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IN THE  
UNITED STATES COURT OF APPEALS  
FOR THE SEVENTH CIRCUIT

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No. 11-2464

PLANNED PARENTHOOD OF INDIANA, INC., *et al.*,  
Plaintiffs/Appellees,

v.

COMMISSIONER OF THE INDIANA STATE DEPARTMENT OF HEALTH, *et al.*,  
Defendants/Appellants.

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On Appeal from the United States District Court for the  
Southern District of Indiana, No. 1:11-cv-630-TWP-DKL  
The Honorable Tanya Walton Pratt, Judge

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**REPLY BRIEF OF APPELLANTS  
COMMISSIONER OF THE INDIANA STATE  
DEPARTMENT OF HEALTH, *et al.***

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## SUMMARY OF THE ARGUMENT

Neither PPIN nor any of its supporting *amici* takes issue with the legitimacy of the central objective of HEA 1210's state contracts qualification provision: to prevent even indirect taxpayer subsidies of abortions. Nor does any of them contend that disqualifying abortion clinics from State contracts is an unreasonable means of achieving that objective, since State payment for Medicaid-covered procedures effectively frees abortion clinic resources for, and thus indirectly subsidizes, elective abortions. They also seem to accept the proposition that *all* provider qualifications—even those they acknowledge to be permissible—may have the effect of depriving a Medicaid patient's free choice of provider. Their burden is to explain why *this* qualification is different in light of statutory text, and they have failed to do so.

First, however, PPIN has not explained how State officials can even *violate* the Medicaid Act, a statute that does nothing more than supply criteria for federal reimbursement. State officials do not “violate” federal law if they lower their drinking age to 18, even though such a move may trigger a loss of federal highway funds. Much less has PPIN explained how the Medicaid Act secures individual *rights* enforceable through Section 1983. *Gonzaga* altered the inquiry for whether federal spending legislation confers enforceable rights, and this Court has not expressly addressed if or how Medicaid confers any such enforceable individual rights. And while the Supreme Court in *Wilder* permitted a Section 1983 cause of action to enforce the now-repealed Boren Amendment, the parties there did not

raise the threshold argument the State presents here, and the Court did not address it. Indiana retains the legal prerogative to deviate from the reimbursement criteria in the federal Medicaid Act, and federal officials can respond (as they already have) by denying Indiana's proposed Medicaid plan amendment. (Indiana has petitioned for reconsideration, and its petition is set for hearing by CMS on December 15, 2011.)

Even if private plaintiffs could somehow "enforce" the free-choice plan requirement, HEA 1210 represents a permissible provider qualification. 42 U.S.C. § 1396a(a)(23) does not require States to pay for services at *any* provider a Medicaid patient might choose, but only for services from a "qualified" provider that complies with State standards. And while PPIN and its *amici* contend the State's theory would render meaningless several provisions of the Medicaid Act permitting States to pick providers for patients under narrow circumstances, HEA 1210 does not pick providers for patients but instead merely imposes a general provider qualification. Even if PPIN were not a Medicaid provider, its Medicaid patients would still be able to choose from among 800 providers that have provided family-planning services in the past.

The text of the Medicaid Act does not restrict State provider qualifications as suggested by PPIN and its *amici*; regardless, HEA 1210 constitutes the sort of "fiscal integrity" qualification that they deem permissible. It protects the fiscal integrity of Medicaid by preventing Medicaid funds from being used to subsidize abortions, which Medicaid generally may not fund under the Hyde Amendment.

Nor does HEA 1210 transgress any constitutional rights. There is no right to State-subsidized abortions, and this law merely carries out Indiana’s decision to prevent abortion subsidies. Again, neither PPIN nor its *amici* have contested the legitimacy of that objective or the reasonableness of its relationship to HEA 1210. This is not a law that seeks to disqualify physicians as punishment for performing abortions, and it does not prevent Medicaid providers from affiliating with abortion clinics, as long as there is no chance for indirect subsidy of abortion.

## ARGUMENT

### **I. Plaintiffs Do Not Have a Cause of Action to Enforce the Medicaid Free-Choice Plan Requirement**

PPIN wants this Court to distill from the cases it cites a general principle that federal spending legislation can be “enforced” under Section 1983, and then use that abstract principle to support a cause of action for its Medicaid claims in this case. This analysis is backward. The *first* question for this court to resolve is whether the defendants are alleged to have *violated* any provision of federal law. If the answer is no, then this Court cannot allow a Section 1983 lawsuit to proceed against the Defendants—unless some binding ruling of the Supreme Court or the Seventh Circuit *compels* this Court to allow the Plaintiffs’ Section 1983 claims notwithstanding the absence of a legal violation. It is PPIN’s responsibility to explain exactly how a State’s officers become federal lawbreakers simply by failing to meet a statutory criterion for federal reimbursement, and it has not done so.

