de novo, *Dana-Farber*, 878 F.3d at 340, and we agree with the district court's rejection of the hospitals' claims.

A.

We first consider the out-of-state hospitals' challenge under the Commerce Clause. The Commerce Clause provides that "Congress shall have Power ... [t]o regulate Commerce ... among the several States." U.S. Const. art. I, § 8, cl. 3. Although the Clause grants Congress affirmative power to regulate interstate commerce, the Clause also contains a "negative" aspect known as the dormant Commerce Clause. *Or. Waste Sys., Inc. v. Dep't of Env't Quality of State of Or.*, 511 U.S. 93, 98 (1994). The dormant Commerce Clause "denies the States the power unjustifiably to discriminate against or burden the interstate flow of articles of commerce." *Id.*

The Supreme Court has laid out two "primary principles" limiting a State's authority under the dormant Commerce Clause: (1) "state regulations may not discriminate against interstate commerce," and (2) "States may not impose undue burdens on interstate commerce." *South Dakota v. Wayfair, Inc.*, 585 U.S. 162,

173 (2018). The challenge in this case involves only the former limit—the bar on discriminating against interstate commerce. As used in the dormant Commerce Clause context, “‘discrimination’ simply means differential treatment of in-state and out-of-state economic interests that benefits the former and burdens the latter.” *United Haulers Ass’n v. Oneida-Herkimer Solid Waste Mgmt. Auth.*, 550 U.S. 330, 338 (2007) (quoting *Or. Waste*, 511 U.S. at 99). State laws that facially discriminate against interstate commerce are virtually *per se* invalid. *Wayfair*, 585 U.S. at 173 (citing *Granholm v. Heald*, 544 U.S. 460, 476 (2005)).

The plaintiff out-of-state hospitals argue that the QAF program discriminates against interstate commerce because California pays QAF supplemental payments only to in-state hospitals. That argument fails. Both the QAF provider tax assessed against in-state hospitals and the QAF supplemental payments given to in-state hospitals are calculated based solely on the in-state provision of medical care to in-state patients. A tax and supplemental payment based on the *in-state* provision of medical care do not unconstitutionally discriminate against *interstate* commerce. The QAF program does not assess a tax against out-of-state hospitals. There is thus no “obvious effort to saddle those outside the State” with the costs of the QAF program, *see Chem. Waste Mgmt., Inc. v. Hunt*, 504 U.S. 334, 346 (1992) (quoting *City of Philadelphia v. New Jersey*, 437 U.S. 617, 629 (1978)); the hospitals incur no costs associated with the QAF program because they are not subject to the QAF provider tax.

It is true that the out-of-state hospitals incur costs to treat Medi-Cal beneficiaries who come across the border to receive medical care. But those costs come from the treatment itself, not from the QAF program.

And Medi-Cal reimburses providers' costs of treating Medi-Cal beneficiaries (including costs incurred by out-of-state hospitals) through the base payments to providers. As for the QAF program, out-of-state hospitals neither incur the costs (the provider tax) nor receive the benefits (the supplemental payments). That program does not discriminate against interstate commerce—there is simply no “differential burden on any part of the stream of commerce” here. *See W. Lynn Creamery, Inc. v. Healy*, 512 U.S. 186, 202 (1994).

B.

The plaintiff out-of-state hospitals' argument under the Equal Protection Clause likewise lacks merit. The Equal Protection Clause mandates that no State shall “deny to any person within its jurisdiction the equal protection of the laws.” U.S. Const. amend. XIV, § 1. Because the challenged program here “neither proceeds along suspect lines nor infringes fundamental constitutional rights,” we apply rational basis review, as the plaintiffs concede. *See FCC v. Beach Commc'ns, Inc.*, 508 U.S. 307, 313 (1993). And under rational basis review, “legislation is presumed to be valid and will be sustained if the classification drawn by the statute is rationally related to a legitimate state interest.” *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 440 (1985). A challenged state law must be upheld under that standard “if there is any reasonably conceivable state of facts that could provide a rational basis” for it. *Beach Commc'ns*, 508 U.S. at 313.

The plaintiff hospitals argue that the QAF program discriminates against out-of-state hospitals without a rational basis. We are unpersuaded. The plaintiff hospitals do not satisfy their burden to show that

limiting QAF supplemental payments to in-state hospitals is irrational.

California could rationally decide to extend QAF supplemental payments only to in-state hospitals as a means of targeting the subsidy to those providers who serve a disproportionate share of Medi-Cal beneficiaries. Equal protection “does not require that a State must choose between attacking every aspect of a problem or not attacking the problem at all.” *Dandridge v. Williams*, 397 U.S. 471, 486–87 (1970). California addressed the problem of ensuring access to Medicaid by focusing chiefly on one aspect: directing the supplemental payments to those private hospitals that provide the lion’s share of services furnished to Medi-Cal beneficiaries. It was not irrational for the State to structure the QAF program on the assumption that the bulk of services to Medi-Cal beneficiaries would be supplied by California hospitals, and correspondingly to give the extra payments to—and collect funding for those payments from—in-state providers alone. Medi-Cal beneficiaries are California residents, and it stands to reason that California facilities would largely provide their medical care.

The plaintiff out-of-state hospitals contend that the State’s rationale is underinclusive because they, too, are private hospitals who provide care to Medi-Cal patients. And they assert that the State’s rationale is also overinclusive because the QAF program gives payments to California private hospitals that serve relatively few Medi-Cal beneficiaries. A law, however, generally “does not fail rational-basis review for being over- or under-inclusive.” *Fraternal Ord. of Police, Metro. Police Dep’t Lab. Comm., D.C. Police Union v. District of Columbia*, 45 F.4th 954, 958 (D.C. Cir. 2022) (citation omitted), *cert. denied*, 143 S. Ct. 577 (2023). Rather, “where rationality

is the test, a State ‘does not violate the Equal Protection Clause merely because the classifications made by its laws are imperfect.’” *Mass. Bd. of Ret. v. Murgia*, 427 U.S. 307, 316 (1976) (quoting *Dandridge*, 397 U.S. at 485). So the question is not whether California could have made the fit more perfect, but whether it was rational for California to draw the distinction it did. *See W. & S. Life Ins. Co. v. State Bd. of Equalization of Ca.*, 451 U.S. 648, 670–72 (1981). We believe it was.

The hospitals also submit that the proffered state interest in targeting private hospitals serving a disproportionate share of Medi-Cal patients should be given minimal weight because it was not set forth in the statute’s purpose section. It instead was advanced only in post-enactment communications between CMS and California agencies. When we assess a law under rational basis review, however, “the legislature’s actual motive is ‘entirely irrelevant’; all that matters is whether there are ‘plausible reasons’ to conclude that the statutory classification furthers a legitimate government interest.” *Fraternal Ord.*, 45 F.4th at 958–59 (quoting *Beach Commc’ns*, 508 U.S. at 313–15). California could rationally conclude that private in-state hospitals serving a disproportionate share of Medi-Cal beneficiaries should be given supplemental monetary support, and the State could rationally decide to advance that goal via the QAF program as it is structured.

C.

The plaintiff hospitals’ last argument is that California’s QAF program violates an HHS regulation, 42 C.F.R. § 431.52. Section 431.52 reads as follows:

- (a) Statutory basis. Section 1902(a)(16) of the Act authorizes the Secretary to prescribe State plan

requirements for furnishing Medicaid to State residents who are absent from the State.

- (b) Payment for services. A State plan must provide that the State will pay for services furnished in another State to the same extent that it would pay for services furnished within its boundaries if the services are furnished to a beneficiary who is a resident of the State, and any of the following conditions is met:
 - (1) Medical services are needed because of a medical emergency;
 - (2) Medical services are needed and the beneficiary's health would be endangered if he were required to travel to his State of residence;
 - (3) The State determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other State;
 - (4) It is general practice for beneficiaries in a particular locality to use medical resources in another State.
- (c) Cooperation among States. The plan must provide that the State will establish procedures to facilitate the furnishing of medical services to individuals who are present in the State and are eligible for Medicaid under another State's plan.

The plaintiff hospitals focus on subsection (b). They read that subsection to impose a payment-parity requirement, under which, they submit, a State must give the same amount of Medicaid payments to a provider for services to the State's residents in any of

the specified categories regardless of whether the provider is located within or outside the State. And that payment-parity requirement, in the plaintiff hospitals' view, applies to California's QAF supplemental payments.

We disagree. We conclude that the regulation does not pertain to payments to providers like California's QAF supplemental payments. We instead read the regulation as addressed to a different type of payment under Medicaid: base payments given in the State's capacity as a Medicaid beneficiary's health-care insurer—i.e., insurance payments for a specific service rendered to a specific beneficiary.

That reading best comports with the terms of the regulation. The plaintiff hospitals rely on subsection (b)'s requirement that a State must “pay for services furnished in another State to the same extent” as if the services were rendered “within its boundaries.” 42 C.F.R. § 431.52(b). That language in subsection (b) must be read against the backdrop of subsection (a), which provides the statutory basis for the regulation and sets out its scope.

To that end, subsection (a) explains that the regulation pertains to “State plan requirements for furnishing Medicaid to State residents who are absent from the State.” 42 C.F.R. § 431.52(a). There are various types of State expenditures under the Medicaid program. Of central relevance for purposes of that regulation, Medicaid in part involves the State acting as insurer for beneficiaries. *See id.* § 435.900–.965 (describing State requirements for administering Medicaid to applicants and beneficiaries); Medicaid Program; Ensuring Access to Medicaid Services, 89 Fed. Reg. 40,542, 40,542–43 (May 10, 2024). But Medicaid also

encompasses other actions a State takes with respect to covered services provided to Medicaid beneficiaries—actions for which the State can also receive federal Medicaid funding even if not acting as a beneficiary’s insurer. For example, States must provide supplemental payments to hospitals that serve a disproportionate share of low-income patients with special needs, *see* 42 U.S.C. § 1396r-4(c), or a State might set up a pool for supplemental payments for in-state trauma care centers, *see* Medicaid Program; Ensuring Access to Medicaid Services, 89 Fed. Reg. at 40,774-75. When a State does so, it is not furnishing insurance to a beneficiary, but instead is providing extra funding to providers to effectuate broader policy ends related to the provision of medical services to needy persons.

