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**In the  
Centers for Medicare and Medicaid Services**

**IN RE INDIANA STATE  
PLAN AMENDMENT 11-011**

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**On Petition for Reconsideration of  
Disapproval of SPA 11-011**

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**PRE-HEARING MEMORANDUM OF  
THE INDIANA OFFICE OF MEDICAID POLICY AND PLANNING  
IN SUPPORT OF ITS PETITION FOR RECONSIDERATION**

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## STATEMENT OF THE ISSUE

As formulated by CMS, the issue here is “[w]hether SPA 11-011 complies with section 1902(a)(23) of the Act.” Exhibit 3 at 1.

### FACTUAL AND PROCEDURAL BACKGROUND

1. The Indiana General Assembly passed, and on May 10, 2011, Governor Mitch Daniels signed into law, House Enrolled Act 1210, Section 1 of which disqualifies abortion providers from State contracts and grants, including those that distribute federal funds. House Enrolled Act 1210, Pub. L. No. 193-2011, Sec.1, (codified at Ind. Code § 5-22-17-5.5). Specifically, the law provides that “[a]n agency of the state may not . . . enter into a contract with . . . or make a grant to[] any entity that performs abortions or maintains or operates a facility where abortions are performed that involves the expenditure of state funds or federal funds administered by the state.” Ind. Code § 5-22-17-5.5(b). The law does not apply to hospitals or ambulatory surgical centers licensed under Indiana Code section 16-21-2, but it does operate, in practical effect, to preclude other abortion service providers from qualifying for Medicaid payments. Ind. Code § 5-22-17-5.5(a).

A State participating in Medicaid must file a state plan amendment with the Centers for Medicare and Medicaid Services whenever the State enacts a “[m]aterial change[] in State law, organization, or policy” respecting Medicaid. 42 C.F.R. § 430.12(c)(1)(ii). On May 13, 2011, the Indiana Office of Medicaid Policy and Planning (“OMPP”), acting pursuant to 42 C.F.R. § 430.12(c)(1)(ii), submitted such a plan amendment (SPA 11-011) to take account of HEA 1210’s exclusion of

providers that perform abortion services from government contracts, including Medicaid.

On June 1, 2011, CMS Administrator Donald M. Berwick sent a letter informing OMPP that he was “unable to approve” SPA 11-011 on the grounds that “Medicaid programs may not exclude qualified health care providers from providing services that are funded under the program because of a provider’s scope of practice.” Exhibit 1 at 1. Contemporaneously, CMS disseminated an “Informational Bulletin” to Indiana and other states asserting, with no citation to authority, that “Medicaid programs may not exclude qualified health care providers . . . from providing services under the program because they separately provide abortion services . . . as part of their scope of practice.” Exhibit 2 at 1-2.

Meanwhile, Planned Parenthood of Indiana (“PPIN”), whose limited patient services include abortions, family planning, and cancer screenings, filed suit in United States District Court for the Southern District of Indiana seeking to enjoin enforcement of HEA 1210’s contract qualification provision as applied to multiple federal programs, including Medicaid. Compl. at 2 (May 10, 2011), *available at* 2011 WL 2438816.<sup>1</sup> On June 24, 2011, the District Court filed its Entry on Motion for Preliminary Injunction, enjoining Defendants from enforcing the contract qualification provision. *Planned Parenthood, Inc. v. Comm’r of the Ind. State Dep’t*

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<sup>1</sup> All citations to District Court filings refer to *Planned Parenthood, Inc. v. Comm’r of the Ind. State Dep’t of Health*, 2011 WL 2532921 (S.D. Ind. 2011) (No. 1:11-cv-630-TWP-TAB), *appeal docketed*, No. 11-2464 (7th Cir. June 29, 2011).

*of Health*, 2011 WL 2532921 (S.D. Ind. 2011), *appeal docketed*, No. 11-2464 (7th Cir. June 29, 2011).

The State has pursued appeals of both the preliminary injunction and, here, CMS's disapproval of SPA 11-011. The State and PPIN, as well as the United States, have filed briefs in the Seventh Circuit relating to the preliminary injunction, and oral argument has been set for October 20, 2011. Meanwhile, following administrative rules, the State submitted a request for reconsideration of its SPA disapproval to CMS. *See* 42 C.F.R. §§ 430.16(a)(1), 430.18(a). CMS denied the request, again stating that “[i]t is not consistent with section 1902(a)(23) for Medicaid programs to exclude qualified health care providers from providing services that are funded under the program because of a provider’s scope of practice.” Exhibit 3 at 1. This denial triggered a formal administrative review hearing, which has been set for December 15, 2011, and briefing from the parties. Assuming that CMS does not approve SPA 11-011, Indiana has a right to appeal to the United States Court of Appeals for the Seventh Circuit. 42 C.F.R. §§ 430.38, 430.102(c).