**A. The “*Suter* Fix” eliminated one rationale for rejecting private enforcement of the Social Security Act; it did not deem any part of the Social Security Act enforceable through Section 1983**

PPIN and its *amici* invoke grounds not cited by the district court for finding a private right action in this case: the so-called “*Suter* Fix,” codified at 42 U.S.C. § 1320a-2. The statute reads:

In an action brought to enforce a provision of this chapter, such provision is not to be deemed unenforceable because of its inclusion in a section of this chapter requiring a State plan or specifying the required contents of a State plan. *This section is not intended to limit or expand the grounds for determining the availability of private actions to enforce State plan requirements* other than by overturning any such grounds applied in *Suter v. Artist M.*, 112 S. Ct. 1360 (1992), but not applied in prior Supreme Court decisions respecting such enforceability; provided, however, that this section is not intended to alter the holding in *Suter v. Artist M.* that section 671(a)(15) of this title is not enforceable in a private right of action.

42 U.S.C. § 1320a-2 (emphasis added).

PPIN quotes only the first sentence of this statute. It omits the all-important second sentence and quotes instead from the House Conference Report, Br. of Appellees at 15, which is not law and which differs significantly from the text that actually received the approval of the House, Senate, and President.

The first sentence in Section 1320a-2 says only that provisions of the Social Security Act cannot be deemed unenforceable in private actions because of their “inclusion in a section of this chapter requiring a State plan or specifying the required contents of a State plan.” It is apparently targeted at footnote 11 in the *Suter* opinion, which invokes *Smith v. Robinson*, 468 U.S. 992 (1984), and *Middlesex County Sewerage Authority v. National Sea Clammers Ass’n*, 453 U.S. 1 (1981), to

argue against a private cause of action to enforce the Social Security Act on account of the “comprehensive remedial scheme” provided by the Act. *Suter*, 503 U.S. 347, 360 n.11 (1992). Footnote 11 of *Suter* leaves that argument open; the first sentence of Section 1320a-2 closes the door on that possibility.

The State’s argument, however, does not rest on either the inclusion of any statutory provision in sections that require State plans or specify the required contents of such plans, or on *Sea Clammers*. Rather, it raises a more fundamental point: State officials have not violated any federal law, and therefore they cannot be sued under Section 1983. That has nothing to do with *Sea Clammers*, or the “inclusion” of the freedom-of-choice provision “in a section of this chapter . . . specifying the required contents of a State plan.” It has to do with the fact that statutes that merely specify criteria for federal reimbursement do not impose legal obligations on State officials. The “*Suter* fix” cannot create a cause of action under Section 1983 when the Medicaid statute imposes no binding legal obligations on State officials.

The second sentence makes clear that Section 1320a-2 merely rejects the novel reasoning that the Supreme Court deployed in *Suter*, while still preserving (paradoxically) the result that the Court reached in that case. But nothing in the *Suter* opinion addresses the argument that the State makes here; the Court focused instead on the open-ended nature of the statutory requirement of “reasonable efforts” to prevent removal of children from their homes and facilitate reunification of families where removal has occurred. *Suter*, 503 U.S. at 359-64. The House

Conference Report, by contrast, sounds as though it wants to freeze into place every decision, from any court, recognizing private causes of action for any provision of the Medicaid Act—a reach that extends far beyond the actual statutory text. *See* H.R. Rep. No. 103-761 at 926 (1994) (Conf. Rep.), *reprinted in* 1994 U.S.C.C.A.N. 2901, 3257, 1994 WL 534741 at \*819 (Sept. 28, 1994).

**B. Precedents do not require finding a cause of action here**

There is no binding legal authority that Section 1396a(a)(23) creates a privately enforceable right. Post-*Gonzaga*, courts have looked both ways on this question. *Compare Harris v. Olszewski*, 442 F.3d 456, 459 (6th Cir. 2006) (holding “that Medicaid’s freedom-of-choice provision creates a private right that may be enforced under § 1983”) *with M.A.C. v. Betit*, 284 F. Supp. 2d 1298, 1307 (D. Utah 2003) (concluding that “the freedom of choice provisions do not contain the unambiguous rights-creating language of *Gonzaga*”). But the Sixth Circuit’s opinion in *Harris* never considered the argument that State officials cannot violate federal law merely by departing from federal reimbursement criteria.

Nor does *Wilder v. Virginia Hospital Ass’n*, 496 U.S. 498 (1990), establish that subsection (a)(23) is enforceable. Although *Wilder* allowed litigants to use Section 1983 to enforce the Boren Amendment, *id.* at 524, the *Wilder* opinion never reached, let alone refuted, the State’s argument here. The *Wilder* Court merely *assumed* that State officials had “violated” the Boren Amendment and then proceeded to consider whether the Boren Amendment established federal “rights” that litigants could vindicate under Section 1983, *see id.* at 508-12, and whether

Congress intended to foreclose Section 1983 as a remedy for Boren Amendment violations, *see id.* at 520-23. What is more, the defendants in *Wilder* *conceded* “that the Boren Amendment requires a State to provide some level of reimbursement to health care providers and that a cause of action would lie under § 1983 if a State failed to adopt any reimbursement provision whatsoever.” *Id.* at 512. The State’s objection to this lawsuit is more fundamental: it is impossible for State officials to “violate” federal statutes that do nothing more than establish conditions for federal reimbursement, as these statutes do not require the States to do anything. *Wilder* did not consider this argument because the litigants in that case did not present it. *See* Br. of Petitioners, *Wilder v. Virginia Hospital Ass’n*, 496 U.S. 498 (1990) (No. 88-2043), 1989 WL 434722.