Subsection (a) speaks in terms of “furnishing Medicaid to State residents who are absent from the State.” 42 C.F.R. § 431.52(a). So the regulation does not encompass *all* expenditures by the State in the Medicaid context, but specifically applies when the State is “furnishing Medicaid to State residents.” *Id.* (emphasis added). That language conveys that the regulation applies when the State provides Medicaid insurance to a beneficiary. When the State acts as an insurer under Medicaid, the beneficiary receives care from a provider, and rather than the beneficiary paying for the service, the State pays for it through Medicaid base payments to the provider. Medicaid Program; Medicaid Managed Care: New Provisions, 67 Fed. Reg. 40,989, 40,989 (June 14, 2002). The State thereby effectively reimburses the beneficiary for the costs of her medical care, although rather than give the beneficiary an insurance payment that would enable the beneficiary in turn to pay the provider for the service, the State just pays the provider directly via base payments. *See Wis. Dep’t of Health &*

Fam. Servs. v. Blumer, 534 U.S. 473, 479 (2002) (“The federal Medicaid program provides funding to States that reimburse needy persons for the cost of medical care.”). Accordingly, when the State effectively reimburses a beneficiary for the costs of services she receives outside the State, the State is “furnishing Medicaid to State residents who are absent from the State”: the State-as-insurer is paying the costs of that beneficiary’s out-of-state medical care. 42 C.F.R. § 431.52(a).

The QAF supplemental payments, by contrast, do not fit comfortably within that language. Unlike with base payments, when the State gives QAF supplemental payments to a provider, it is not “furnishing Medicaid to State residents.” *Id.* (emphasis added). Unlike with base payments, that is, the QAF supplemental payments do not amount to insurance payments to Medi-Cal beneficiaries for the costs of medical services they receive. As the plaintiff hospitals themselves have characterized QAF payments, “QAF monies are NOT payments for services rendered.” J.A. 508. Instead, through QAF supplemental payments, the State gives a set of providers extra (i.e., supplemental) money to generally increase funds flowing to them in recognition of their serving Medi-Cal beneficiaries. Unlike when the State acts as insurer for a Medicaid beneficiary who receives medical care outside the State’s borders, then, QAF payments do not constitute “furnishing Medicaid to State residents who are absent from the State.” 42 C.F.R. § 431.52(a).

That understanding of the overall scope of the regulation, per the introductory subsection (a), informs the proper understanding of subsection (b), the provision centrally relied on by the plaintiff hospitals. The latter subsection, entitled “Payment for services,”

requires a “State plan [to] provide that the State will pay for services furnished in another State to the same extent that it would pay for services furnished within its boundaries if the services are furnished to a beneficiary who is a resident of the State,” and one of a series of conditions is met. 42 C.F.R. § 431.52(b). The “pay[ments] for services furnished ... to a beneficiary” addressed by subsection (b), *id.*, when considered against the backdrop of subsection (a), are base payments for specific services given to a specific beneficiary, not supplemental subsidies extended to providers. As just noted, the plaintiff hospitals themselves have stressed that “QAF monies are NOT payments for services rendered.” J.A. 508. And if QAF funds are “not payments for services rendered,” it stands to reason that they also may not be covered by a provision entitled “Payment for services,” whose operative text is addressed to “pay[ments] for services furnished.” *See also* Plaintiffs’ Compl. ¶ 63, J.A. 31 (“QAF supplemental payment” is “separate from and in addition to Medicaid payments for services rendered”).

The history of the regulation supports that understanding of its scope. Originally, the regulation stated that “[m]edical assistance will be furnished to eligible individuals who are residents of the State but are absent therefrom to the same extent” 45 C.F.R. § 248.40(a)(1) (1970). In 1978, HHS updated the language to say that the “State will furnish medicaid ... while that recipient is in another State, to the same extent that medicaid is furnished to residents in the State.” 42 C.F.R. § 431.52(b) (1978). Finally, in 1991, the current language took effect. Neither of the amendments purported to make any substantive changes to the regulation. *See* Medicare and Medicaid Programs; OBRA ’87 Conforming Amendments, 56 Fed.

Reg. 8,832, 8,832 (1991); Medicaid Regulations; Reorganization and Rewriting, 43 Fed. Reg. 45,176, 45,176 (1978). Rather, in all its iterations, the regulation has been concerned with furnishing Medicaid to a beneficiary when outside their home State. Put differently, the regulation has consistently addressed base payments made in the State's capacity as an insurer of individual beneficiaries rather than supplemental payments made in the State's capacity as a policymaker giving bulk disbursements to hospitals.

In sum, because the regulation speaks to contexts in which the State acts as an insurer for Medicaid beneficiaries covered by the State plan, and because QAF supplemental payments do not amount to insurance payments made to Medicaid beneficiaries, we reject the plaintiff hospitals' argument that California's QAF program implicates—much less violates—the regulation.

Our dissenting colleague reads the regulation differently. In his view, the regulation applies not only to base payments to beneficiaries but also to supplemental subsidies to providers like the QAF payments. But even if the payment of QAF subsidies to hospitals relates in some way to the provision of services, *see* Dissenting Op. 5, that does not mean that those supplemental subsidies amount to insurance payments to Medicaid beneficiaries, which we understand to be the focus of the regulation. Under our colleague's interpretation, the regulation would compel the State to extend QAF supplemental payments to out-of-state providers on par with in-state providers even though the out-of-state providers (unlike in-state providers) do not pay the QAF provider tax that funds the supplemental payments. There is no reason to construe the regulation to require that kind of windfall

for out-of-state providers: the plaintiff out-of-state hospitals do not deny that they already receive supplemental Medicaid subsidies from their own States, but they now seek to be awarded additional funding from another State’s (California’s) subsidy pool, into which they do not pay. The better reading of the regulation—as a provision addressed to base payments, not supplemental subsidies—avoids that counterintuitive result.

Our colleague’s contrary understanding is grounded in part in the statutory term “medical assistance,” which he reads as covering QAF payments and other subsidies bearing a relationship to the provision of medical “care and services,” per the statutory definition of “medical assistance.” Dissenting Op. 6–7 (citing 42 U.S.C. §§ 1396a(a)(16), 1396d(a)). The term “medical assistance,” however, does not appear in the regulation at issue. Our colleague seeks to connect the regulation to that statutory term in a two-step argument disagreeing with our understanding of the regulation’s scope.

First, our colleague notes that subsection (a) of the regulation—which, as explained, provides that the regulation concerns the “furnishing [of] Medicaid to State residents who are absent from the State”—indicates that the statutory authorization for the regulation is 42 U.S.C. § 1396a(a)(16). And that authorizing statute allows for regulations that require state Medicaid plans to include provisions “with respect to the furnishing of medical assistance to ... residents of the State [who] are absent therefrom.” Our colleague assumes that, if the regulation’s reference to “furnishing [of] Medicaid to State residents” is confined to base payments, then the same must be true of the authorizing

statute's reference to "furnishing of medical assistance" to State residents. *See* Dissenting Op. 6.

But that cannot be so, our colleague submits, due to the second step of his analysis. Here, he brings into play a second statute, which provides for federal reimbursements to States for Medicaid expenses, 42 U.S.C. § 1396b(a)(1). That reimbursement statute, like the just-described authorizing statute, uses the term "medical assistance"—here, in providing for federal reimbursements to States of a share of the "amount expended ... as medical assistance under the State plan." That reimbursement statute's reference to "medical assistance" must encompass QAF subsidies, our colleague observes, because it is undisputed that federal Medicaid funding to States includes QAF subsidies. And if that is so, our colleague reasons, the authorizing statute's reference to "furnishing of medical assistance" to State residents must also include QAF subsidies, and then, so too must the regulation. *See* Dissenting Op. 6–7.

In short, our colleague assumes as a first step that the regulation's scope matches the authorizing statute's scope, and he next assumes as a second step that the authorizing statute's scope matches the reimbursement statute's scope. And because the reimbursement statute undisputedly pertains to QAF subsidies, he reasons, then so too must the authorizing statute, and thus the regulation as well. We are unpersuaded by either of the two steps.

Consider, initially, the assumption at the latter step that because the reimbursement statute encompasses QAF subsidies, then the authorizing statute must as well. The federal agency charged with administering the Medicaid program disagrees with that assumption. The

government argues before us that the authorizing statute has “no bearing on subsidies that States pay to providers” like the QAF subsidies. Gov’t Br. 28. Yet the government also acknowledges that federal reimbursements to States encompass the QAF program. *Id.* at 4-5. The government might view the scope of the authorizing and reimbursement statutes to differ because, while both statutes reference “medical assistance,” the surrounding language is different. The authorizing statute speaks to “the furnishing of medical assistance ... to individuals.” 42 U.S.C. § 1396a(a)(16). The reimbursement statute refers to “the total amount expended ... as medical assistance under the State plan.” 42 U.S.C. § 1396b(a)(1). While we are not asked to definitively resolve the matter here, it could be that the “furnishing of medical assistance to individuals” concerns base payments for specific services furnished to specific beneficiaries, but the “total amount expended as medical assistance” includes QAF subsidies. *Cf.* 42 U.S.C. § 1396b(bb)(1)(B)(iv) (referring to “the total Medicaid payments made to an inpatient hospital provider, including the supplemental payment”).

Regardless, even assuming the authorizing statute’s reference to “furnishing of medical assistance to individuals” encompasses QAF subsidies, that would not necessarily mean—at the first step of our colleague’s reasoning—that the regulation at issue also has that reach. The authorizing statute gives the Department the authority to establish regulations providing for the “inclusion” in State Medicaid plans “of provisions ... with respect to furnishing of medical assistance under the plan to individuals who are residents of the State but are absent therefrom.” 42 U.S.C. § 1396a(a)(16). Nothing in that statute requires that any regulations adopted by the Department must encompass the entire sweep of the

statutory authorization. Instead, the Department could opt to establish regulations with a narrower reach, pertaining solely to base payments to beneficiaries for services they receive. We conclude, for all the reasons explained, that the Department did just that in adopting a regulation addressed to “furnishing Medicaid to State residents.” 42 C.F.R. § 431.52(a).