2. The objective of HEA 1210, Section 1, is to prevent indirect taxpayer subsidy of abortion. Medicaid covers many medical services, but not abortion, except where the mother’s life is in danger or where the pregnancy resulted from rape or incest. *See* Omnibus Appropriations Act of 2009, Pub. L. No. 111-8, §§ 507-08, 123 Stat. 524, 802-03 (2009) (enacting H.R. 1105) (the “Hyde Amendment”); Ind. Code §§ 12-15-5-1(17), 16-34-1-2; 405 Ind. Admin. Code 5-28-7. Yet, according to Dr.

George Wilson, Assistant Professor of Accounting at Butler University, when an abortion provider also supplies other medical services, any Medicaid payments it receives for non-abortion services support the operation as a whole—including, among other things, the cost of facilities, staffing, and utilities—and so indirectly subsidizes its abortion operation. *See* Exhibit 15 at ¶ 12 (“Medicaid subsidies for any services supply the required revenue for an entire organization when commingled with an organization’s other funds.”).<sup>2</sup> Because money is fungible, taxpayer money is functionally used to support abortions whenever the State pays money to an entity that performs abortions. Even when a taxpayer subsidy is designated exclusively for non-abortion services, it frees resources that would otherwise have been used for those non-abortion services and makes them available for abortions.

What is more, Medicaid reimbursements for particular services or procedures are not determined by the allocation of specific costs to the provider for providing that service. *See* Exhibit 15 at ¶ 11; 405 Ind. Admin. Code 1-1-3. To begin, there is no cost allocation accounting model that can definitively prevent payments for one service from cross-subsidizing another service provided by the same entity. *See* Exhibit 15 at ¶ 17 (“With the various number of acceptable cost allocation methodologies which yield differing results there is no way to exactly attribute costs

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<sup>2</sup> Both the Declaration of Martin J. Birr, Exhibit 4, and the Declaration of Dr. George Wilson, Exhibit 15, refer to PPIN’s audited financial statements, so for ease of reference, the financial statements are included as Exhibits 5 and 6 instead of as attachments to the Declarations.

to particular services . . . .”) (citing Shyam Sunder, *Simpson’s Reversal Paradox and Cost Allocation*, 21 J. Acct. Res. 222, 222-23 (1983)). Especially when there is no specific cost allocation model and no tracking of costs associated with payable Medicaid services whatever, Medicaid funds inherently cover some portion of the costs of other services, such as abortion, which are not properly payable under Medicaid laws and regulations. *See* Exhibit 4 at ¶ 19; Exhibit 15 at ¶ 19.

The practices of PPIN underscore the Indiana General Assembly’s concerns about indirect subsidy of abortion. PPIN’s audited financial statements for 2009 and 2010 give rise to a reasonable inference that it commingles Medicaid reimbursements with other revenues it receives. *See* Exhibit 5 at 21; *see also* Exhibit 6 at 22. Those financial statements provide no record that PPIN makes any effort either to segregate Medicaid reimbursements from other unrestricted revenue sources or to allocate the costs of its various lines of business, whether abortion, family planning, cancer screenings, or other services. *See* Exhibits 4-6, 15.

In particular, note thirteen of the 2010 audit identifies seven sources of restricted federal funding by title or grant name, but does not mention Medicaid. *See* Exhibit 6 at 19. Instead, Medicaid, as a revenue line, is shown with other unrestricted sources of income in the audit report’s Consolidating Schedule—Statement of Activities Information, between patient fees and donations and net investment income. *See* Exhibit 6 at 19. This indicates that, while PPIN may not receive Medicaid reimbursements related directly to abortions (as federal and state laws generally prohibit), the Medicaid reimbursements it does receive for other

services are pooled or commingled with other monies it receives and thus help pay for total operational costs, such as management, personnel, facilities, equipment, and other overhead, thus subsidizing PPIN's abortion business. See Exhibit 4 at ¶ 19; Exhibit 15 at ¶ 19.

Based on these financial statements, Martin J. Birr, CPA and Trustee Lecturer in Accounting at the Indiana University Kelley School of Business, testified in PPIN's district court case that "one could conclude that Medicaid revenues in effect subsidize PPI's abortion services indirectly." Exhibit 4 at ¶ 19. Dr. George Wilson agrees, concluding that, "given PPIN's mix of services, the process for calculating PPIN's Medicaid payments, and PPIN's apparent lack of any rigorous cost allocation system, there is a significant probability that Medicaid payments to Planned Parenthood cross-subsidize its abortion services." Exhibit 15 at ¶ 19.

In this regard it is worth noting that, while Indiana has argued throughout its federal court litigation against PPIN that Medicaid cross-subsidy of abortion occurs, PPIN has never refuted the notion or even suggested that it uses some sort of financial master control document to prevent indirect funding of abortion.

