No. 12-1039

IN THE
Supreme Court of the United States

SECRETARY OF THE INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION, IN HER OFFICIAL CAPACITY, ET AL.,

Petitioners,

v.

PLANNED PARENTHOOD OF INDIANA, INC., ET AL.,

Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

REPLY BRIEF FOR THE PETITIONERS

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REPLY BRIEF FOR THE PETITIONERS

I. The Case Is Ready for Review

There is nothing "preliminary" about the decision below, which definitively resolved questions of statutory interpretation and suggested no role for further factual development. The Court routinely issues writs of certiorari at the preliminary injunction stage in cases that turn on purely legal questions unlikely to benefit from additional proceedings. *See, e.g.*, *Arizona v. United States*, 132 S. Ct. 2492 (2012) (reviewing preliminary injunction against state immigration law challenged on preemption grounds); *Nat'l Meat Ass'n v. Harris*, 132 S. Ct. 965 (2012) (reviewing preliminary injunction against ban on slaughter of nonambulatory animals in federally regulated swine slaughterhouses on preemption grounds); *Nat'l Aeronautics & Space Admin. v. Nelson*, 131 S. Ct. 746 (2011) (reviewing preliminary injunction against background checks of NASA employees in non-sensitive positions on the grounds that such checks violate a constitutional right to informational privacy).

There would likewise be nothing remarkable about taking this case now.

II. Circuits Are Split over the Continued Relevance of *Wilder*, and Neither the "*Suter* Fix" Nor the Supremacy Clause Makes Medicaid Privately Enforceable

1. Respondents do not disagree that *Blessing* and *Gonzaga* dramatically altered the standard for whether federal spending statutes are enforceable via Section 1983. *See* Pet. at 11-13. In fact, they scramble to demonstrate that the Seventh Circuit supposedly relied on *Gonzaga* without "even remotely suggest[ing] that it deemed *Wilder* controlling[.]" Br. in Opp. at 8. But they give the game away when they concede that the Seventh Circuit faulted the State's argument as "hard to reconcile with *Wilder*[.]" *Id.* (quoting Pet. App. 21a).

Wilder does not provide the controlling standard—*Gonzaga* and *Blessing* do. Yet lower courts are split over whether to undertake a complete *Blessing*/*Gonzaga* analysis in Medicaid cases or to take the *Wilder* shortcut. *Contrast Bertrand ex rel. Bertrand v. Maram*, 495 F.3d 452, 456-57 (7th Cir. 2007) (relying on *Wilder* as the standard for Medicaid cases), *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 192 (3d Cir. 2004) (holding that *Wilder* trumps *Gonzaga*), *and S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 605 (5th Cir. 2004) (relying on *Wilder* to determine which Medicaid plan provisions are enforceable), *with Mandy R. ex rel. Mr. & Mrs. R. v. Owens*, 464 F.3d 1139, 1148 (10th Cir. 2006) (holding that, "[e]ven though *Wilder*

addressed a similar statute, our approach is controlled by *Gonzaga*"), *Martes v. Chief Executive Officer of S. Broward Hosp. Dist.*, 683 F.3d 1323, 1326-30 (11th Cir. 2012) (citing *Gonzaga* and *Blessing* but not *Wilder* in rejecting private enforcement of a Medicaid plan provision), *and Jones v. Dist. of Columbia*, 996 A.2d 834, 845 (D.C. 2010) (rejecting private enforcement of a Medicaid plan provision and observing that *Wilder* holds little significance post-*Gonzaga*).

What is more, Respondents' own analysis demonstrates exactly the analytical problem this Court needs to resolve. In arguing that Section 1396a(a)(23) creates individual rights, Respondents cite *only* the portion of statutory text that appears at subsection 23 and ignore the critical introductory clause that precedes it: "A State plan for medical assistance must . . . ." *See Dolan v. U.S. Postal Serv.*, 546 U.S. 481, 486 (2006) (requiring courts to "read[] the whole statutory text, [and] consider[] the purpose and context of the statute" when assessing whether federal statutes create individual rights). As a consequence, Respondents falsely assert that subsection 23 is cast "in mandatory terms," *i.e.*, that "Indiana 'must . . . provide' for beneficiaries to choose freely among providers[.]" Br. in Opp. at 13. To the contrary, the Medicaid Act requires Indiana to do *nothing*. It merely sets forth what a plan for medical assistance must do *if* it is to qualify for federal financial participation, and then requires the

Secretary to respond accordingly. 42 U.S.C. §§ 1396a(a), 1396c.

Lower courts routinely invoke *Wilder* as a reason to ignore these facially obvious terms of the Medicaid Act. This festering doctrinal uncertainty and disregard for the plain text of congressional enactments demands the Court's immediate attention.

2. Respondents argue that the whole dispute over whether *Gonzaga* or *Wilder* provides the proper standard for permitting private Medicaid claims is moot because 42 U.S.C. § 1320a-2 "was enacted precisely to foreclose the argument . . . that no provision of the Social Security Act can ever be enforced through § 1983." Br. in Opp. at 4-5.