Finally, our dissenting colleague suggests that our interpretation of that regulation is in tension with a separate regulation pertaining to upper federal payment limits under Medicaid. *See* Dissenting Op. 7 (citing 42 C.F.R. § 447.1). The latter regulation references “payments made by State Medicaid agencies for Medicaid services.” That provision, according to our colleague, encompasses QAF subsidies, and if “payments ... for Medicaid services” for purposes of that regulation include QAF subsidies, he reasons, then the same should be true of the regulation at issue here. No party in this case, however, cites or relies on the upper-payment-limit regulation, so its proper interpretation is not before us. And whatever the scope of that provision may be, there is no reason to assume that it would dictate whether a differently worded regulation addressed to “furnishing Medicaid to State residents,” 42 C.F.R. § 431.52(a), pertains to base payments and not supplemental subsidies, as we have concluded it does.

* * * * *

For the foregoing reasons, we affirm the judgment of the district court.

So ordered.

KATSAS, *Circuit Judge*, dissenting: A federal regulation requires a State, when reimbursing hospitals for services furnished to its Medicaid beneficiaries, to “pay for services furnished in another State to the same extent that it would pay for services furnished within its boundaries.” 42 C.F.R. § 431.52(b). California pays in-state and out-of-state hospitals base amounts keyed to specific services furnished to beneficiaries. On top of that, California provides in-state hospitals, but not out-of-state hospitals, with supplemental payments keyed to all Medicaid services furnished by the hospital. My colleagues conclude that these targeted supplemental payments do not violate the regulation. For the reasons that follow, I respectfully disagree.

I

Medicaid is a cooperative federal-state program that funds healthcare for low-income individuals. 42 U.S.C. § 1396 *et seq.* It is administered by the States and jointly funded by federal and state governments. To participate in Medicaid, a State must develop and obtain federal approval for a plan to provide “medical assistance” to the needy. *Id.* § 1396a(a). If a plan receives approval, the federal government must reimburse the State for a percentage of amounts spent in providing “medical assistance” under the plan. *Id.* § 1396b(a)(1). The term “medical assistance” means “part or all of the cost” of providing covered “care and services” to beneficiaries, as well as “the care and services themselves.” *Id.* § 1369d(a). States may fund their share of these expenses through certain taxes on healthcare providers. *Id.* § 1396b(w).

A state plan must set forth “rates of payment” for covered services. 42 U.S.C. § 1396a(a)(13)(A). Such rates may include “base” payments keyed to specific

services provided, as well as certain “supplemental” payments determined more generally. *Id.* § 1396b(bb); *see also* Medicaid & CHIP Payment & Access Comm’n, Medicaid Base and Supplemental Payments to Hospitals (April 2024), <https://perma.cc/WR86-GLMM>. But there are “upper payment limits” for hospitals, with base and supplemental payments jointly counting against the same limits. 42 U.S.C. § 1396b(bb)(1)(B)(iv).

This case involves payment for services provided to beneficiaries out-of-state. The Medicaid statute requires a state plan to include, “to the extent required by regulations,” provisions for “the furnishing of medical assistance under the plan to individuals who are residents of the State but are absent therefrom.” 42 U.S.C. § 1396a(a)(16). When certain exigencies are present, the implementing regulation requires the State to “pay for services furnished in another State to the same extent that it would pay for services furnished within its boundaries if the services are furnished to a beneficiary who is a resident of the State.” 42 C.F.R. § 431.52(b).

California participates in Medicaid through its Medi-Cal program. Cal. Welf. & Inst. Code § 14000 *et seq.* California funds its share of Medicaid expenses in part through a tax on hospitals called a “quality assurance fee” (QAF). *Id.* § 14169.52(a). It pays the tax proceeds to in-state hospitals as “supplemental amounts”—which are keyed to Medi-Cal patient volume—for treating Medi-Cal beneficiaries. *Id.* §§ 14169.54(a), 14169.55(a). California makes these payments to “improv[e] hospital reimbursement through supplemental Medi-Cal payments.” *Id.* § 14169.50(b). The payments are in addition to base payments and are set to “result in payments to hospitals that equal” the Medicaid upper payment limits. *Id.* §§ 14169.54(a), 14169.55(a); *see id.*

§ 14169.59; J.A. 543–47. By increasing its own Medi-Cal spending, California also seeks “to increase federal financial participation” in providing the covered care. Cal. Welf. & Inst. Code § 14169.50(d).

The Centers for Medicare & Medicaid Services approved a plan amendment allowing California to pay these QAF subsidies. A group of out-of-state hospitals near the California border sought judicial review. They urged that the subsidies, targeted exclusively to in-state hospitals, violate the Commerce Clause, the Equal Protection Clause, and the regulation on payment for out-of-state care. The district court rejected these arguments and granted summary judgment to CMS. *Asante v. Azar*, 656 F. Supp. 3d 185 (D.D.C. 2023).

II

In my view, the QAF payments violate the out-of-state payment regulation because they flow only to in-state hospitals. In pertinent part, the regulation requires California to “pay for services furnished in another State to the same extent that it would pay for services furnished within its boundaries if the services are furnished to a beneficiary who is a resident of the state.” 42 C.F.R. § 431.52(b). In other words, if California would pay for “services furnished” to a Medi-Cal beneficiary by an in-state hospital, it likewise must pay, “to the same extent,” if an out-of-state hospital provides the services. California respects that requirement insofar as it makes the same base payments regardless of whether Medi-Cal beneficiaries receive treatment in-state or out-of-state. But the QAF payments then give *in*-state hospitals *additional* compensation for treating Medi-Cal beneficiaries. These payments are aimed at “improving hospital reimbursement through supplemental Medi-Cal

payments to hospitals.” Cal. Welf. & Inst. Code § 14169.50(b); *see also id.* § 14169.50(a) (QAF payments aim “to improve funding for hospitals and obtain all available federal funds to make supplemental Medi-Cal payments to hospitals”). They are “in addition to” the base payments that all hospitals receive for treating Medi-Cal beneficiaries. *Id.* §§ 14169.54(a), 14169.55(a). And the state plan confirms that California makes the payments “for the provision of hospital inpatient services” to Medi-Cal beneficiaries. J.A. 543. In other words, QAF payments are extra payments to in-state hospitals for services furnished through Medicaid.

The government objects that the regulation addresses coverage but not payment amounts. In other words, it reads the requirement to “pay for” in-state and out-of-state services “to the same extent” as meaning that a State must *cover* the same services regardless of where they are provided—not that it must pay the same *amount* (or pay under the same formula) regardless of where the services are provided. For good reason, my colleagues do not adopt this contention. Section 431.52 is titled “Payments for services furnished out of State,” and subsection (b) is likewise titled “Payment for services.” Those would be odd titles if the regulation were addressed only to what services must be covered. Moreover, the operative text does not simply require a State to “pay” *some* amount for—*i.e.*, to cover—services regardless of where they are provided. Instead, it requires a State to pay “to the same extent” regardless of where the services are provided. That phrase governs the required amount of payment.

My colleagues adopt a different theory to exclude QAF payments from the out-of-state payment regulation. They conclude that 42 C.F.R. § 431.52 covers only base payments keyed to specific individual services

provided to Medicaid beneficiaries—not supplemental payments for treating Medicaid beneficiaries more generally. They derive this limit not from subsection (b), which sets forth the legally operative text, but from subsection (a), which is titled “Statutory basis.” In its entirety, subsection (a) states that “Section 1902(a)(16) of the [Medicaid] Act,” which is codified at 42 U.S.C. § 1396a(a)(16), “authorizes the Secretary [of Health and Human Services] to prescribe State plan requirements for furnishing Medicaid to State residents who are absent from the State.” 42 C.F.R. § 431.52(a). My colleagues reason that QAF payments, as general subsidies untethered to specific individual medical procedures, do not involve “furnishing Medicaid to *State residents*.” *See ante* at 12-15.

With respect, I do not think subsection (a) is so limiting. To begin with, the phrase “to State residents” simply reflects a truism that one State need not provide Medicaid benefits to another State’s residents. In my view, the key phrase in subsection (a) is the immediately preceding one—“furnishing Medicaid.” The dispositive question it frames is whether QAF payments are for “furnishing Medicaid” to beneficiaries. The answer is clearly yes: The California legislature repeatedly declared QAF payments to be “supplemental Medi-Cal payments to hospitals.” Cal. Welf. & Inst. Code § 14169.50(a), (b), (d) & (e). They are made “for the provision of ... hospital services” to Medi-Cal beneficiaries. *Id.* §§ 14169.54(a) (outpatient), 14169.55(a) (inpatient). And while they are not disaggregated into individual services provided, they do reflect how much “Medicaid” each hospital has “furnish[ed]” because they are keyed to the number of Medi-Cal patient days of each hospital. *See id.* §§ 14169.54(b), 14169.55(b), 14169.59; J.A. 542–53. Whether California pays hospitals a base

amount for each appendectomy performed for Medi-Cal beneficiaries, or a supplemental amount keyed to the total number of patient-days attributable to appendectomies performed for Medi-Cal beneficiaries, the State is still paying hospitals for “furnishing Medicaid to State residents.” Moreover, the regulation implements a statutory directive to provide for “the furnishing of medical assistance” to beneficiaries who receive treatment out-of-state. 42 U.S.C. § 1396a(a)(16). And “medical assistance”—a key phrase at the heart of the Medicaid statute—is defined as “payment of part or all of the cost” of covered “care and services” provided to beneficiaries, “or the care and services themselves.” *Id.* § 1396d(a). So the dispositive statutory question is whether QAF payments are for furnishing medical “care and services,” and again the answer is clearly yes.¹

In addition, my colleagues’ position would foreclose federal funding for any portion of the QAF payments, and so proves too much. As explained above, the regulatory requirement “for furnishing Medicaid to State residents” out-of-state parallels the statutory authorization for regulations regarding “the furnishing of medical assistance” to such residents. *See* 42 U.S.C.

¹ My colleagues do not quarrel with the point that QAF payments involve “the furnishing of medical assistance” under the statute. Instead, they seek to distinguish that phrase from “furnishing Medicaid to State residents” under the implementing regulation. *Ante* at 19. As explained above, the parallel between the two phrases seems to me obvious. My colleagues’ primary response is to observe that an implementing regulation may sweep less broadly than its authorizing statute. *See id.* As a general proposition, that is certainly true. But the regulatory provision they invoke here, subsection (a) of 42 C.F.R. § 431.52, is not so limiting. And in any event, the legally operative regulatory provision is subsection (b), which covers QAF payments by its terms.