3. Under HEA 1210, Medicaid providers that perform abortion services have a choice: they may either cease performing abortions or cease being Medicaid providers. Because enforcement of HEA 1210 has been preliminarily enjoined by a

federal district court (improperly, in the State’s view), no one knows which route Indiana’s Medicaid providers that provide abortion services would choose.<sup>3</sup>

In this regard, it is significant that on June 15, 2011, the Indiana Family and Social Services Administration (“FSSA”) issued a Notice of Intent to Adopt a Rule that will clarify that HEA 1210’s reference to “any entity that performs abortions or maintains or operates a facility where abortions are performed,” in Indiana Code section 5-22-17-5.5(b)(2), “does *not* include a separate affiliate of such entity, if the entity does not benefit, even indirectly, from government contracts or grants awarded to the separate affiliate.” Exhibit 8 (emphasis added). In the wake of the District Court’s injunction against enforcement of HEA 1210, however, FSSA has proceeded no further with its rulemaking efforts. But if HEA 1210 becomes fully enforceable, PPIN’s resolution of how to manage its affairs will no doubt be informed by the terms of FSSA’s proposed rule. It may be that the affiliation solution will prove workable enough that PPIN, either itself or through an affiliate

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<sup>3</sup> The short-term conduct of Indiana’s largest abortion provider, PPIN, does not reasonably give rise to inferences about what it might do if the law were enforceable over the long term. During most of the brief period when the law was in effect, PPIN received enough private donations that it was able both to provide abortions and see Medicaid patients. Pls.’ Reply Br. at 19 (June 2, 2011), *available at* 2011 WL 2447450 (citing Supp. Decl. of Betty Cockrum, ¶¶ 4-6). PPIN did stop seeing Medicaid patients for four days—between June 21 and June 24—as it waited on the preliminary injunction ruling. *See* Heather Gillers, *Stopgap Funds for Clinics Run Out*, Indianapolis Star, June 21, 2011, at B1, *available at* 2011 WLNR 12349044. Based on the preliminary injunction, Indiana has paid valid Medicaid claims for PPIN’s covered services even during that brief period when HEA 1210 was enforced. *See* Exhibit 7. This brief experience with enforcement of HEA 1210 does not reveal how PPIN would manage its affairs over the long term if HEA 1210 were to be enforced.

that does not provide or subsidize abortions, will continue being a Medicaid provider notwithstanding HEA 1210.

4. Even without providers that perform abortion services such as Planned Parenthood in the Medicaid program, Medicaid beneficiaries seeking family planning services in Indiana could choose from among approximately 800 other Medicaid providers that have historically billed for family planning services and are located in the counties where Planned Parenthood currently has clinics. Exhibit 9 at 1-2. For example, Marion County (Indiana's largest county) has 192 other providers, and there are 118 in Lake County (second largest), 71 in St. Joseph County and 63 in Allen County. Exhibit 9 at 1-2. Thus, SPA 11-011 does not deprive Medicaid beneficiaries of the opportunity to obtain family planning services from an otherwise qualified provider. At most, it could lead to a small reduction of available Medicaid providers that provide family planning services in any particular geographic area, leaving patients with an abundance of choices.

#### **SUMMARY OF THE ARGUMENT**

It has long been a tenet of Supreme Court doctrine that, out of respect for State sovereignty and the Tenth Amendment, conditions on federal funding to States must be unambiguous. *See Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981). This is a particularly important principle when it comes to applying Medicaid, which provides States with “flexibility in designing plans that meet their individual needs” and allows States “considerable latitude in formulating

the terms of their own medical assistance plans.” *Addis v. Whitburn*, 153 F.3d 836, 840 (7th Cir. 1998).

Administrator Berwick’s letter rejecting Indiana’s plan amendment invoked the free-choice plan requirement only in the most general terms, and made no mention of the State’s authority under Section 1396a(p)(1) to determine provider qualifications. *See* Exhibits 1, 3. The textual and structural limits of the free-choice provision, along with the State’s authority over provider qualifications and the general existence of many other provider qualifications around the country that inherently reduce patient choice, all render the rejection of Indiana’s plan amendment contrary to law. Particularly in the context of State-enacted provider qualifications authorized by 42 U.S.C. § 1396a(p)(1), the “free-choice” plan requirement of Section 1396a(a)(23) is anything but unambiguous, and thus it cannot be the basis for rejecting SPA 11-011.

Approval of SPA 11-011 is especially warranted in light of the fact that Indiana has not yet been allowed to enforce HEA 1210 for a meaningful period of time. There is simply no data concerning the actual impact of HEA 1210 on patient choice. While Indiana’s largest abortion provider, PPIN, claims it would cease being a Medicaid provider if HEA 1210 were permitted to go into effect, it has yet to be confronted with that choice over the long term. Furthermore, the Indiana Family and Social Services Administration has issued a notice of proposed rulemaking that might facilitate PPIN’s continued participation in Medicaid, so long as its Medicaid payments do not subsidize an affiliated abortion provider. *See* Exhibit 8.

And regardless of PPIN's ultimate decision whether to participate in Medicaid under HEA 1210, in counties where PPIN has clinics, over 800 other Medicaid providers who have in the past provided family planning services remain. This means that, under SPA 11-011, there would still be abundant patient choice among family planning service providers.