In any event, after *Gonzaga University v. Doe*, 536 U.S. 273 (2002), *Wilder* can bind this Court no further than the now-repealed Boren Amendment at issue in that case. *Gonzaga* limited *Wilder*’s holding to provisions in the Medicaid Act that “explicitly confer[] specific *monetary* entitlements upon the plaintiffs,” which the free-choice plan provision does not do. *Id.* at 280 (emphasis added). *Gonzaga* also noted that “[o]ur more recent decisions . . . have rejected attempts to infer enforceable rights from Spending Clause statutes[,]” *id.* at 281, and reiterated that:

In legislation enacted pursuant to the spending power, the typical remedy for state noncompliance with federally imposed conditions is *not a private cause of action for noncompliance but rather action by the Federal Government to terminate funds to the State.*

*Id.* at 280 (emphasis added) (quoting *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 28 (1981)); see also *id.* (“Since *Pennhurst*, only twice have we found spending legislation to give rise to enforceable rights.”). And while the United States notes that *it* may sue for a plan violation, the availability of a common law contract claim has no relevance to a private plaintiff’s asserted statutory claim.

PPIN cites obsolete pre-*Gonzaga* cases dealing with other Social Security Act programs to argue for private enforcement of federal reimbursement conditions. Br. of Appellees at 16 (citing *Shea v. Vialpando*, 416 U.S. 251, 265 (1974); *Carleson v. Remillard*, 406 U.S. 598, 600 (1972); *King v. Smith*, 392 U.S. 309, 333 (1968)). Notably, the Court in both *Shea* and *King* merely assumed the existence of a Section 1983 cause of action without analysis. See *Shea*, 416 U.S. at 252-53; *King*, 392 U.S. at 334.

But even more telling is the limited reach of *Carleson*, where the Court adjudicated a class-action AFDC preemption claim. *Carleson*, 406 U.S. at 599-600. That decision presupposed, but did not address, the existence of a cause of action to enforce the Supremacy Clause. *Id.* at 604 (holding that the State’s definition of “eligible dependent children” was invalid under the Supremacy Clause because it conflicted with the federal definition). Yet in *Independent Living Center of Southern California, Inc. v. Maxwell-Jolly*, 572 F.3d 644, 652-57 (9th Cir. 2009), cert. granted in part, *Maxwell-Jolly v. Independent Living Center of Southern California, Inc.*, 131 S. Ct. 992 (2011), the Ninth Circuit did not even cite *Carleson* when confronted with the Supremacy Clause cause-of-action issue. In the briefs to the Supreme

Court in *Maxwell-Jolly* (now docketed as *Douglas*), only one of the parties cites *Carleson*, and then only for the proposition that the Supremacy Clause applies equally to all federal statutes whether or not they were enacted as spending legislation. See Br. for Dominguez Respondents in Case No. 09-1158, *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, Nos. 09-958, 09-1158, and 10-283, 2011 WL 3319552 at \*21 n.10.<sup>1</sup>

The point is that a Supreme Court decision that only implicitly presumes an answer to a threshold question does not actually decide that question and thereby bind lower courts. See, e.g., *Ariz. Christian Sch. Tuition Org. v. Winn*, 131 S. Ct. 1436, 1448 (2011) (“When a potential jurisdictional defect is neither noted nor discussed in a federal decision, the decision does not stand for the proposition that no defect existed.”); see also *Maine v. Thiboutot*, 448 U.S. 1, 31 (1980) (Powell, J., dissenting) (stating that the “rule” against imputing precedential value to questions not directly addressed by the court “applies with even greater force to questions involving the availability of a cause of action, because the question whether a cause of action exists—unlike the existence of federal jurisdiction—may be assumed without being decided.”).

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<sup>1</sup> The State’s view on this issue is that a State Medicaid plan that does not comport with Section 1396a(a)(23) is not “incompatible” with federal law. Br. of Appellants at 26. States may, consistent with federal law, maintain Medicaid plans that do not qualify for federal reimbursement. Thus, unlike in *Illinois Ass’n of Mortgage Brokers v. Office of Banks & Real Estate*, 308 F.3d 762, 765-66 (7th Cir. 2002), there is nothing here that can be preempted by federal law, so there is no Supremacy Clause cause of action. In any event, the Supreme Court is very likely to resolve this issue this October Term in *Douglas v. Independent Living Center of Southern California, Inc.*, 131 S. Ct. 992 (2011) (granting certiorari sub nom. *Maxwell-Jolly v. Indep. Living Ctr. of S. Cal.*).