§ 1396a(a)(16); 42 C.F.R. § 431.52(b). And Medicaid authorizes federal funding only for a percentage of amounts that a State expends to provide “medical assistance” under its plan, 42 U.S.C. § 1396b(a)(1), as well as for various administrative expenses, *id.* § 1396b(a)(2) to (7). So if QAF payments did not qualify as “medical assistance” under section 1396a(a)(16), then the federal government could not pay for a share of those subsidies through Medicaid. And nobody—including my colleagues—defends that conclusion.²

Consider also the upper payment limits. Base and supplemental payments count against them. *See* 42 U.S.C. § 1396b(bb)(1)(B)(vi). But only payments “for Medicaid services” count. 42 C.F.R. § 447.1. So under the regulations, payments “for Medicaid services” must include base and supplemental payments. Moreover, California law treats QAF payments as subject to the “applicable federal upper payment limit,” and it fixes their amount to ensure that the total payments made to hospitals—with QAF payments included—equal but do not exceed that limit. Cal. Welf. & Inst. Code § 14169.55(a). California thus sought federal approval to include QAF payments in its plan on the assumption that they count against the upper limits. J.A. 561, 592–603. In approving the plan amendment, CMS likewise treated the QAF payments as subject to the “upper payment limit,” but concluded that these payments, “when added to the base rate payments and other supplemental payments received by private hospitals in California, are within the upper payment limits.” J.A.

² My colleagues posit that QAF payments might involve “amount[s] expended ... as medical assistance” under § 1396b(a)(1), but not “furnishing of medical assistance to individuals” under § 1396a(a)(16). *Ante* at 18–19. Again, the parallel seems obvious.

535. In sum, both CMS and California took as a given that QAF supplemental payments, like the base payments received by in-state and out-of-state hospitals, are payments for Medicaid services.³

Two final points in response to my colleagues. First, they suggest that out-of-state hospitals would obtain a “windfall” in receiving QAF payments while not paying the QAF tax. *Ante* at 16. But California does not offer hospitals the payments in return for the tax. Nor could it, for federal regulations prohibit a State from linking its Medicaid taxes and its Medicaid payments in that way. *See* 42 C.F.R. § 433.68(b)(3) & (f)(3); J.A. 309-10. Instead, California imposes the tax as one means for raising revenue to pay its share of Medicaid expenses. And it separately pays hospitals in return for treating California residents who are Medi-Cal—and thus Medicaid—beneficiaries. In sum, my approach would simply require California to pay out-of-state hospitals the same amount that it would pay in-state hospitals for services provided to Medi-Cal patients. I do not see that as a windfall.⁴

³ My colleagues note that the parties do not address the upper payment limits in this court. *Ante* at 19. But the agency order under review rests squarely on the premise that QAF payments are “for Medicaid services” and thus subject to the limits. J.A. 535. Moreover, we should consider all pertinent regulations in seeking to best construe the one directly at issue, as my colleagues elsewhere recognize. *Ante* at 14–15. And I can discern no plausible ground for concluding that QAF payments are “for Medicaid services” under the regulation on upper payment limits, but are not for “furnishing Medicaid to State residents” under 42 C.F.R. § 431.52.

⁴ Even if out-of-state hospitals could opt into the QAF tax in return for QAF payments, their failure to do so would not suggest any windfall. The QAF tax is keyed to a hospital’s *entire* patient base, while the QAF payments are keyed to the amount of

Second, my colleagues invoke the plaintiff hospitals' statement in the district court that QAF subsidies, in contrast to base payments, "are not payments for services rendered." J.A. 508 (cleaned up); *see ante* at 15. The hospitals did not make that statement in addressing any of the statutory or regulatory provisions that bear on the scope of 42 C.F.R. § 431.52(b). Instead, they made it to support a different argument that California, in making the QAF payments, acts as a regulator for dormant Commerce Clause purposes. And the government, opposing the plaintiffs' position, urged that "base rates," which all agree involve California acting as a market participant, and "QAF payments" are indistinguishable for Commerce Clause purposes. J.A. 487. Thus, to the extent there is any tension between the parties' respective positions on the regulatory and constitutional issues presented in this case, it is one that appears on both sides of the dispute.

III

California pays in-state hospitals more for furnishing care to Medi-Cal beneficiaries than it would pay similarly situated out-of-state hospitals for furnishing the same care. This payment scheme violates the clear command of 42 C.F.R. § 431.32(b), so I must respectfully dissent from part II.C of the Court's opinion. And because the payment scheme violates the regulation, I would not reach the question whether it also violates the Constitution.

treatment provided to *Medi-Cal* patients only. *See ante* at 4–5. Because out-of-state hospitals treat vastly fewer Medi-Cal patients than do in-Medstate hospitals, the hypothetical bargain suggested by my colleagues would be wildly unfavorable to the out-of-state hospitals.

APPENDIX B

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Case No. 20-cv-601 (TSC)

ASANTE, ET AL.,

Plaintiffs,

v.

ALEX M. AZAR II, Secretary,
U.S. Department of Health
and Human Services, *et al.*,

Defendants.

Filed February 14, 2023

MEMORANDUM OPINION

Plaintiffs are eight hospitals located in Arizona, Nevada, and Oregon. Compl. ¶ 10, ECF No. 1. Defendants are the federal agencies and officials responsible for administering Medicaid: the Department of Health and Human Services (“HHS”); former Secretary of HHS, Alex Azar; the Centers for Medicare and Medicaid Services (“CMS”); and former CMS Administrator, Seema Verma. *Id.* ¶¶ 11-14. Plaintiffs contend that California’s subsidy distribution scheme discriminates against them in violation of the Commerce Clause and the Equal Protection Clause, and that it violates the Administrative Procedure Act (“APA”) and the Medicaid Act, specifically 42 U.S.C. § 1396a(a)(16) and its implementing regulation, 42 C.F.R. § 431.52. *Id.* ¶ 7.

Plaintiffs and Defendants have both moved for summary judgment. Pls.' Mot. for Summ. J., ECF No. 37; Defs.' Cross Mot. for Summ. J., ECF No. 42. For the reasons set forth below, the court will **DENY** Plaintiffs' motion and **GRANT** Defendants' motion.

I. BACKGROUND

A. Factual Background

In 2010, California created the Quality Assurance Fee ("QAF") program, which requires certain California hospitals to pay a QAF, but exempts state public hospitals, small and rural hospitals, long-term care hospitals, and specialty hospitals (except for charitable research hospitals). ECF No. 37-1 at 14. The collected fees are matched with federal Medicaid funds and then distributed to California hospitals, including hospitals that are exempt from the QAF. *Id.* Each year the California Department of Health Care Services ("Department"), pursuant to a state plan amendment ("SPA") approved by CMS, pays California hospitals over \$4 billion in federal Medicaid QAF subsidies. Compl. ¶ 1. The Department does not, however, pay those subsidies to out-of-state "border hospitals," which are located 55 miles or less from the California border. *Id.* Border hospitals are critical for enrollees in California's Medicaid program ("Medi-Cal") who live in certain rural areas of California because the border hospitals are sometimes the closest major medical center available to them. *Id.* ¶ 4. The border hospitals provide over seventy percent of the inpatient care that California Medi-Cal beneficiaries receive from out-of-state hospitals. *Id.*

Plaintiffs are border hospitals that provide services to Medi-Cal patients while they are in Arizona, Oregon, or Nevada. *Id.* ¶ 2. Plaintiffs are part of a larger group

of thirty-seven border hospitals that provide services to Medi-Cal enrollees but that do not receive a portion of the QAF subsidy.

All states participating in the Medicaid program must adopt a state plan and obtain approval of amendments from CMS. 42 U.S.C. §§ 1396a(a), 1396b; ECF No. 37-1 at 10. The QAF program at issue here covers the period from July 1, 2019, through December 31, 2021. ECF No. 37-1 at 17. During that time, Congress expressly delegated to former Secretary Azar the responsibility and authority to administer the Medicaid program and to review state Medicaid plans and plan amendments for compliance with federal law. Compl. ¶ 14; 42 U.S.C. § 1396a(b) (“The Secretary shall approve any plan which fulfills” the statutory requirements). Former Secretary Azar delegated to former Administrator Verma and CMS the authority to administer the Medicaid program pursuant to the Social Security Act, 42 U.S.C. §§1396a(13)(A)(iv), 1396r-4(a)(1)(B). Compl. ¶ 14.

B. Procedural Background

Since 2010, out-of-state hospitals have filed several lawsuits attempting to enjoin the QAF program and receive a portion of the subsidy distribution. *Id.* ¶ 16-17. Plaintiffs previously settled claims with California regarding the QAF program period from 2009 to June 30, 2019. *Id.* ¶ 19-29.

Plaintiffs first brought these claims against these Defendants on August 20, 2019, when CMS had not yet approved the 2019 QAF Program. *See Asante v. Azar*, No. 19-cv-02512-TSC (D.D.C. 2019), ECF No. 1. Consequently, the court dismissed the action without prejudice because there had been no final agency action. *See Asante v. Azar*, No. 19-cv-02512 (D.D.C. February

14, 2020), ECF No. 33. On February 14, 2020, CMS approved the Department's QAF waiver requests for July 1, 2019, to December 31, 2021. SPA 19-0018 Tax Waiver Approval, 00769, Administrative Record Joint Appendix (A.R.J.A.); SPA 19-0019 Tax Waiver Approval, 00305, A.R.J.A. On February 25, 2020, Defendants approved California's QAF program for that same program period. SPA 19-0018 CMS Approval Letter, 00002, A.R.J.A.; SPA 19-0019 CMS Approval Letter, 00002, A.R.J.A. This approval was a final agency action.

On February 28, 2020, Plaintiffs filed the complaint in this case and moved for a preliminary injunction preventing the federal government from paying approximately \$4 billion in supplemental Medicaid funds to California for disbursement to in-state hospitals. ECF No. 2, Pls.' Mot. for Prelim. Inj. This court denied Plaintiffs' Motion for Preliminary Injunction because they had not shown that their alleged \$15 million loss from California's distribution of all QAF funds constituted irreparable harm. Mem. Op. Re Pls.' Mot. for Prelim. Inj., ECF No. 32; Order Den. Pls.' Mot. for Prelim. Inj., ECF No. 33.