## ARGUMENT

### **The Free-Choice Plan Requirement Does Not Preclude States From Disqualifying Providers that Perform Abortion Services From Medicaid in Order to Prevent Indirect Taxpayer Subsidy of Abortion**

#### **A. Funding restrictions imposed on States must be “unambiguous”**

Decades ago, the Supreme Court established a principle of interpreting federal funding programs that is critically important here: “if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously.” *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981). The rationale for the clear-statement rule, which is analogous to doctrine applicable to statutory abrogations of sovereign immunity, lies in the respect owed to State sovereignty and the ability of States to guard against unwitting accessions to federal power. “The legitimacy of Congress’ power to legislate under the spending power thus rests on whether the State voluntarily and knowingly accepts the terms of the ‘contract.’” *Id.*

The clear-statement rule applies with equal force when a federal agency determines in the first instance whether a particular condition exists. *See Com. of Va., Dep’t of Educ. v. Riley*, 106 F.3d 559, 566 (4th Cir. 1997) (en banc). In *Riley*,

the en banc Fourth Circuit rejected the Department of Education’s interpretation of the Individuals with Disabilities in Education Act (“IDEA”) to impose on States an obligation to educate expelled handicapped students.<sup>4</sup> Specifically, the court addressed whether the IDEA statutory text, which requires States to “ha[ve] in effect a policy that assures all children with disabilities the right to a free appropriate public education,” 20 U.S.C. § 1412(1), unambiguously required states to provide tutors to handicapped students who had been expelled for reasons unrelated to their disability. *Riley*, 106 F.3d at 566. A literal reading of that text, the court ruled, at most *implied* such a condition, and implied conditions do not meet the clear statement rule. *Id.* The clear statement rule applies, the court observed, “not simply in determining whether a statute applies to the States, but also in determining whether the statute applies in the particular manner claimed.” *Id.* at 568 (citing *Gregory v. Ashcroft*, 501 U.S. 452, 460-70 (1991)).

Critically, in rebutting the argument that the federal agency’s interpretation of IDEA’s obligations was entitled to deference, the Fourth Circuit said “[i]t is axiomatic that statutory ambiguity defeats altogether a claim by the Federal Government that Congress has unambiguously conditioned the States’ receipt of federal monies in the manner asserted.” *Id.* at 567. Accordingly, CMS may not

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<sup>4</sup> Congress later amended IDEA to require States to provide educational services to disabled children expelled from school for misconduct unrelated to their disabilities, but the “subsequent amendment . . . in no way undermines the reasoning of *Riley*.” *Amos v. Maryland Dept. of Pub. Safety & Corr. Services*, 126 F.3d 589, 603 n.8 (4th Cir. 1997) *cert. granted in part, judgment vacated*, 524 U.S. 935 (1998).

impose any spending condition on Indiana unless it is unambiguously imposed by the Medicaid statute itself. The broad “free choice of provider” provision relied on by CMS does not unambiguously preclude Indiana from enforcing a provider qualification that might have the incidental effect of reducing the pool of available providers.

**B. The free-choice plan requirement does not unambiguously limit State authority to set provider qualifications**

Section 1396a(a)(23) cannot properly be understood to preclude a State provider qualification directed at the financial integrity of Medicaid that happens to have the collateral effect of slightly reducing patient choice. Indeed, if that is what Section 1396a(a)(23) stands for, *every* provider qualification would be in jeopardy, since keeping even one provider outside the Medicaid program inevitably limits some beneficiary’s free choice.

1. One cannot read Section 1396a(a)(23) and know that States may not impose provider qualifications unrelated to restricting patient choice that incidentally happen to reduce patient choice by a small amount. Such a reading of Section 1396a(a)(23) would represent a serious restriction on the exercise of State prerogatives concerning qualifications to practice various medical professions (which in turn are predicates for Medicaid provider eligibility). If Congress intended such a restriction, it would surely have spelled out that desire in unmistakable detail. *Cf. Riley*, 106 F.3d at 566. It did not do so, however, and inferring a restriction against rules that only incidentally affect patient choice is

improper. *See Kelly Kare, Ltd. v. O'Rourke*, 930 F.2d 170, 177-78 (2d Cir. 1991) (permitting Medicaid administrators to exclude previously qualified providers notwithstanding Section 1396a(a)(23)).

The key to understanding the free-choice plan requirement is to recognize that it presupposes *qualified* providers. That is, a Medicaid plan must allow a beneficiary to receive care from a provider “qualified to perform the service.” 42 U.S.C. § 1396a(a)(23). The Supreme Court has said that the free-choice plan requirement speaks only to providers that “continue[] to be qualified” in the Medicaid program. *O'Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773, 785 (1980).

Based on *O'Bannon*, the Second Circuit in *Kelly Kare, Ltd. v. O'Rourke*, 930 F.2d 170 (2d Cir. 1991), held that, notwithstanding Section 1396a(a)(23), Westchester County, New York's Medicaid administrator could unilaterally end a contract with a Medicaid provider without cause. *Id.* at 177-78. Regardless of the reason for the county's refusal to execute a provider agreement (*i.e.*, regardless whether it related to provider “qualifications” or some other barrier to entry), Medicaid recipients were not able to obtain Medicaid-reimbursed services from Kelly Kare. *Id.* Yet, the court ruled, such lost choice was only an “incidental burden on their right to choose” under Section 1396a(a)(23). *Id.* at 178. According to the court, “Medicaid's freedom of choice provision is not absolute.” *Id.* at 177. It provides at most that a State plan must afford the right to choose among providers who have been able to enter the market. *See id.* at 178.