Furthermore, most of the Seventh Circuit cases that PPIN cites are also pre-*Gonzaga*. See *Miller by Miller v. Whitburn*, 10 F.3d 1315 (7th Cir. 1993); *Smith v. Miller*, 665 F.2d 172 (7th Cir. 1981); *Addis v. Whitburn*, 153 F.3d 836 (7th Cir. 1998). The one that is not, *Collins v. Hamilton*, 349 F.3d 371 (7th Cir. 2003), did not address the cause of action issue, and so does not constitute binding circuit precedent that federal reimbursement criteria can be “enforced” through a private right of action.

As for *Bertrand ex rel. Bertrand v. Maram*, 495 F.3d 452 (7th Cir. 2007), and *Bruggeman ex rel. Bruggeman v. Blagojevich*, 324 F.3d 906 (7th Cir. 2003), this Court assumed without analysis that Section 1396a(a)(8) could be enforced through a Section 1983 claim. PPIN tries to stretch *Bruggeman* into something more definitive, see Br. of Appellees at 19, but the *Bertrand* decision makes it clear that “we think it best to proceed as in *Bruggeman*: to assume that there is such an entitlement, while leaving resolution to the future.” *Bertrand*, 495 F.3d at 457-58. As this passage indicates, assuming the existence of a cause of action where the parties have not raised the issue does not create binding precedent, but rather leaves the issue for the future.

## **II. The Free-Choice Plan Requirement Does Not Preclude States From Disqualifying Abortion Clinics From Medicaid in Order to Prevent Indirect Taxpayer Subsidy of Abortion**

HEA 1210’s contract qualifications provision is designed to prevent indirect taxpayer subsidy of abortion. Neither PPIN nor any of its supporting *amici* takes issue with the legitimacy of this rationale, which is a significant concession in light

of the arguments they do make. HEA 1210 is designed to protect Medicaid from the very abuses and threats to fiscal integrity that PPIN and the United States say must characterize State qualifications under Section 1396a(p)(1).

**A. HEA 1210 establishes a legitimate provider qualification and is permissible under the free-choice plan requirement**

Two different sections of Medicaid work together to allow Indiana to disqualify abortion clinics from becoming Medicaid providers. Section 1396a(a)(23) says that a State plan must allow for a beneficiary to receive care from “any institution, agency, community pharmacy, or person *qualified* to perform the service or services required . . . who undertakes to provide him such services.” 42 U.S.C. § 1396a(a)(23)(A) (emphasis added). Section 1396a(p)(1) then 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).

Through Section 1396a(p)(1), Congress wanted to make it explicit that States have responsibility for deciding provider qualifications. Congress did not choose to explicitly lay out every possible qualification, but instead granted States wide latitude to make the decisions. *Cf. Pennhurst*, 451 U.S. at 16 (holding that spending legislation can impose binding conditions on states only if expressed “unambiguously”). Accordingly, Section 1396a(a)(23) cannot mean that State plans may impose no restrictions that incidentally limit the array of available providers. *See King by King v. Sullivan*, 776 F. Supp. 645, 656 (D.R.I. 1991) (“The ‘freedom of

choice’ subsection cannot prevent the State from adopting administrative processes that are necessary for allocating and delivering its limited medical assistance funds efficiently.”). That is why it is significant that this Court has held that the free-choice plan requirement does not require the continuing authorization of existing facilities that fail to meet new qualification requirements. *See Bruggeman*, 324 F.3d at 911 (citing *O’Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773, 785-86 (1980)).

To be sure, Medicaid-participating States are not free to eliminate all choices of providers and continue to qualify for federal reimbursement. *See Chisholm v. Hood*, 110 F. Supp. 2d 499, 506 (E.D. La. 2000); *Bay Ridge Diagnostic Lab. Inc. v. Dumpson*, 400 F. Supp. 1104, 1105, 1108 (E.D.N.Y. 1975). But a State may *reduce* patient choice incident to a qualification targeting some legitimate government objective, such as not paying family members as caregivers, *see Carter v. Gregoire*, 672 F. Supp. 2d 1146, 1153, 1157 (W.D. Wash. 2009), *aff’d*, 362 Fed. App’x 743 (9th Cir. 2010) (holding that a rule against paying “a home care agency . . . for in-home personal care . . . if the care is provided to a client by a family member” is consistent with the free-choice plan requirement). Preventing indirect subsidy of abortion is just such a legitimate, indeed important, government objective.