Plaintiffs—who have not named California as a defendant in this matter—claim California's QAF program is discriminatory because it limits the distribution of federal QAF funds to in-state hospitals, even though both in-state and out-of-state hospitals treat Medi-Cal patients. ECF No. 37-1 at 17. They argue that “for the effect of the QAF program to be non-discriminatory, the plaintiff ‘border hospitals’ should receive the same net QAF benefit as these in-state hospitals.” *Id.* at 16. Plaintiffs contend this discriminatory scheme violates the Commerce Clause, Equal Protection Clause, and the Medicaid Act, and that

Defendants' approval and funding of the scheme violate the APA.

II. STANDARD OF REVIEW

Ordinarily, summary judgment is appropriate when the pleadings and the evidence demonstrate that "there is no genuine dispute as to any material fact." Fed. R. Civ. P. 56(a). However, when, as here, the court is reviewing a final agency action under the APA, Rule 56(a)'s standard does not apply. *See Roberts v. United States*, 883 F. Supp. 2d 56, 62 (D.D.C. 2012). Instead of reviewing the record for disputed facts that would preclude summary judgment, the court's role is more limited: "[T]he function of the district court is to determine whether or not as a matter of law the evidence in the administrative record permitted the agency to make the decision it did." *Sierra Club v. Mainella*, 459 F. Supp. 2d 76, 90 (D.D.C. 2006) (quotation marks and citation omitted). This standard of review is "narrow," and a court applying it "is not to substitute its judgment for that of the agency." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

The APA "sets forth the full extent of judicial authority to review executive agency action for procedural correctness." *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 513 (2009). A court must "hold unlawful and set aside agency action, findings, and conclusions" that are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). An agency action is arbitrary and capricious if the agency "entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be

ascribed to a difference in view or the product of agency expertise.” *Motor Vehicle Mfrs.*, 463 U.S. at 43. The APA also requires courts to “hold unlawful and set aside agency action, findings, and conclusions” that are “contrary to constitutional right, power, privilege, or immunity.” 5 U.S.C. § 706(2)(B).

III. ANALYSIS

A. Medicaid Act

Plaintiffs claim that HHS, through CMS, approved an SPA allowing California to exclude out-of-state hospitals from its QAF subsidy distribution in violation of a federal statute, 42 U.S.C. § 1396a(a)(16), and its implementing regulation, 42 C.F.R. § 431.52. ECF No. 37-1 at 39-41.

i. *Chevron* and *Auer/Kisor* Analysis

In assessing a challenge to an agency action based on a statute, a court must apply the test set forth in *Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842-43 (1984): “If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress.” *Chevron*, 467 U.S. at 842-43. But “if the statute is silent or ambiguous with respect to the specific issue,” then the reviewing court must defer to the agency’s interpretation so long as “the agency’s answer is based on a permissible construction of the statute.” *Id.* at 843. “If Congress has explicitly left a gap for the agency to fill ... [s]uch legislative regulations are given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute.” *Id.* at 843-44.

In assessing a challenge to an agency’s interpretation of its own regulation, a court must apply

the test set forth in *Auer v. Robbins*, 519 U.S. 452, 461 (1997), and clarified in *Kisor v. Wilkie*, 139 S. Ct. 2400, 2414-18 (2019): A court defers to an agency’s interpretation of its rules only if a regulation is “genuinely ambiguous... And before concluding that a rule is genuinely ambiguous, a court must exhaust all the ‘traditional tools’ of construction.” *Kisor*, 139 S. Ct. at 2415 (citing *Chevron*, 467 U.S. at 843, n.9). “Under *Auer*, as under *Chevron*, the agency’s reading must fall within the bounds of reasonable interpretation.” *Kisor*, 139 S. Ct. at 2416 (quotations omitted).

Under 42 U.S.C. § 1396a(a)(16), “a State plan for medical assistance must... provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions (conforming to such regulations) with respect to the furnishing of medical assistance under the plan to individuals who are residents of the State but are absent therefrom.” 42 U.S.C. § 1396a(a)(16).

42 C.F.R. § 431.52(b) states:

A State plan must provide that the State will pay for services furnished in another State to the same extent that it would pay for services furnished within its boundaries if the services are furnished to a beneficiary who is a resident of the State, and any of the following conditions is met:

- (1) Medical services are needed because of a medical emergency;
- (2) Medical services are needed and the beneficiary’s health would be endangered if he were required to travel to his State of residence;

(3) The State determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other State;

(4) It is general practice for beneficiaries in a particular locality to use medical resources in another State.

Here, Congress left a gap for the agency to fill when it conferred on the Secretary the authority to review and approve state Medicaid plans as a condition for disbursing federal Medicaid payments. *See* 42 U.S.C. §1396b. In carrying out this duty, the Secretary must ensure that each state plan complies with a vast network of specific statutory requirements. *See generally* 42 U.S.C. § 1396a. Congress also delegated to HHS the authority to implement 42 U.S.C. §1396 by issuing rules, and in 1991 HHS amended 42 C.F.R. § 431.52. *See* Medicare and Medicaid Programs; OBRA '87 Conforming Amendments, 56 Fed. Reg. 8832-01 (Mar. 1, 1991). The amendment makes clear that there is a payment requirement in the Medicaid Act, but it is unclear whether payment is owed to healthcare providers or beneficiaries (or both) for coverage of service. Plaintiffs focus on the word “payment” and argue that the “regulation clearly mandates that the State ‘will pay’ and ‘would pay’ for services furnished to State residents by out-of-state providers.” ECF 37-1 at 41. Defendants argue however, that the statute and regulation’s “provisions require only that Medicaid cover out-of-state medical services for beneficiaries to the same extent as it covers in-state services.” ECF 42-2 at 17.

The court must consider whether the statute is “genuinely ambiguous,” *Kisor*, 139 S. Ct. at 2415, “with respect to the specific issue.” *Chevron*, 467 U.S. at 843. Here the specific issue is whether the relevant provisions require a state plan to pay out-of-state providers in a way *that is identical* to the way in-state providers are paid, meaning that in-state and out-of-state hospitals would receive the same base rate for reimbursement, as well as any supplemental payments such as the QAF subsidy.

The Medicaid Act does not guarantee identical payments to providers. Neither 42 U.S.C. § 1396a(a)(16) nor 42 C.F.R. § 431.52 mention “hospitals,” “providers,” or “health care practitioners,” unlike other sections of the Medicaid Act which expressly mention those entities. 42 U.S.C. § 1396a(a)(13), (30), (37). The Secretary chose an interpretation consistent with the literal meaning of § 1396a(a)(16) and 42 C.F.R. § 431.52, and that interpretation falls “within the bounds of reasonable interpretation” under both *Auer* and *Chevron*. *Kisor*, 139 S. Ct. at 2416. Bearing in mind the Supreme Court’s admonition that “deference in accordance with *Chevron* ... is warranted 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,” *Gonzales v. Oregon*, 546 U.S. 243, 255-56 (2006) (quotations omitted), the court will defer to the agency’s interpretation of the Medicaid Act, and therefore finds that the QAF program does not violate the Act.

B. APA

Plaintiffs claim that in allowing the California SPAs to exclude the border hospitals from the QAF subsidy

distribution, Defendants violate the Commerce Clause, the Equal Protection Clause, and the Medicaid Act. ECF No. 37-1 at 27. Plaintiffs urge the court to set aside Defendants' decision because it is "arbitrary, capricious, an abuse of discretion," "otherwise not in accordance with law," and "contrary to constitutional right, power, privilege, or immunity." ECF No. 37-1 at 11.

i. Arbitrary and Capricious

In assessing an arbitrary and capricious challenge to agency action, the court's review must be "highly deferential" and begins with a presumption that the agency's actions are valid. *Env't. Def. Fund, Inc. v. Costle*, 657 F.2d 275, 283 (D.C. Cir. 1981). A court exercising its narrowly defined duty under the APA must consider whether the agency acted within the scope of its legal authority, whether the agency adequately explained its decision, and whether the agency based its decision on facts in the record and relevant factors. *See Marsh v. Oregon Natural Res. Council*, 490 U.S. 360, 378 (1989); *Citizens to Preserve Overton Park, Inc. v. Volpe*, 400 U.S. 402, 415-16 (1971); *Camp v. Pitts*, 411 U.S. 138, 142 (1973); *Pro. Drivers Council v. Bureau of Motor Carrier Safety*, 706 F.2d 1216, 1220 (D.C. Cir. 1983); *see also Spadone v. McHugh*, 864 F. Supp. 2d 181, 187 (D.D.C. 2012) (citation omitted) ("A decision is arbitrary or capricious under the APA if an agency failed to provide a reasoned explanation, failed to address reasonable arguments, or failed to consider an important aspect of the case.").

Under Section 706(2)(A) of the APA, Plaintiffs "bear[] the burden of establishing the invalidity of the agency's action." *Magneson v. Mabus*, 85 F. Supp. 3d 221, 225 (D.D.C. 2015). Plaintiffs have not met this burden because they have not shown that Defendants

failed to adequately explain their decision, base their decision on facts in the record, or consider relevant factors. ECF No. 37-1 at 11, 53.

In approving California's SPAs, CMS noted that it had weighed, among other considerations, the relevant provisions of the Medicaid Act and California's policy goals. SPA 19-0018 CMS Approval Letter, 00004, A.R.J.A.; SPA 19-0019 CMS Approval Letter, 00004, A.R.J.A. The agency even considered the arguments Plaintiffs made in *Asante v. Azar*, 19-2512 (D.D.C. 2019). See SPA 19-0018 CMS Approval Letter, 00003, A.R.J.A.; SPA 19-0019 CMS Approval Letter, 00003, A.R.J.A. CMS's SPA approval letters noted that it "gave additional consideration to the state's exclusion of out-of-state hospitals and asked the state to further explain its policy goal with this program and its compliance with the Medicaid statute as well as the Constitution's Commerce Clause and Equal Protection Clause," before ultimately finding that the SPAs were consistent with the relevant Medicaid Act statutes. *Id.* Moreover, the administrative record indicates that CMS corresponded frequently with California before approving both SPAs. Certified List of Administrative Record Contents for SPA 19-0018, ECF No. 36-1; Certified List of Administrative Record Contents for SPA 19-0019, ECF No. 36-2. For example, before CMS approved SPA 19-0018 on February 25, 2022, CMS and California corresponded before the plan was submitted, again regarding preliminary review questions, and on three separate occasions regarding requests for additional information. ECF No. 36-1. CMS and California corresponded with the same frequency before CMS approved SPA 19-0019, which was approved on the same day as SPA 19-0018. ECF No. 36-2. The Administrative Record therefore shows that Defendants considered the

fact that out-of-state hospitals were excluded from the subsidy and considered California's as well as Plaintiffs' positions before approving the SPAs. Consequently, Plaintiffs have not shown that Defendants' actions were arbitrary and capricious under Section 706(2)(A).

ii. Contrary to Constitutional Right

Apart from the power of review granted by the APA, the court "has the authority to examine and rule on any actions of a federal agency that allegedly violate the Constitution." *Rydeen v. Quigg*, 748 F. Supp. 900, 905 (D.D.C. 1990), *aff'd mem.*, 937 F.2d 623 (Fed. Cir. 1991) (citing *Porter v. Califano*, 592 F.2d 770, 780 (5th Cir. 1979)). But the APA "also provides for the Courts to make an independent assessment of constitutional issues," and the court's role is the same "whether the plaintiff sues directly under the Constitution or under [the APA]." *Id.* at 905 n.8 (citing 5 U.S.C. § 706(2)(B)).