Continuing with this logic, the Seventh Circuit has held that Section 1396a(a)(23) is meant “to give the recipient a choice among available facilities, not to require the creation or authorization of new facilities.” *Bruggeman ex rel. Bruggeman v. Blagojevich*, 324 F.3d 906, 911 (7th Cir. 2003) (citing *O’Bannon*, 447 U.S. at 785-86; *Kelly Kare*, 930 F.2d at 177). If the free-choice plan requirement does not “require the . . . authorization of new facilities,” *id.*, then implicitly it does not require the continuing authorization of existing facilities that fail to meet new qualification requirements.

To be sure, there are circumstances where courts have found violations of the free-choice plan requirement, but only where the State rules in question eliminated all choice whatever. For instance, the State of Louisiana was not allowed to force school-aged children to seek services at their respective schools, as opposed to an independent provider. *Chisholm v. Hood*, 110 F. Supp. 2d 499, 506 (E.D. La. 2000). In another instance, the City of New York was enjoined from implementing a program by which Medicaid eligible providers bid for *exclusive* contracts to serve a borough of the city. *Bay Ridge Diagnostic Lab. Inc. v. Dumpson*, 400 F. Supp. 1104, 1105, 1108 (E.D.N.Y. 1975). The program would have created only one provider for each borough and prohibited beneficiaries from seeking services from any other provider. *Id.* at 1105.

By stark contrast, SPA 11-011 does not limit Medicaid recipients to one or even a few providers. Unlike the laws at stake in *Chisholm* and *Bay Ridge*, SPA 11-011 is neither targeted at reducing choice, nor limits options of care *within* the

sphere of State Medicaid-qualified providers. Rather than clearing the entire market of choices and competitors, HEA 1210 at most results in a small *collateral* reduction in provider choice, which of course is a common occurrence in such a highly regulated system as the practice of medicine. *See, e.g., Number of Nursing Facilities*, statehealthfacts.org, <http://www.statehealthfacts.org/comparetrend.jsp?cat=8&sort=a&sub=97&yr=92&typ=1&ind=411&srgn=16> (showing that the total number of Medicaid-certified nursing facilities in Indiana varied from year to year with a high of 506 and a low of 468 in the years between 2003 and 2009). Medicaid providers who run afoul of myriad laws and regulations may not even be able to practice medicine at all, let alone do so at taxpayer expense, yet no one would claim that such incidental impact on patient choice runs afoul of the free-choice provision.

2. Next, there is simply insufficient experience under HEA 1210 to draw any conclusions about whether it would yield fewer Medicaid providers. There is nothing in the text or structure of HEA 1210 that leads to the inevitable conclusion that the number of Medicaid providers will necessarily decline when it is fully implemented, and it is entirely possible that Medicaid providers that perform abortion services may, once the statute is fully implemented, cease providing abortions rather than cease providing Medicaid services.

Inferring that reduction in providers will necessarily follow from HEA 1210 is especially suspect in light of FSSA's proposed promulgation of a rule that would permit Medicaid providers to affiliate with abortion providers, as long as there is no opportunity for Medicaid to cross-subsidize abortions. *See Exhibit 8; cf. Rust v.*

*Sullivan*, 500 U.S. 173, 196 (1991) (observing that Title X grantees were free to provide abortion referrals and services, as long as it kept that practice “separate and distinct” from its federally-funded family planning practice).

Indeed, Planned Parenthood has already separated its abortion services into a separate affiliated entity in Texas in response to a similar law enacted several years ago. *See Planned Parenthood of Houston and Se. Texas v. Sanchez*, 403 F.3d 324, 342 (5th Cir. 2005) (upholding a Texas law excluding entities that perform abortions from receiving Title X funds, and noting that “[w]hile creating affiliates might entail some time and expense, and might not be the most convenient arrangement, this extra effort alone would not relegate the state statute to preemption”); Texas Department of State Health Services, *DSHS Rider 69 Report: Family Planning Affiliate Requirement 2*, available at <http://www.texas.gov> (showing that the Texas Department of State Health Services funded six contractors that were affiliated with an abortion service provider in Fiscal Year 2010). *See also Planned Parenthood of Mid-Missouri and Eastern Kansas v. Dempsey*, 167 F.3d 458, 463 (8th Cir. 1999) (upholding a Missouri law disqualifying abortion clinics from receiving funds under Title X because recipients could continue “to exercise their constitutionally protected rights through independent affiliates”).

What is more, even if Indiana’s largest abortion provider, PPIN, were to cease being a Medicaid provider, choices would abound for Medicaid patients. In the counties where PPIN has offices, approximately 800 *other* family planning

providers that do not perform abortions would remain available for Medicaid beneficiaries. *See* Exhibit 9. And there is no telling whether additional Medicaid providers might step forward to provide family planning services to serve the market left behind by PPIN.