**1. There is no basis for Plaintiffs’ narrow definition of “qualification,” and CMS’s rejection of Indiana’s plan amendment is not entitled to deference**

Each successive brief filed by the Plaintiffs and the United States seems to set forth a different “definition” of what kinds of qualifications are acceptable under the free-choice plan requirement in their view. In the District Court, Plaintiffs

argued that the State could only disqualify a provider if it does not “possess[] the necessary qualifications” or is not “fitted for a given purpose.” [Docket No. 48 at 10 n.9]. Now Plaintiffs have expanded the permissible bases for disqualification to include failure to “demonstrate[ ] effectiveness and efficiency in providing” services, Br. of Appellees at 23, “incompetent practitioners and inappropriate care . . . [and] programmatic fraud[,]” *id.* at 26, and lack of “integrity or professional competence,” *id.* at 28. PPIN now 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, Inc. v. Perales*, 878 F.2d 577, 578-79 (2d Cir. 1989). 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.

The United States argued in the District Court that disqualifications must relate to providers’ “fitness to provide or properly bill for Medicaid services.” [Docket No. 66 at 10]. It now suggests 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.” U.S. Br. at 15. Later, however, it allows that State qualifications for Medicaid providers need only be “reasonable,” arriving at this description via an HHS regulation issued nearly a decade before the enactment of Section 1396a(p)(1), which allows States to set “reasonable standards relating to the qualifications of providers.” U.S. Br. at 16 (quoting 43 Fed. Reg. 45176, 45189 (Sept. 29, 1978) (to be 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*.

Yet neither the United States, nor PPIN nor the National Health Law Program argues that HEA 1210 is “unreasonable.” Indeed, all seem to accept the legitimacy of the State’s rationale for adopting this statute—to preclude indirect subsidy of abortions that may not be funded by taxpayer dollars—and the “reasonableness” of HEA 1210 as a means for achieving that objective.<sup>2</sup>

Nor is it sufficient to say that CMS’s rejection of Indiana’s plan amendment is owed *Chevron* deference simply because the agency has interpretive authority regarding Medicaid generally. *See* Br. of Appellees at 33. The precise determination at issue here, relating to which providers are “qualified,” is also a matter of *State* authority. Indeed, HHS has itself issued a regulation declaring that “[n]othing contained in this part [regarding State-initiated exclusions from Medicaid] should

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<sup>2</sup> As the State observed in its opening brief, the Office of the Inspector General may disqualify providers from participation in Medicare and Medicaid if they have defaulted on health education loan and scholarship obligations. 42 C.F.R. § 1001.1501. While this disqualification is specifically authorized by statute, it remains relevant to any evaluation of the “reasonableness” of HEA 1210. It does not relate to the provider’s “quality of services,” nor does it relate to any rules broken in the course of providing care, but instead has to do with another important federal policy concern—“[t]here is plainly a connection between requiring a physician who is benefitting from government programs to meet his or her financial obligations to the government, by repayment of loans.” Health Care Programs: Fraud and Abuse; Amendments to OIG Exclusion and CMP Authorities Resulting From Public Law 100-93, 57 Fed. Reg. 3298-01, 3313 (Jan. 29, 1992). If it is reasonable for the federal government to police fiscal integrity using federal program disqualification, it is reasonable for the State to do so as well.

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 State’s argument would not “render[] null-and-void” a “plethora of regulations promulgated by HHS to give effect to the requirements of the Medicaid Act.” Br. of Appellee at 35. Whether a federal agency is owed deference depends on the precise statute at issue; here the interrelationship of Sections 1396a(a)(23) and 1396a(p)(1) is one of fundamental Medicaid structure, not interstitial lawmaking entitled to deference. And to the extent that the United States argues for deference in light of statutory ambiguity, Br. of U.S. at 20-22, that very ambiguity precludes the imposition of restrictions on States. *See Pennhurst*, 451 U.S. at 17 (spending legislation imposes binding conditions on States only if expressed “unambiguously”).

In any event, CMS’s *ad hoc* rejection of Indiana’s plan amendment provides no attempt to account for section 1396a(p)(1) and no principled basis for rejecting HEA 1210 as a qualification, which further erodes any justification for deference.

**2. In practice, both courts and HHS have allowed States to set qualifications for providers**

In *Plaza Health Laboratories*, a provider was suspended for dumping medical waste into the Hudson River. 878 F.2d at 578-79. This is without question a provider qualification unrelated to patient care, and is thus a prime example of the kind of congressionally unanticipated—and yet perfectly reasonable and necessary—State restriction that is protected by the necessarily broad scope of Section 1396a(p)(1). PPIN defends suspension for polluting as protection of *patient*

health and safety, Br. of Appellees at 32, but the provider’s Medicaid eligibility was suspended for violating laws protecting public health generally, not Medicaid patients in particular. *See Plaza Health Laboratories*, 878 F.2d at 579. In any event, HEA 1210 is no less related to the fiscal integrity of Medicaid—which PPIN and the United States agree is a permissible basis for provider qualifications—than waste dumping is to patient health and safety.