1. Commerce Clause

Plaintiffs claim that HHS, through CMS, approved an SPA that allows California to exclude out-of-state hospitals from its QAF subsidy distribution in violation of the Commerce Clause. ECF No. 37-1 at 17. The Commerce Clause grants Congress power to "regulate Commerce ... among the several States." U.S. CONST. art. I, § 8, cl. 3. Although the Clause is framed as a positive grant of power to Congress, courts have consistently held that the Clause contains a further, negative command, known as the dormant Commerce Clause, limiting the power of the states to discriminate against interstate commerce. *See New Energy Co. v. Limbach*, 486 U.S. 269, 273 (1988) ("This 'negative' aspect of the Commerce Clause prohibits economic protectionism-that is, regulatory measures designed to benefit in-state economic interests by burdening out-of-

state competitors.”). Two exceptions can save state regulations that would otherwise be unconstitutional under the dormant Commerce Clause: congressional consent and state action that qualifies as market participation. *See* 15 Bus. & Com. Litig. Fed. Cts. § 163:36 (5th ed.).

1(a). Congressional Consent

“Dormant Commerce Clause restrictions apply only when Congress has not exercised its Commerce Clause power to regulate the matter at issue.” *Tennessee Wine & Spirits Retailers Ass’n v. Thomas*, 139 S. Ct. 2449, 2465 (2019). Congress “may use its powers under the Commerce Clause to ‘[confer] upon the States an ability to restrict the flow of interstate commerce that they would not otherwise enjoy.’” *New England Power Co. v. New Hampshire*, 455 U.S. 331, 340 (1983) (quoting *Lewis v. BT Inv. Managers, Inc.*, 447 U.S. 27, 44 (1980)). The congressional directive exempting a state statute from Commerce Clause scrutiny must be “unmistakably clear.” *See Maine v. Taylor*, 477 U.S. 131, 139 (1986).

Defendants argue that dormant Commerce Clause restrictions do not reach the QAF distribution scheme because Congress expressly delegated to the HHS Secretary—who delegated to the CMS Administrator—the responsibility and authority to administer the Medicaid program and to review California’s Medicaid plans and plan amendments. *See* ECF No. 42-2 at 33. But federal agency approval does not eliminate an alleged constitutional defect. *See Pharm. Rsch. & Mfrs. Am. v. Thompson*, 259 F. Supp. 2d 39, 82 n.28 (D.D.C. 2003) (“Although Congress authorized the Secretary to approve state Medicaid plans, it did not unmistakably delegate to him the ability to authorize state programs that violate the Commerce Clause”), *aff’d sub nom.*

Pharm. Rsch. & Mfrs. Am. v. Thompson, 362 F.3d 817, 827 (D.C. Cir. 2004); see also *Mary Hitchcock Mem'l Hosp. v. Cohen*, No. 15-cv-453-LM, 2016 WL 1735818, at *4 (D.N.H. May 2, 2016) (holding that state Medicaid programs are not exempt from Commerce Clause scrutiny). In *Western and Southern Life Insurance Co. v. State Board of Equalization of California*, 451 U.S. 648, 653 (1981), the Supreme Court found that a state law imposing a discriminatory and retaliatory tax on out-of-state insurance companies did not violate the Commerce Clause because the McCarren-Ferguson Act (15 U.S.C. § 1012(a)) removed any Commerce Clause restrictions on a state's power to tax the insurance business. ("Section 2(a), 59 Stat. 33, 15 U.S.C. § 1012(a), declares: 'The business of insurance ... shall be subject to the laws of the several States which relate to the regulation or taxation of such business.' The unequivocal language of the Act suggests no exceptions."). In *Pharmaceutical Research & Manufacturers of America*, the D.C. Circuit held that a state's HHS-approved prescription drug program that had the practical effect of controlling out-of-state drug prices did not violate the Commerce Clause because a federal statute—not the state program itself—specifically required interstate price conformity. 362 F.3d at 827.

Here, CMS approved the waiver allowing California to exclude out-of-state hospitals from their QAF subsidy distribution, but the federal statute authorizing the program did not expressly direct the state to pay only in-state hospitals. See 42 U.S.C. Section 1396a(a)(16); 42 C.F.R. § 431.52. Consequently, the congressional consent exemption does not apply.

1(b). Market Participation

When a state acts as a market participant, rather than a market regulator, its decisions are exempt from dormant Commerce Clause challenge. *See Dep't of Revenue of Ky. v. Davis*, 553 U.S. 328, 339 (2008) (exempting from the Commerce Clause states that go beyond regulation and participate in the market so as to exercise the right to favor their own citizens over others.). A state acts as a participant rather than a regulator when it buys, sells, or directly pays for something in the market rather than taxes something in the market. *See* Dan T. Coenen, *Untangling the Market-Participant Exemption to the Dormant Commerce Clause*, 88 MICH. L. REV. 395, 422 (1989) (“When a state government regulates or taxes, it turns over nothing that belongs to it; rather, it compels private action through the exercise of raw governmental power. In contrast, when a state government buys or sells, it is controlling and distributing its own resources.”).

Relying on *Asante v. California Department of Health Care Services*, 886 F.3d 795, 800 (9th Cir. 2018), Defendants note that the plaintiffs in that case are the same Plaintiffs here, and that “the Ninth Circuit has already found that California is acting as a market participant when determining Medicaid payment rates.” ECF No. 42-2 at 36. But *Asante v. California Department of Health Care Services* challenged reimbursement to out-of-state hospitals for Medicaid base rates, whereas this case challenges supplemental payments. 886 F.3d at 801 (“Here the Department sets rates of reimbursement to hospitals for those who are essentially insured as beneficiaries under Medi-Cal in a manner much like that of a private insurer participating in the market”). The QAF program involves “supplemental payments to hospitals that are separate

from and in addition to Medicaid payments for services rendered,” i.e., base payments. Compl. ¶ 63. In other words, the QAF program is a type of subsidy to California hospitals.

The Supreme Court has found that state action having the purpose and/or effect of providing a subsidy is a form of state regulation, not market participation. See *New Energy Co. of Indiana v. Limbach*, 486 U.S. 269, 277 (1988) (“the tax credit scheme has the purpose and effect of subsidizing a particular industry... That does not transform it into a form of state participation in the free market). The Court has suggested that a pure or direct subsidy by a state or local government is generally permissible under the Commerce Clause. See *Camps Newfound/Owatonna, Inc. v. Town of Harrison*, 520 U.S. 564, 590-91 (1997). In *West Lynn Creamery, Inc. v. Healy*, 512 U.S. 186 (1994), the Court held that a pricing program consisting of a subsidy and a nondiscriminatory tax on all dairy farmers violated the dormant Commerce Clause because the tax was effectively imposed only on out-of-state dairy farmers. It noted that a “pure subsidy funded out of general revenue ordinarily imposes no burden on interstate commerce, but merely assists local business.” *Id.* at 199. In *New Energy Co. of Indiana v. Limbach*, 486 U.S. 269, 278 (1988), the Court explained that “[t]he Commerce Clause does not prohibit all state action designed to give its residents an advantage in the marketplace, but only action of that description in connection with the State’s regulation of interstate commerce. Direct subsidization of domestic industry does not ordinarily run afoul of that prohibition.” (emphasis omitted).

This case does not involve a pure subsidy funded by general revenue. QAF payments are akin to disproportionate share hospital (DSH) payments in that

they both operate like a subsidy, using hospital dollars to obtain federal matching funds, and then returning the hospital dollars along with the federal monies to the hospitals. *West Virginia University Hospitals, Inc. v. Rendell*, No. 1:CV-06-0082, 2007 WL 3274409, at *9 (M.D. Pa. Nov. 5, 2007), involved a state Medicaid program that provided “trauma disproportionate share hospital” payments solely to in-state hospitals that treated large numbers of Medicaid and low-income patients. There, the court held that the state did not “fall within the market participant exception to the dormant Commerce Clause.” *Id.* at *9. The court reasoned that “as a component of Pennsylvania’s State Plan for Medicaid, the Trauma DSH payments are jointly funded by Pennsylvania and the federal government.” *Id.* As in *Rendell*, the challenged subsidy here involves a mix of state and federal funds. Therefore, the market participation exemption does not apply, and the court must analyze whether the QAF program violates the dormant Commerce Clause.

1(c). Dormant Commerce Clause Analysis

In evaluating a regulation under the dormant Commerce Clause, a court must first ask whether the regulation “directly regulates” or “discriminates against interstate commerce,” or has the “effect ... [of] favor[ing] in-state economic interests over out-of-state interests.” *Thompson*, 259 F. Supp. 2d at 80. If there is a direct effect, “then the [regulation] (and the Secretary’s approval of it) must be struck down without further inquiry.” *Id.* Proof of discriminatory impact is sufficient for a facially neutral law to be deemed discriminatory. See *Hunt v. Wash. State Apple Advert. Comm’n*, 432 U.S. 333, 352-53 (1977) (holding invalid state statute prohibiting display of state-specific apple grades on containers shipped into the state because of

discriminatory impact on interstate commerce); *C & A Carbone, Inc. v. Town of Clarkstown*, 511 U.S. 383, 391 (1994) (holding invalid town ordinance requiring solid waste processed or handled within town be processed or handled at town's transfer station because of discriminatory impact on interstate commerce).