In short, nothing on the face of HEA 1210 dictates that there must be a reduction in Medicaid providers, much less does it target elimination of all patient choices in an entire field of medicine. Only through actual enforcement of the law, which has been preliminarily enjoined by a federal district court, can anyone know the actual impact of HEA 1210. Accordingly, a decision rejecting Indiana’s plan amendment on the assumption that it will reduce patient choice is premature at best.

**C. The Medicaid Act expressly embraces State authority to establish provider qualifications such as HEA 1210**

SPA 11-011 should also be approved because it implements a provider qualification under 42 U.S.C. § 1396a(p)(1), which provides that “[i]n addition to any other authority, a State may exclude any individual or entity . . . for any reason for which the Secretary could exclude the individual or entity from participation in [Medicare].” 42 U.S.C. § 1396a(p)(1).

1. The letters and interpretive bulletin issued by Administrator Berwick and CMS in response to Indiana’s proposed plan amendment make no effort to reconcile Section 1396a(a)(23) with Section 1396a(p)(1). Exhibits 1-3. Indeed, the documents do not even acknowledge the existence of Section 1396a(p)(1). Instead,

they claim only that that the “SPA would eliminate the ability of Medicaid beneficiaries to receive services from specific providers for reasons unrelated to their *qualifications* to provide such services.” Exhibit 3 at 1 (emphasis added). However, the letters do not explain how SPA 11-011 can be understood as anything other than a “qualification[] to provide [] services” in Indiana, or how other qualifications that also may have the collateral impact of reducing provider choice are valid if this one is not. Exhibit 3.

Legislative history supports Indiana’s understanding that Section 1396a(p)(1) empowers States to establish a wide range of provider qualifications. Senate Report 100-109 shows that Congress intended to protect the State’s authority to exclude providers for reasons other than those granted to the Secretary. It first mentions that Section 1396a(p)(1) affords States the ability to prevent “fraud and abuse” and “to protect the beneficiaries . . . from incompetent practitioners and from inappropriate or inadequate care.” S. Rep. No. 100-109, at 2 (1987). But it unambiguously adds that Section 1396a(p)(1) “is not intended to preclude a State from establishing, under State law, *any other bases for excluding individuals or entities* from its Medicaid program.” *Id.* at 20 (emphasis added).

Furthermore, regulations promulgated by HHS implementing Section 1396a(p)(1) carry forward what the plain text and legislative history of the section already provide—broad State authority over qualifications. HHS has provided that “[n]othing contained in this part [regarding State-initiated exclusions from Medicaid] should be construed to limit a State’s own authority to exclude an

individual or entity from Medicaid for any reason or period authorized by State law.” 42 C.F.R. § 1002.2(b). The Ninth Circuit has said that this regulation means exactly what it says: “not only does the applicable federal statute fail to prohibit states from suspending providers from state health care programs for reasons other than those upon which the Secretary of HHS may act, the governing regulation specifically instructs that states have such authority.” *Guzman v. Shewry*, 552 F.3d 941, 950 (9th Cir. 2009). As with Section 1396a(p)(1) itself, neither Administrator Berwick’s letters rejecting Indiana’s plan amendment nor its interpretive bulletin of June 1, 2011, mentions 42 C.F.R. § 1002.2(b) or attempts to explain why it does not apply.

2. HHS’s broad regulatory interpretation of Section 1396a(p)(1) is supported by federal case law. In *First Medical Health Plan, Inc. v. Vega-Ramos*, 479 F.3d 46 (1st Cir. 2007), the First Circuit interpreted the qualifications authority provided by Section 1396a(p)(1) not as a *limitation* on the power of the State to regulate its Medicaid program, but as a specific *delegation* of power to a State seeking federal contributions to its Medicaid program. The court, citing the legislative history of Section 1396a(p)(1), held that the provision “was intended to permit a state to exclude an entity from its Medicaid program for *any* reason established by state law.” *Id.* at 53.

In another case, the Second Circuit upheld a State’s disqualification of a Medicaid provider who dumped medical waste into a river. *Plaza Health Laboratories, Inc. v. Perales*, 878 F.2d 577, 578-79 (2d Cir. 1989). That

disqualification had nothing to do with providing competent medical care and everything to do with other compelling State objectives, and it no doubt eliminated *some* patient's choice of Medicaid provider.

Indeed, pursuant to Section 1396a(p)(1)'s qualifications authority, States have enacted and enforced many different provider qualifications. In addition to disqualifying providers who pose financial conflicts-of-interest (*Vega-Ramos*) and who illegally dump hazardous waste (*Plaza Health Laboratories*), States disqualify providers who commit fraud (*Guzman*, 552 F.3d at 950) and who fail to keep records in accord with state law (*Triant v. Perales*, 491 N.Y.S.2d 486, 488 (N.Y. App. Div. 1985)).

3. Although it is unclear how CMS interprets “qualifications” other than to exclude SPA 11-011, it is useful to note that Indiana’s decision to disqualify abortion providers would seem to be a valid qualification under the standards set forth by PPIN and the United States in the related federal court litigation.