PPIN also claims that *First Medical Health Plan, Inc. v. Vega-Ramos*, 479 F.3d 46 (1st Cir. 2007), is inapposite because the anti-self-dealing statute at issue qualified as a means of preventing “fraud and abuse.” Br. of Appellees at 31. Not only is that phrase absent from Section 1396a(p)(1), but “abuse” is exactly what HEA 1210 addresses: the abuse that occurs 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, *Vega-Ramos*, 479 F.3d at 53, it can establish provider qualifications as a barrier to indirect taxpayer subsidy of abortions.

It remains significant that CMS has approved a plan amendment allowing Indiana to refuse to qualify additional Medicaid beds in nursing facilities in certain circumstances, a move that implicates provider choice for at least some patients. *See App. 149-52*. PPIN principally argues that this plan amendment is irrelevant because authority for it is found in “federal law.” Br. of Appellees at 30 n.14. The “federal law” that allows it, however, is not statutory law, but HHS’s own regulations. *App. 151-52*. PPIN’s argument is that the permissibility of a State rule

that may interfere with a patient's provider choice depends not on federal statutes or neutral principles interpreting them, but only on HHS's policy or political preferences. That view, however, is fundamentally inconsistent with PPIN's broader argument that the free-choice plan requirement absolutely entitles a Medicaid recipient to her particular choice of provider. *See* Br. of Appellees at 20-25.

Put another way, given the arguments made by the United States in this case, it seems reasonable to infer that, in the federal government's view, HHS could not, consistent with the free-choice plan requirement, promulgate a regulation permitting States to disqualify abortion clinics. *See* U.S. Br. at 10-19. But 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 abortion clinics from being providers, because both may preclude some patient's provider choice. Indeed, HEA 1210 compares favorably to a cap on nursing home beds in that regard since any reduction in provider capacity would be incidental rather than direct. Indiana's 2006 plan amendment demonstrates that the position of the United States on provider free-choice has not in the past turned on whether a plan amendment might reduce patient choice.

The Second Circuit's decision in *Kelly Kare, Ltd. v. O'Rourke*, 930 F.2d 170 (2d Cir. 1991), dispenses with any pretense that a mere reduction in patient choice violates the free-choice plan provision. In *Kelly Kare*, a class of patients claimed that terminating a provider's contract without cause improperly interfered with their free-choice rights. *Id.* at 173. The Court rejected that argument on the grounds

that, under *O'Bannon*, government action that incidentally affects patient free choice is permissible under Section 1396a(a)(23). *Id.* at 177-78.

PPIN argues that *Kelly Kare* is inapposite because the court did not address the issue of complete provider decertification. Br. of Appellees at 24; *Kelly Kare*, 930 F.2d at 177. It is hard to see why it matters if patient choice is reduced owing to contract cancellation or formal provider disqualification. The point remains that patients did not have access to their desired provider, but that mere fact did not contravene the free-choice plan requirement.

Unable to distinguish *Kelly Kare*, PPIN ultimately invites this Court both to ignore the Supreme Court's precedent in *O'Bannon* and to create a conflict with the Second Circuit. Br. of Appellees at 25 (contending that the Second Circuit's opinion was "wrongfully decided"). The Court should decline these invitations and rule that incidentally reducing patient choices does not violate Section 1396a(a)(23).

**B. The State's reading of Section 1396a(p)(1) would not render any other Medicaid provisions meaningless**

PPIN argues that reading Section 1396a(p)(1) as written would render other provisions of Medicaid meaningless. Br. of Appellees at 28-29. First, PPIN's reading that the State's authority is coextensive with the Secretary's would itself render meaningless the text "[i]n addition to any other authority . . ." contained in Section 1396a(p)(1). Second, as the State has explained, the text authorizing States to exclude providers for any reason that could be invoked by the Secretary directly

confers power and does not merely permit states to enact laws of that sort. Br. of Appellants at 29-31.

Third, nearly all other provisions cited by PPIN and its *amici* presuppose State laws, rules, policies or decisions that *facially target or facially limit* the number or range of providers patients may use *as such*, not laws directed at other objectives that may only incidentally reduce the number of available providers.

- 42 C.F.R. § 431.51(c)(4): Allows State Medicaid agencies to “[l]imit[] the providers who are available to furnish targeted case management services . . . to target groups that consist solely of individuals with developmental disabilities or with chronic mental illness.”

This regulation presumes a State rule that, unlike HEA 1210, is entirely designed to eliminate all but a handful of providers for a particular program.

- Section 1396a(a)(23)(B): Permits Puerto Rico, the Virgin Islands, and Guam (but only these territories) to restrict provider choice (as it relates to family-planning providers) in a managed care program.

This regulation, too, presumes a State rule that, unlike HEA 1210, is entirely designed to eliminate all but a handful of providers for a particular program.

- Section 1396n(a): Provides that a State will not be deemed out of compliance with the free-choice plan provision based on (1) exclusive contracts with providers that supply specified services and (2) reasonable time-limited restrictions on choice by recipients who have used covered items or services excessively.

Subsection 1 has to do with provider exclusivity, and subsection 2 with *recipient* abuse; neither has to do with general provider qualifications.