A facially neutral law is not discriminatory if it “does not prohibit the flow of interstate goods, place added costs upon them, or distinguish between in-state and out-of-state companies in the retail market.” *Exxon Corp. v. Governor of Md.*, 437 U.S. 117, 126 (1978) (finding state statute barring producers or refiners of petroleum products from operating retail service stations within Maryland nondiscriminatory because it had no impact on the relative proportions of local and out-of-state goods sold in Maryland, and had no demonstrable effect on interstate flow of goods); *see also Minnesota v. Clover Leaf Creamery Co.*, 449 U.S. 456, 472 (1981) (finding state statute prohibiting milk retailers from selling their products in plastic containers nondiscriminatory because it allowed milk to continue to move freely across the Minnesota border); *Nat'l Ass'n of Optometrists & Opticians v. Harris*, 682 F.3d 1144, 1154-55 (9th Cir. 2012) (finding state statute prohibiting licensed opticians and optical companies from offering and advertising eyewear and eye examinations at same location nondiscriminatory because it did not interfere with the flow of eyewear into California).

In *Pike v. Bruce Church, Inc.*, 397 U.S. 137 (1970), a cantaloupe grower successfully challenged the constitutionality of an Arizona statute prohibiting the transport of uncrated cantaloupes from Arizona to California for packing and processing. The Supreme Court explained the general rule: “Where the statute regulates even-handedly to effectuate a legitimate local

public interest, and its effects on interstate commerce are only incidental, it will be upheld unless the burden imposed on such commerce is clearly excessive in relation to the putative local benefits.” *Id.* at 142. Courts applying the *Pike* test must first “examine[] whether the State’s interest is legitimate” and then determine “whether the burden on interstate commerce clearly exceeds the local benefits.” *Brown-Forman Distillers Corp. v. N.Y. State Liquor Auth.*, 476 U.S. 573, 579 (1986) (citing *Pike*, 397 U.S. at 142). State laws frequently survive the *Pike* test. *See, e.g., United Haulers Ass’n. v. Oneida–Herkimer Solid Waste Mgmt. Auth.*, 550 U.S. 330, 346-47 (2007) (applying *Pike* and upholding “flow control” ordinances requiring private haulers to obtain permits to collect solid waste and deliver it to the state-created authority for processing because incidental burden on interstate commerce did not exceed environmental public benefits); *Northwest Cent. Pipeline Corp. v. State Corp. Comm’n of Kan.*, 489 U.S. 493, 525-26 (1989) (applying *Pike* and upholding state regulation providing that producers’ entitlements to certain quantities of natural gas would be permanently cancelled if production were substantially delayed, because incidental burden on interstate commerce did not exceed environmental public benefit). The *Pike* balancing test gives courts “enormous discretion because there is no formula or standard for how to compare the burdens on interstate commerce with the benefits of the state or local government; indeed the court is comparing two very different things.” Erwin Chemerinsky, *Constitutional Law: Principles and Policies*, 480, Sixth Edition (2019).

For example, in *Minnesota v. Clover Leaf Creamery Co.*, in upholding a statute banning the sale of milk in plastic containers, the Court first found that the state’s

interest in environmental protection and conservation was legitimate and not “simple protectionism.” 449 U.S. at 471. Further, it found that the burden on interstate commerce was not clearly excessive because plastic manufacturers could produce other products and the interstate market was not significantly impacted. *Id.* at 472-74.

Here, the QAF program does not directly regulate or discriminate against interstate commerce because it does not tax out-of-state hospitals, require out-of-state hospitals to participate, or change the base payments out-of-state hospital receive for providing Medi-Cal services. The QAF program has only an indirect or incidental effect on interstate commerce because the border hospitals that treat California Medi-Cal patients will not receive the QAF subsidy that California hospitals receive. Accordingly, the program must be analyzed under the *Pike* test.

Applying the first part of the *Pike* test—whether the state’s interest is legitimate—California’s stated goals for the QAF program are to: 1) improve access to health care for some of the state’s most vulnerable residents, 2) improve reimbursement and secure additional federal funds for those hospitals essential to maintaining the Medi-Cal safety net, 3) provide funding for healthcare coverage for low income children in California, and 4) target those private hospitals in California that are most likely to serve a significant volume of Medi-Cal beneficiaries and are therefore integral to maintaining Medi-Cal access. *See* SPA 19-0018 CMS Approval Letter, 00004, A.R.J.A.; SPA 19-0019 CMS Approval Letter, 00004, A.R.J.A. Like the environmental interest in the plastic ban in *Minnesota v. Clover Leaf Creamery Co.*, California’s stated goals are legitimate and not simply protectionist.

In applying part two of the *Pike* Test—whether the burden on interstate commerce exceeds the local benefits—Plaintiffs have not established that there *is* a burden on interstate commerce. Plaintiffs do not claim that if they do not receive the QAF subsidy, their Medi-Cal patients will be unable to access care, nor that the quality of care will diminish, or even that they will lose funding. According to CMS, border hospitals will continue to treat Medi-Cal patients, will continue to receive base payments, and will not operate at a loss. *See* SPA 19-0018 - SPA Will Not Trigger Access Rule, 00766, A.R.J.A. (CMS email to DHS confirming SPAs “will not diminish access to care for Medi-Cal beneficiaries or decrease rates for hospitals servicing Medi-Cal beneficiaries”); SPA 19-0018 CMS Approval Letter, 00003, A.R.J.A. (CMS found “no indication or argument raised that the current Medi-Cal payment rates for out-of-state services are insufficient to ensure access of out-of-state Medicaid services to California Medi-Cal beneficiaries.”); Compl. ¶ 63 (“supplemental payments...shall not affect any other payments to hospitals). Consequently, under the *Pike* test, the QAF program does not create a burden on interstate commerce that clearly exceeds the local benefits and therefore does not violate the dormant Commerce Clause.

2. Equal Protection Clause

Plaintiffs claim that the QAF Program violates the Equal Protection Clause of the Fourteenth Amendment, which prohibits a state from denying “any person within its jurisdiction the equal protection of the laws.” U.S. CONST. amend. XIV, § 1. The Equal Protection Clause applies to the federal government through the Due Process Clause of the Fifth Amendment. *See Bolling v. Sharpe*, 347 U.S. 497, 499-500 (1954). Thus, the

“[e]qual protection analysis in the Fifth Amendment area is the same as that under the Fourteenth Amendment.” *Buckley v. Valeo*, 424 U.S. 1, 93 (1976).

To succeed on an equal protection claim, a plaintiff must “demonstrate that he was treated differently than similarly situated individuals and that the [government’s] explanation does not satisfy the relevant level of scrutiny.” *Settles v. U.S. Parole Comm’n*, 429 F.3d 1098, 1102 (D.C. Cir. 2005). Where, as here, an equal protection claim does not involve a suspect class, the court applies rational basis scrutiny. *See FCC v. Beach Commc’ns., Inc.*, 508 U.S. 307, 313 (1993) (noting that government actions “must be upheld against equal protection challenge if any reasonably conceivable state of facts could provide a rational basis for the classification”). “Review of an equal protection claim in the context of agency action is similar to that under the APA ... [that is,] the only question is whether ... treatment of [the plaintiff] was rational (i.e., not arbitrary and capricious).” *Nazareth Hosp. v. Sec’y. U.S. Dep’t of Health and Hum. Servs.*, 747 F.3d 172, 180 (3d Cir. 2014); *see also Cooper Hosp./Univ. Med. Ctr. v. Burwell*, 179 F.Supp. 3d 31, 47 (D.D.C. 2016). The Supreme Court has cautioned that where there are “plausible reasons” for Congress’ action, “our inquiry is at an end.” *Beach Commc’ns, Inc.*, 508 U.S. at 313-14 (citations omitted).

Two courts considering equal protection challenges to Medicaid plans found that reimbursing out-of-state hospitals for Medicaid care at a lower base rate than in-state hospitals violated the Equal Protection Clause. *See W. Va. Univ. Hosps., Inc. v. Casey*, 701 F. Supp. 496, 520 (M.D. Pa. 1988), *rev’d in part on other grounds* by 885 F.2d 11 (3d Cir. 1989), *rev’d in part on other grounds* by 499 U.S. 83 (1991); *Children’s Hosp. & Med. Ctr. v. Bonta*, 97 Cal. App. 4th 740, 771 (Cal. Ct. App. 2002). Another court found

that distributing trauma DSH payments solely to in-state hospitals violated the Equal Protection Clause. *Rendell*, No. 1:CV-06-0082, 2007 WL 3274409, at *8. But these decisions are inapplicable here because none involve a supplemental payment based on a provider tax.

In *Rendell*, the court held that a border hospital was similarly situated to in-state hospitals and that the state's proffered justification—improvement of access to trauma care for Pennsylvania residents—was not rationally related to denying the trauma DSH payment to out-of-state hospitals. *Id.* Notably, none of the hospitals in *Rendell*—in-state or out-of-state—paid a fee connected to the trauma DSH payments. While the QAF and DSH programs here are similar, the QAF program obtains matching funds through fees, whereas DSH programs, like the one in *Rendell*, obtain matching funds through intergovernmental transfers. Compl. ¶ 64. Plaintiffs are not similarly situated to the California hospitals receiving the QAF subsidy because they do not pay the QAF fee. SPA 19-0018 CMS Approval Letter, 00005, A.R.J.A.

Plaintiffs point out that paying the QAF fee is not a prerequisite for receiving a QAF subsidy, as forty “non-designated public hospitals” and twenty-six “designated public hospitals” in California receive QAF funds but are exempt from QAF fees. Pls.’ Statement of Facts, ECF No. 37-2 at 3. Plaintiffs claim that they are similarly situated to those hospitals, ECF No. 37-1 at 37, but the California hospitals that are exempt from the QAF fees and receive the subsidy are “small and rural hospitals.” SPA 19-0018 CMS Approval Letter, 00005, A.R.J.A. In its review process, CMS considered whether border hospitals should receive the QAF subsidy and concluded that they would be “not likely to meet th[e] definition” of “small and rural hospitals as defined in Section 124840 of the California Health and Safety Code” “even if they were in fact located

in California.” *Id.* Consequently, Plaintiffs are not similarly situated to the California hospitals receiving the QAF subsidy without paying the fee because they would not meet the standard for exemption even if they were in the state.