PPIN has argued that disqualification is proper if the provider fails to “demonstrate[] effectiveness and efficiency in providing” services, Br. of Appellees at 23, *Planned Parenthood, Inc. v. Comm’r of the Ind. State Dep’t of Health*, No. 11-2464 (7th Cir. Aug. 29, 2011), or if the provider demonstrates “incompetent practitioners and inappropriate care . . . [or] programmatic fraud[,]” *id.* at 26, or lack of “integrity or professional competence,” *id.* at 28. PPIN would even permit qualifications that “establish[] and maintain[] health standards[,]” *id.* at 32, presumably to account for the waste-dumping disqualification upheld in *Plaza*

*Health Laboratories*. PPIN also tries to distinguish *Vega-Ramos* as a regulation of “abuse.” *Id.* at 31. PPIN has shown no basis in the statute for any of these limitations, the only common theme of which is that (according to PPIN) they happen to exclude HEA 1210.

Even so, “efficiency” and “abuse” are exactly the problems that HEA 1210 addresses: the inefficiencies and abuses that occur when Medicaid dollars indirectly subsidize abortions not exempt from the Hyde Amendment. If a State can establish provider qualifications as a barrier to spending taxpayer dollars through self-dealing, it can establish provider qualifications as a barrier to indirect taxpayer subsidy of abortions.

The United States argued in the District Court that disqualifications must relate to providers’ “fitness to provide or properly bill for Medicaid services.” Statement of Interest of the U.S. at 10 (June 16, 2011). In the Seventh Circuit it suggested that State qualifications under Section 1396a(p)(1) may also exclude providers who commit “criminal offenses related to the delivery of services or abuse or neglect of patients.” Br. of United States as Amicus Curiae at 15, *Planned Parenthood, Inc. v. Comm’r of the Ind. State Dep’t of Health*, No. 11-2464 (7th Cir. Sept. 6, 2011). It also allowed that State qualifications for Medicaid providers need only be “reasonable,” arriving at this description via a proposed HHS regulation issued nearly a decade before the enactment of Section 1396a(p)(1), which would have allowed States to set “reasonable standards relating to the qualifications of

providers.” *Id.* at 16 (quoting 43 Fed. Reg. 45176, 45189 (Sept. 29, 1978) (codified at 42 C.F.R. § 431.51(d)(2))).

This alone is enough to show that Sections 1396a(a)(23) and 1396a(p)(1) fail to impose “unambiguous” conditions on States that accept federal funds, as required by *Pennhurst*, 451 U.S. at 17.

Even if one were to accept, as a limit on Section 1396a(p)(1) authority, the interpretation suggested by the United States, SPA 11-011 still survives. Neither the United States, nor PPIN, nor the District Court has refuted Indiana’s grounds for enacting HEA 1210—to prevent indirect taxpayer subsidy for abortion and carry out the policies behind the Hyde Amendment. HEA 1210 thus does not exclude providers based on the “scope of practice” for its own sake. Exhibit 3 at 1. It instead ensures that the people’s money does not fund, even indirectly through shared staff salaries or overhead, the practice of abortion. Accordingly, SPA 11-011 fits comfortably within the federal government’s non-textual “billing practices” interpretation of Section 1396a(p)(1), which is also concerned with ensuring that Medicaid reimbursements are issued only for those services properly covered by Medicaid, or its “reasonableness” limitation.<sup>5</sup> Indeed, the United States did not, in its Seventh Circuit brief, argue that HEA 1210 was by any measure “unreasonable.”

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<sup>5</sup> What is more, CMS legitimizes State policing of Medicaid misuse by conducting audits to ensure that States do not use Medicaid to fund ineligible activities. In Pennsylvania, for example, the State legislature decided to direct Medicaid disproportionate share payments to hospitals associated with medical schools in order to support the schools themselves. CMS audited this practice, disapproved of it as a misuse of Medicaid funds, and said that it would not approve future Pennsylvania plan amendments unless it stopped. Exhibit 10 at 1-2. Indiana’s desire to prevent Medicaid from indirectly subsidizing abortion is just as

**D. CMS has approved other SPAs that would reduce recipient choice**

In its letters to the State, CMS appears to be taking the position that provider free choice is an absolute right under Medicaid, even as against rules that only exclude providers, if at all, as a collateral consequence of a qualification directed at a compelling government objective. This cannot be the correct, let alone unambiguous, meaning of Section 1396a(a)(23), as CMS's own actions demonstrate.

In this proceeding the State asked CMS to produce, among other documents, all disapprovals of State plan amendments predicated on Section 1396a(a)(23) going back ten years. Exhibit 11 at 5 (requesting for production “[a]ll formal denials by CMS, from 2001 to present, of proposed State Plan Amendments based on, or referencing as a reason for denial, 42 U.S.C. § 1396a(a)(23) or Section 1902(a)(23) of the Medicaid Act.”). In the State's review of over 7,000 pages that CMS produced, it was able to find only three other disapprovals of SPAs relying on Section 1396a(a)(23), all of which concerned the State of Maryland and none of which bears any similarity to SPA 11-011.

Of those three, two were denied because Maryland had not provided evidence showing that provider certification requirements would yield “sufficient providers” in the State for Functional Family Therapy, Exhibit 16, or Multisystemic Therapy, Exhibit 17. In the third, Maryland would have limited the range of permissible case management providers to state case managers only. Exhibit 18 at 6947, 6978.