- Section 1396n(b)(4): Permits States, under specified circumstances, to request a waiver of certain requirements of the Medicaid Act so as to restrict the providers from which an individual may receive services other than family-planning services.

Again, this regulation presumes a State rule that, unlike HEA 1210, is entirely designed to eliminate all but a handful of providers for a particular program.

The lone exception is the portion of Section 1396a(a)(23)(B) providing that “nothing in this paragraph shall be construed as requiring a State to provide medical assistance for such services furnished by a person or entity convicted of a felony under Federal or State law for an offense for which the State agency determines is inconsistent with the best interests of beneficiaries under the State plan.” But if that jumbled text is to be taken as the lone basis for State-enacted provider qualifications under Section 1396a(p)(1), that would eliminate disqualifications for many types of misconduct not predicated on felony convictions, including (for example), dumping hazardous waste, *see Plaza Health Laboratories*, 878 F.2d at 578-79, self-dealing, *see Vega-Ramos*, 479 F.3d at 53, or failing to maintain records in accordance with state law, *see Triant v. Perales*, 491 N.Y.S.2d 486, 488 (N.Y. App. Div. 1985).

HEA 1210 does not target or limit the number of available providers. Rather, it says that to be a provider a facility cannot be an abortion clinic. If an abortion clinic chooses to retain an abortion practice and therefore ceases to be a provider, that is merely an incidental effect of the law, not its central objective. This is in contrast with any state programs permitted by the statutes above that directly and intentionally limit available providers to one, or two, or a handful, as part of a waiver program designed to achieve particular efficiencies or savings. Here, even if PPIN chooses its abortion practice over its Medicaid practice, that would still leave

roughly 800 providers in Indiana who have offered family planning services in the past. App. 60-61. Neither PPIN nor the United States cites any other cases where a State was deemed to have “violated” the free-choice plan requirement by incidentally reducing the number of available providers by less than one percent.

### **III. The Health Services Block Grant Program Does Not Preclude States From Disqualifying Abortion Clinics From Receiving Grants**

PPIN’s contention that the block grant program preempts HEA 1210 is unconvincing for one simple reason: there is no indication that Congress intended to prohibit states from regulating the administration of Disease Intervention Services grants. PPIN argues that a federal regulation, 42 C.F.R. § 51b.106(e), demonstrates a specific congressional intent to prohibit States from adding their own qualifications to federal grant eligibility requirements. That subsection outlines conditions that the *Secretary* may impose, but it does not preclude *States* from imposing additional conditions on the receipt of grant funds. This regulation is certainly not enough to overcome the strong presumption against preemption.

Ultimately, PPIN has cited no eligibility requirement or restriction on State administration within the block grant program, and that program therefore does not preclude States from declining to grant funds to abortion providers in order to prevent indirect taxpayer subsidy of abortions.

### **IV. HEA 1210 Is Not Preempted By the Hyde Amendment**

PPIN suggests that the Hyde Amendment somehow preempts HEA 1210. Br. of Appellees at 38-39. First, PPIN has no standing to raise this issue because it has

never even asserted that it performs abortions exempted from the Hyde Amendment's restrictions. *See S.D. Myers, Inc. v. City & County of San Francisco*, 253 F.3d 461, 475-76 (9th Cir. 2001) (holding that plaintiff had no standing to argue that city ordinance, which barred him from receiving municipal contracts, was preempted by ERISA because plaintiff failed to allege that he would be eligible for the contracts if the ordinance were struck down). All PPIN has alleged is that it regularly performs first-trimester abortions. [See Docket No. 1 at 11 ("PPIN only provides abortion services to women who are in their first trimester of pregnancy.")].

Next, HEA 1210 does not by its terms preclude coverage for abortions exempted from the Hyde Amendment's funding restrictions, and it does not disqualify from Medicaid *all* facilities that perform abortions. Rather, HEA 1210 prohibits State contracts with *abortion clinics* (a subcategory of all medical procedure facilities distinguished by the regular provision of abortion services) but specifically exempts hospitals and ambulatory surgical centers (medical procedure facilities that historically perform only occasional abortions and that are not understood to offer abortions as a central portion of their business). So, Medicaid-eligible women who seek abortions exempted from the Hyde Amendment's restriction on Medicaid coverage may yet obtain such abortions at hospitals or ambulatory surgical centers. In fact, abortions that take place where the life of the mother is at stake would self-evidently occur in a hospital setting anyway, likely in

an emergency, and not by way of a planned procedure at PPIN or other abortion clinics.

Finally, even to the extent that HEA 1210 might prevent Medicaid funding of some abortions that would otherwise be covered, that does not require facial invalidation of the statute. Any preemption declared by the court could be no broader than for abortions exempt from the Hyde Amendment. *See Dalton v. Little Rock Family Planning Servs.*, 516 U.S. 474, 476-78 (1996) (holding that Arkansas statute stating “No public funds shall be used to pay for any abortion, except to save the mother’s life” could only be enjoined from being enforced against Medicaid-funded abortions covered by the Hyde Amendment). Even if the State can be required to pay an abortion clinic for abortions exempted from the Hyde Amendment’s restrictions, it must still be permitted to preclude all other State government contracts for other services at abortion clinics.