Defendants also provided a rational basis for deciding to exclude out-of-state hospitals from the QAF program. The Department found it “reasonable for the California Legislature to prioritize in-state private hospitals for receipt of supplemental payments based on where the bulk of utilization is taking place and for purposes of a specialized revenue source.” SPA 19-0018 Asante Answers, 00549, A.R.J.A. Indeed, although Plaintiffs emphasized the number of Medi-Cal patients they serve, they did not indicate how that number compared to the overall Medi-Cal population. In contrast, the Department found that “border hospital utilization by Medi-Cal beneficiaries is still relatively de minimis compared to in-state private hospital utilization.” *Id.* Given that the border hospitals and the in-state hospitals are not similarly situated, and the Department provided a rational basis for the QAF program, the program does not violate the Equal Protection Clause.

IV. CONCLUSION

For the reasons set forth above, the court will **DENY** Plaintiffs’ Motion for Summary Judgment and **GRANT** Defendants’ Cross Motion for Summary Judgment.

Date: February 14, 2023

Tayna S. Chutkan
TANYA S. CHUTKAN
United States District Judge

55a

APPENDIX C

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Case No. 20-cv-601 (TSC)

ASANTE, ET AL.,

Plaintiffs,

v.

ALEX M. AZAR II, Secretary,
U.S. Department of Health
and Human Services, *et al.*,

Defendants.

Filed February 14, 2023

ORDER

For the reasons set forth in the accompanying Memorandum Opinion, ECF No. 50, the court hereby **DENIES** Plaintiffs' Motion for Summary Judgment, ECF No. 37, and **GRANTS** Defendants' Cross Motion for Summary Judgment, ECF No. 42.

Date: February 14, 2023

Tayna S. Chutkan
TANYA S. CHUTKAN
United States District Judge

57a

APPENDIX D

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 23-5055

ASANTE, ET AL.,

Appellants,

v.

ROBERT F. KENNEDY, JR.,
in his official capacity, Secretary, Department
of Health and Human Services, et al.

Appellees.

Filed July 17, 2025

Before: Srinivasan, Chief Judge,
Katsas and Childs, Circuit Judges

ORDER

Upon consideration of appellants' petition for panel
rehearing filed on May 19, 2025, it is

ORDERED that the petition be denied.

Per Curiam

FOR THE COURT:

Clifton B. Cislak, Clerk

BY: /s/

Daniel J. Reidy

Deputy Clerk

59a

APPENDIX E

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 23-5055

ASANTE, ET AL.,

Appellants,

v.

ROBERT F. KENNEDY, JR.,
in his official capacity, Secretary, Department
of Health and Human Services, et al.

Appellees.

Filed July 17, 2025

Before: Srinivasan, Chief Judge; Henderson,
Millett, Pillard, Wilkins, Katsas, Rao, Walker,
Childs, Pan, and Garcia, Circuit Judges

ORDER

Upon consideration of appellants' petition for rehearing en banc, the response thereto, and the absence of a request by any member of the court for a vote, it is

ORDERED that the petition be denied.

Per Curiam

FOR THE COURT:

Clifton B. Cislak, Clerk

BY: /s/

Daniel J. Reidy

Deputy Clerk

APPENDIX F

RELEVANT STATUTES AND REGULATIONS

42 U.S.C. § 1396a(a)(16)

§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

* * *

(16) provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions (conforming to such regulations) with respect to the furnishing of medical assistance under the plan to individuals who are residents of the State but are absent therefrom;

* * *

42 U.S.C. § 1396b(a)(1)

§ 1396b. Payment to States

(a) Computation of amount

From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this subchapter, for each quarter, beginning with the quarter commencing January 1, 1966—

(1) an amount equal to the Federal medical assistance percentage (as defined in section 1396d(b) of this title, subject to subsections (g) and (j) of this section and section 1396r-4(f) of this title) of the total amount expended during such quarter as medical assistance under the State plan; plus

* * *

62a

42 U.S.C. § 1396b(w)(4)(B)

§ 1396b. Payment to States

* * *

(w) Prohibition on use of voluntary contributions, and limitation on use of provider-specific taxes to obtain Federal financial participation under Medicaid

(4) For purposes of paragraph (1)(A)(iii), there is in effect a hold harmless provision with respect to a broad-based health care related tax imposed with respect to a class of items or services if the Secretary determines that any of the following applies:

* * *

(B) All or any portion of the payment made under this subchapter to the taxpayer varies based only upon the amount of the total tax paid.

* * *

42 U.S.C. § 1396b(bb)(1)(B)(iv)

§ 1396b. Payment to States

* * *

(bb) Supplemental payment reporting requirements

(1) Collection and availability of supplemental payment data

* * *

(B) Requirements

Each report submitted by a State in accordance with the requirement established under subparagraph (A) shall include the following:

* * *

(iv) An assurance that the total Medicaid payments made to an inpatient hospital provider, including the supplemental payment, will not exceed upper payment limits.

42 U.S.C. § 1396d(a)

§ 1396d. Definitions

For purposes of this subchapter—

(a) Medical assistance

The term “medical assistance” means payment of part or all of the cost of the following care and services or the care and services themselves, or both (if provided in or after the third month before the month in which the recipient makes application for assistance or, in the case of medicare cost-sharing with respect to a qualified medicare beneficiary described in subsection (p)(1), if provided after the month in which the individual becomes such a beneficiary) for individuals, and, with respect to physicians’ or dentists’ services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title) not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI, who are—

* * *

Cal. Welf. & Inst. Code § 14169.50

§ 14169.50. Legislative findings and declarations

The Legislature finds and declares all of the following:

(a) The Legislature continues to recognize the essential role that hospitals play in serving the state's Medi-Cal beneficiaries. To that end, it has been, and remains, the intent of the Legislature to improve funding for hospitals and obtain all available federal funds to make supplemental Medi-Cal payments to hospitals.

(b) It is the intent of the Legislature that funding provided to hospitals through a hospital quality assurance fee be continued with the goal of increasing access to care and improving hospital reimbursement through supplemental Medi-Cal payments to hospitals.

(c) It is the intent of the Legislature to recognize the fundamental structure of the components used to develop a successful hospital quality assurance fee program.

(d) It is the intent of the Legislature to impose a quality assurance fee to be paid by hospitals, which would be used to increase federal financial participation in order to make supplemental Medi-Cal payments to hospitals, and to help pay for health care coverage for low-income children.

(e) The State Department of Health Care Services shall make every effort to obtain the necessary federal approvals to implement the quality assurance fee described in subdivision (d) in order to make supplemental Medi-Cal payments to hospitals.

(f) It is the intent of the Legislature that the quality assurance fee be implemented only if all of the following conditions are met:

(1) The quality assurance fee is established in consultation with the hospital community.

(2) The quality assurance fee, including any interest earned after collection by the department, is deposited into segregated funds apart from the General Fund and used exclusively for supplemental Medi-Cal payments to hospitals, direct grants to public hospitals, health care coverage for low-income children, and for the department's direct costs of administering the program.

(3) No hospital shall be required to pay the quality assurance fee to the department unless and until the state receives and maintains federal approval of the quality assurance fee and related supplemental payments to hospitals.

(4) The full amount of the quality assurance fee assessed and collected remains available only for the purposes specified by the Legislature in this article.

Cal. Welf. & Inst. Code § 14169.54(a)

§ 14169.54. Private hospital outpatient services; supplemental payments

(a) Private hospitals shall be paid supplemental amounts for each subject fiscal quarter in a program period for the provision of hospital outpatient services as set forth in this section. The supplemental amounts shall be in addition to any other amounts payable to hospitals with respect to those services and shall not affect any other payments to hospitals. The supplemental amounts shall result in payments equal to the statewide aggregate upper payment limit for private hospitals for each subject fiscal year.

* * *

Cal. Welf. & Inst. Code § 14169.55(a)**§ 14169.55. Private hospital inpatient services; supplemental payments**

(a) Private hospitals shall be paid supplemental amounts for the provision of hospital inpatient services for each subject fiscal quarter in a program period as set forth in this section. The supplemental amounts shall be in addition to any other amounts payable to hospitals with respect to those services and shall not affect any other payments to hospitals. The inpatient supplemental amounts shall result in payments to hospitals that equal the applicable federal upper payment limit for the subject fiscal year, except that with respect to a subject fiscal year that begins before the start of a program period or that ends after the end of the program period for which the payments are made, the inpatient supplemental amounts shall result in payments to hospitals that equal a percentage of the applicable upper payment limit where the percentage equals the percentage of the subject fiscal year that occurs during the program period.

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42 C.F.R. § 431.52**§ 431.52 Payments for services furnished out of State.**

(a) *Statutory basis.* Section 1902(a)(16) of the Act authorizes the Secretary to prescribe State plan requirements for furnishing Medicaid to State residents who are absent from the State.

(b) *Payment for services.* A State plan must provide that the State will pay for services furnished in another State to the same extent that it would pay for services furnished within its boundaries if the services are furnished to a

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beneficiary who is a resident of the State, and any of the following conditions is met:

- (1) Medical services are needed because of a medical emergency;
- (2) Medical services are needed and the beneficiary's health would be endangered if he were required to travel to his State of residence;
- (3) The State determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other State;
- (4) It is general practice for beneficiaries in a particular locality to use medical resources in another State.

(c) *Cooperation among States.* The plan must provide that the State will establish procedures to facilitate the furnishing of medical services to individuals who are present in the State and are eligible for Medicaid under another State's plan.

42 C.F.R. § 436.403(a)

§ 436.403 State residence.

(a) *Requirement.* The agency must provide Medicaid to eligible residents of the State, including residents who are absent from the State. The conditions under which payment for service is provided to out-of-State residents are set forth in § 431.52 of this chapter.

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42 C.F.R. § 447.272(b)(1)

§ 447.272 Inpatient services: Application of upper payment limits.

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(b) *General rules.*

(1) Upper payment limit refers to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles in subchapter B of this chapter.

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42 C.F.R. § 447.321(b)(1)

§ 447.321 Outpatient hospital and clinic services: Application of upper payment limits.

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(b) *General rules.*

(1) Upper payment limit refers to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles in subchapter B of this chapter.

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