Not so. That provision was a narrowly targeted response to *Suter v. Artist M.*, 503 U.S. 347 (1992), which held that child beneficiaries could not sue to enforce conditions of grants awarded under the Adoption Assistance and Child Welfare Act of 1980. *Id.* at 350. This "*Suter* fix" targets 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 Association*, 453 U.S. 1 (1981), to question private enforcement on account of the "comprehensive remedial scheme" provided by the Social Security Act. *Suter*, 503 U.S. at 360 n.11. The State's argument here raises a more fundamental point: Medicaid creates no

individual rights that state officials might conceivably violate and thereby subject themselves to redress via Section 1983. That issue has nothing to do with *Sea Clammers*, which addresses only whether, *notwithstanding* a federal statute's creation of individual rights, the statute's alternative remedies foreclose Section 1983 claims. *Sea Clammers*, 453 U.S. at 20-21.

Moreover, the *Suter* fix itself expressly disclaims any intent to "limit or expand the grounds for determining the availability of private actions to enforce State plan requirements[.]" 42 U.S.C. § 1320a-2. It therefore cannot itself be understood to create a cause of action under Section 1983. If anything, Congress, when it repealed the Boren Amendment, communicated its intention to negate the *only* Medicaid private enforcement this Court has permitted. H.R. Rep. No. 105-149, at 591 (1997) ("It is the Committee's intention that, following enactment of this Act, neither this nor any other provision of Section 1902 will be interpreted as establishing a cause of action for hospitals and nursing facilities relative to the adequacy of the rates they receive.").

3. Respondents argue that review of this case is not worthwhile because Indiana's statute can be challenged through a preemption claim. Br. in Opp. at 22-23. First, the courts below did not address this alternative theory, and its hypothetical availability

does not undermine the need for review of the issues actually resolved.

Second, Respondents overstate the viability of their alternative plea for relief under the Supremacy Clause. Last term the Court heard arguments as to whether the Medicaid Act could be privately enforced via the Supremacy Clause, but dismissed the writ and remanded without deciding the case. *See Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 132 S. Ct. 1204, 1211 (2012). The issue whether Medicaid plan requirements can be enforced through the Supremacy Clause arises only because of the legal patchwork resulting from attempts to enforce Medicaid through Section 1983. As explained in the State's Petition at page 22, the Court should therefore be equally interested in addressing the antecedent Section 1983 enforcement question.

In all events, Respondents' preemption theory must fail for reasons similar to those which doom its Section 1983 claim. Section 1396a(a)(23) establishes a criterion for federal reimbursement of State payments. A non-conforming State plan may not qualify for federal reimbursement, but it does not "conflict" with federal law (just as it does not violate individual rights). States may, consistent with federal law, maintain Medicaid plans that do not qualify for federal reimbursement.

III. Whether States May Exclude Abortion Providers from Medicaid Is a Nationally Important Question Warranting Review

Respondents do not directly refute the State's central grounds for granting the Petition on question 2, *i.e.*, that the decision below cannot be reconciled with decisions from other circuits and that the issue is nationally important because many states are considering measures similar to HEA 1210. Indeed, they acknowledge that the Second Circuit's decision in *Kelly Kare, Ltd. v. O'Rourke*, 930 F.2d 170 (2d Cir. 1991), "contains language inconsistent with the analysis of the Seventh Circuit[.]" Br. in Opp. at 21. Other than by previewing their merits arguments, Respondents urge denial of question 2 only because "*Kelly Kare* was decided before the federal government issued its authoritative interpretation of § 1396a(a)(23)[.]" The federal government has issued no such "authoritative interpretation," however, and indeed its apparent refusal to do so in response to Indiana's plan amendment further underscores the need for this Court's intervention.

1. Because HEA 1210 enacted a new provider qualification not previously included in Indiana's "plan for medical assistance," state officials submitted a plan amendment for approval by HHS. Indiana is still awaiting final agency determination of whether its plan amendment complies with the Medicaid Act. Final briefing to CMS was completed

on September 11, 2012, over a month before the Seventh Circuit issued the decision below. If CMS ever issues a final determination against the proposed plan amendment, the State may appeal. 42 C.F.R. §§ 430.38, 430.102(c). The decision below affirming an injunction against enforcement of HEA 1210, however, seems to have alleviated the need for a final agency decision, at least in CMS's view.

In all events, neither an interlocutory nor even a final decision by CMS will resolve the tension between the Second Circuit and the Seventh Circuit on this issue. Those two circuits disagree about whether, particularly in light of *O'Bannon v. Town Court Nursing Center*, 447 U.S. 773, 785-86 (1980), Section 1396a(a)(23) permits incidental reduction in the number of available Medicaid providers. *O'Bannon* held that Section 1396a(a)(23) is not absolute, and similarly only this Court can ensure that all states have the equal latitude to impose Medicaid provider exclusions.