**V. There Is No Constitutional Right to Subsidized Abortions, So Disqualifying Abortion Clinics From Government Contracts to Prevent Subsidy Does Not Impose Unconstitutional Conditions on Abortion**

PPIN continues to pursue its theory that HEA 1210 imposes an unconstitutional condition on the right to abortion. Br. of Appellees at 41-46. The Fifth Circuit, however, has already rejected this argument. *Planned Parenthood of Houston and Se. Tex. v. Sanchez*, 480 F.3d 734, 742 n.3 (5th Cir. 2007) (“By remanding the entire case to the district court with instructions to dissolve the injunction, however, we implicitly rejected [the plaintiffs’ Fourteenth Amendment

unconstitutional condition] claim as well.”). And for good reason: ensuring that taxpayer funds do not indirectly fund abortions imposes no obstacle to the right to abortion. *See, e.g., Rust v. Sullivan*, 500 U.S. 173, 201 (1991) (“The Government has no constitutional duty to subsidize an activity merely because the activity is constitutionally protected.”).

What is more, the Supreme Court has expressly held that “the State need not commit any resources to facilitating abortions . . . .” *Webster v. Reproductive Health Servs.*, 492 U.S. 490, 511 (1989). HEA 1210 does not prevent women from procuring abortions, and it does not preclude doctors from performing abortions at privately funded facilities, so it is analogous to the regulation against using public hospitals for abortions *upheld* in *Webster*. *Id.* at 509 (observing that the statute left “pregnant wom[e]n with the same choices as if the State had chosen not to operate any public hospitals at all.”).

HEA 1210 is not like the hypothetical rule singled out in *Webster* where a state “barred doctors who performed abortions in private facilities from the use of public facilities for any purpose.” *Id.* at 510, n.8. In that scenario, no government interest justified the public facility ban except to punish doctors who performed abortions elsewhere. HEA 1210 does not similarly deprive abortion providers of government support for non-abortion procedures just for the sake of symbolically punishing abortion; rather, it does so to achieve the legitimate and important government interest of preventing indirect taxpayer subsidy of abortion. PPIN makes no argument against the validity of this important government interest, and

indeed makes no argument that, contrary to the evidence, inferences and assumptions supporting the statute, *see* App. at 63-64, it successfully prevents Medicaid dollars from indirectly subsidizing abortions.

What is more, PPIN may establish independent affiliates for providing abortion services and still keep its Medicaid funding. FSSA is in the process of promulgating a rule that would permit Planned Parenthood to receive Medicaid funding if abortions were provided by “a separate affiliate” that “does not benefit, even indirectly, from government contracts or grants awarded to [Planned Parenthood].” App. 148. By allowing Medicaid providers to have independent abortion clinic affiliates that would not indirectly benefit from Medicaid funding, Indiana demonstrates that the intent of the law is not to disqualify abortion providers simply because they perform abortions, but instead to prevent indirect Medicaid subsidy of abortions.

PPIN says that FSSA’s Notice of Intent to Adopt a Rule to this effect is a “subterfuge” meant to “cure the unconstitutional condition of HEA 1210.” Br. of Appellees at 46. PPIN thus appears to be frustrated that the State is, through its rulemaking authority, attempting to prevent any possibility of overbroad applications of HEA 1210, *i.e.*, applications where affiliates are sufficiently separate that no indirect funding of abortion may occur. There is no “subterfuge,” only an attempt to tailor application of HEA 1210 as narrowly as possible while remaining faithful to the General Assembly’s important goal of preventing indirect subsidy of abortion.

PPIN urges the Court to keep the preliminary injunction in place while Indiana promulgates its rule. But that would turn this facial challenge into an as-applied challenge to a future rule. That is not only a different, unripe case, but, as PPIN has not even attempted to refute the legitimacy and fit of the State’s rationale for HEA 1210 as it stands, PPIN cannot plausibly argue that a rule expressly limiting its application can somehow create a separate as-applied constitutional problem. Even without a rule further defining how it will apply, HEA 1210 is narrowly targeted at achieving an important and entirely legitimate government objective—avoiding indirect taxpayer subsidy of abortions—so PPIN’s facial challenge cannot succeed on the merits and its preliminary injunction must be dissolved.

### CONCLUSION

The preliminary injunction should be REVERSED and VACATED.

Respectfully submitted,

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## CERTIFICATE OF WORD COUNT

I verify that this brief, including footnotes and issues presented, but excluding certificates, contains 6,915 words according to the word-count function of Microsoft Word, the word-processing program used to prepare this brief.

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## CERTIFICATE OF SERVICE

I hereby certify that on September 26, 2011, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Seventh Circuit by using the CM/ECF system.

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