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legitimate as CMS's own desire to prevent Medicaid from subsidizing Pennsylvania's medical schools.

Here, Indiana does not require Medicaid patients to seek family planning services from a single source, and indeed has provided evidence that, even if PPIN were not a Medicaid provider, over 800 Medicaid providers who have in the past provided family planning services would remain. Exhibit 9.

These limited, inapposite Section 1396a(a)(23) disapprovals show that CMS apparently does not routinely invoke that section as the basis for rejecting a plan amendment that might happen to cause a slight reduction in the number of providers available to patients.

Indeed, CMS has approved other plan amendments that would undoubtedly reduce patient choice. For example, in 2006, CMS allowed the State to refuse to qualify additional beds for Medicaid in nursing facilities in certain circumstances. See Exhibit 12. This refusal happens to be explicitly permitted by HHS's own regulations, but that only underscores the general view of CMS and HHS that regulations collaterally impacting patient choice find no barrier in Section 1396a(a)(23). See also 42 C.F.R. § 1002.2(b). That is, in relation to Section 1396a(a)(23), there is no principled distinction between a State plan requirement that limits nursing-home beds at otherwise-qualified providers and one that disqualifies providers that perform abortion services; both may preclude some patient's provider choice.

Other approved Medicaid practices deny a recipient's freedom of choice even more directly. The Georgia state plan says that no *individual* providers of Community Mental Health Rehabilitative Services are accepted into its Medicaid

program. Exhibit 13 at 1. This precludes Medicaid patients from choosing providers who wish to maintain solo practices.

CMS permits other limits on patient choice that arrive via accreditation or licensing requirements. For example, CMS approved a Louisiana plan amendment providing that prosthetic and orthopedic service providers must be accredited by either the American Board for Certification in Orthotics, Prosthetics, and Pedorthics, or by the Board for Orthotist/Prosthetist Certification. *See* Exhibit 14; La. Rev. Stat. § 40:1300.281. The American Board, in turn, requires providers to do things such as display all licenses, certificates, and permits to operate the business in an area accessible to the public, adopt a mission statement, perform periodic performance appraisals of its staff, and prohibit smoking in the facility. *See ABC Facility Accreditation Standards*, American Board for Certification in Orthotics, Prosthetics, and Pedorthics, Inc., *available at* <http://www.abcop.org/accreditation/Documents/ABC%20Standards%20FINAL%20203-10-11.pdf>. Such requirements have nothing to do with patient care or billing and would necessarily exclude any non-accredited providers—such as those without a mission statement—from participating in Louisiana’s Medicaid program. Therefore, Medicaid patients would not be able to receive services from those providers.

In fact, there are all kinds of accreditation and licensing requirements that have nothing to do with patient care or financial integrity but that, because they are part of a State’s qualifications to be a Medicaid provider, inevitably lead to a

reduction in patient choice. In Indiana, such requirements include, among other things, restrictions on advertising (845 Ind. Admin. Code 1-6-4) and license display (846 Ind. Admin. Code 1-3-2). Indeed, practitioners can lose their licenses, and thus their Medicaid provider status, by failing to pay child support. *See* Ind. Code § 25-1-1.2-8.

In California, physicians must notify patients that medical doctors are regulated by the Medical Board of California either by asking the patient to sign a document containing that information or by posting such a notice “in at least 48-point type in Arial font[.]” Cal. Code Regs. tit. 16, § 1355.4. Montana requires that in order to have a license, a physician must be able to communicate in English. Mont. Code Ann. § 37-3-305 (2011). In New Mexico, all applicants for a medical license “who are not United States citizens must provide proof that they are in compliance with the immigration laws of the United States.” N.M. Code R. § 16.10.2.9.

Because States routinely incorporate such licensing requirements into their Medicaid plans, *see, e.g.,* Indiana State Medicaid Plan, [http://www.indianamedicaid.com/ihcp/StatePlan/Complete\\_Plan.pdf](http://www.indianamedicaid.com/ihcp/StatePlan/Complete_Plan.pdf) at 373, it is apparent that an incidental reduction in provider choice occasioned by a SPA requirement directed at some legitimate State objective unrelated to patient choice (or even patient care or provider billing practices) does not violate the free-choice provision of Section 1396a(a)(23). Here, if in fact SPA 11-011 were to cause any reduction in patient choice once fully implemented (and it is not clear that it would),

any such reduction would be incidental to the advancement of compelling State goals unrelated to patient choice and therefore would not implicate Section 1396a(a)(23).

In any case, particularly when viewed in context with Section 1396a(p)(1) and various decisions by CMS and the courts, Section 1396a(a)(23) fails to provide an unambiguous condition that would prevent Indiana from disqualifying from Medicaid providers that perform abortion services.

### CONCLUSION

SPA 11-011 should be approved.

Respectfully submitted,

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## CERTIFICATE OF SERVICE

I do hereby certify that a copy of the foregoing has been duly served upon counsel for the parties of record listed below by e-mail and first-class United States Mail postage pre-paid, on this 18th day of October, 2011.

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