2. In addition to demonstrating the irreconcilability of the decision below with *Kelly Kare*, the Petition also outlined inconsistencies with *Guzman v. Shewry*, 552 F.3d 941 (9th Cir. 2008); *First Medical Health Plan, Inc. v. Vega-Ramos*, 479 F.3d 46 (1st Cir. 2007); *Plaza Health Laboratories, Inc. v. Perales*, 878 F.2d 577 (2d Cir. 1989); and *Triant v. Perales*, 491 N.Y.S.2d 486 (N.Y. App. Div. 1985). Respondents do not expressly deny or persuasively refute these additional conflicts.

Respondents at first insist that, notwithstanding *O'Bannon*, Section 1396a(a)(23) provides Medicaid recipients with an "absolute" guarantee of provider choice. Br. in Opp. at 14 ("[T]his language is straightforward and absolute."). But they change their tune when confronted with the fact that the provider exclusions upheld in *Guzman*, *Vega-Ramos*, *Plaza Health Labs.*, and *Triant* necessarily mean that *some* recipients were denied provider choice. Thus Respondents acknowledge that Section 1396a(a)(23) protects choice only as to "qualified" providers, and even that Section 1396a(p)(1) "permits states to exclude providers for any reason that providers could be excluded from the Medicare program[.]" Br. in Opp. at 18. But they would delimit what counts as a legitimate qualification based, conveniently enough, on the facts of the *Guzman*, *Vega-Ramos*, *Plaza Health Labs.*, and *Triant* cases. Br. in Opp. at 20-21.

There is no statutory basis for so defining the Medicaid provider qualifications that States may impose. And even the limits Respondents propose should permit HEA 1210 as a "financial integrity" qualification. Br. in Opp. at 20-21.

3. Respondents also argue that "Indiana's interpretation [would] read the free-choice-of-provider provision out of existence [and] would also render meaningless numerous other provisions of the Medicaid Act." Br. in Opp. at 18. This is not

true. The State's theory supports Section 1396a(a)(23) as a restriction against state laws targeting patient choice *as such*, as in *Chisholm v. Hood*, 110 F. Supp. 2d 499, 506 (E.D. La. 2000) (prohibiting Louisiana from forcing school-aged children to seek services at their respective schools, as opposed to an independent provider), and *Bay Ridge Diagnostic Laboratory, Inc. v. Dumpson*, 400 F. Supp. 1104, 1105, 1108 (E.D.N.Y. 1975) (prohibiting New York City from implementing a program by which Medicaid eligible providers bid for *exclusive* contracts to serve a borough of the city).

All other provisions Respondents cite are likewise fully consistent with the State's interpretation of the provider-choice provision as a restriction against rules targeting provider choice, not a ban on all rules that incidentally may reduce provider choice.

- **Section 1396a(p)(1)**: This section *directly* confers on states the authority to exclude providers for any reason that providers could be excluded from the Medicare program, while also preserving exclusion authority arising from state law that already could be a basis for disqualifying a provider.

- **Section 1396a(a)(23)(B)**: Permits Puerto Rico, the Virgin Islands, and Guam to restrict provider choice in a managed care program relating to family planning. This

relates not to the general provider choice protection that Respondents invoke in this case, but instead to the more specific restriction applicable to managed care programs (Section 1396n(b)(1)), which is not implicated in this case.

- **Section 1396n(a)**: Permits (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 permits provider exclusivity in a narrow circumstance, as an exception to what Section 1396a(a)(23) prevents more generally (*i.e.*, rules targeting choice as such), as the State has conceded all along. Subsection 2 addresses *recipient* abuse, not provider qualifications.

- **Section 1396n(b)(4)**: Permits states to request a waiver allowing it to restrict the providers from which an individual may receive services. Again, this allows an exception that would permit state targeting of provider choice as such, which Section 1396a(a)(23) otherwise precludes.

HEA 1210 does not target or limit the number of available providers. It says only that an abortion-services provider cannot be a Medicaid provider. A clinic's choice to cease being a Medicaid provider so

that it may provide abortion services is merely an incidental effect of the law, not its central objective.[1] The permissibility of such laws is implied by the holding in *O'Bannon* that Section 1396a(a)(23)'s protection of provider choice is not absolute.

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The decision below conflicts with other circuits on the scope of state authority to set Medicaid provider qualifications. The Court should take this case to explain what the provider-choice plan requirement really means and how it interacts with state authority over provider qualifications.

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[1] Indeed, prior to the district court's injunction in this matter, the Indiana Family and Social Services Administration issued a notice of proposed rulemaking announcing that HEA 1210's reference to "any entity that performs abortions or maintains or operates a facility where abortions are performed," Ind. Code § 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[.]" Pet. App. 121a (emphasis added). In light of the injunction issued by the district court, FSSA has taken no further action to promulgate such a rule, but the limits of the statutory text alone is enough to preclude disqualification of mere *affiliates* of abortion providers.

CONCLUSION

The petition should be granted.

Respectfully submitted,

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Dated: April 24, 2013