No. 11–2464

IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

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

v.

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

On Appeal From The United States District Court
For The Southern District of Indiana.
No. 1:11-cv-630 – Tanya Walton Pratt, Judge

BRIEF FOR THE UNITED STATES AS *AMICUS CURIAE* IN SUPPORT OF APPELLEES

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STATEMENT OF INTEREST

The United States respectfully submits this *amicus curiae* brief pursuant to Rule 29(a) of the Federal Rules of Appellate Procedure. We are submitting this brief because the Indiana statute at issue on this appeal violates the Medicaid Act, which is administered by the U.S. Department of Health and Human Services ("HHS").

This case concerns the Medicaid Act's "free choice of providers" requirement, 42 U.S.C. § 1396a(a)(23), and its implementation by HHS. Section 1396a(a)(23) gives Medicaid recipients "the right to choose among a range of qualified providers, without government interference." *O'Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773, 785 (1980) (emphasis omitted). The regulations that implement this requirement allow States to set "reasonable standards relating to the qualifications of providers." 42 C.F.R. § 431.51(c)(2).

The State of Indiana receives federal funds under the Medicaid program and is thus bound by the requirements imposed by the Act and by HHS in administering the Act. Federal funds pay for more than half of the cost of Medicaid benefits in Indiana. A new Indiana statute prohibits providers that perform abortions from participating in Medicaid.

The effect of that exclusion is to prevent Medicaid recipients from obtaining services that are unrelated to abortion (such as cancer screening, testing for sexually transmitted disease, and contraception) from such providers.

Plaintiffs are Planned Parenthood of Indiana ("PPIN"), two PPIN employees, and two Medicaid beneficiaries who receive annual examinations and other services at their local PPIN health centers. They alleged that the new Indiana statute violates their right under the Medicaid Act to obtain services from any qualified provider, and sought a preliminary injunction. The United States filed a Statement of Interest in support of the request for a preliminary injunction. The Statement of Interest explained that the Administrator of HHS's Centers for Medicare & Medicaid Services ("CMS") had denied Indiana's proposed amendment to its state Medicaid plan on the ground that the changes made by the new Indiana statute would violate the Medicaid Act's free choice of providers requirement. The district court issued a preliminary injunction, concluding plaintiffs are likely to succeed on the merits and that the balance of harms warrants injunctive relief. The State has appealed.

The United States has a substantial interest in the issues raised by the State's appeal. Indiana contends that States have the unfettered right to exclude any provider or class of providers from the Medicaid program. The district court correctly rejected that contention, which would make the free choice of providers requirement illusory and the specific statutory exceptions to that requirement superfluous. Indiana's assertion of "carte blanche" authority "to expel otherwise competent Medicaid providers" (Short App. 22) is contrary to HHS's interpretation of the Medicaid statute and would be untenable even without regard to the deference that is owed to the Administrator's determination.

Indiana also contends, as a threshold matter, that the free choice of providers requirement cannot be enforced by Medicaid recipients in an action brought pursuant to 42 U.S.C. § 1983. The State urges this Court to reject the contrary holding of *Harris v. Olszewski*, 442 F.3d 456 (6th Cir. 2006), where the Sixth Circuit (per Judge Sutton) held that Medicaid recipients may enforce the free choice of providers requirement in a § 1983 action. The Sixth Circuit, in so ruling, accepted the arguments made by

the United States as *amicus curiae*.[1] The Sixth Circuit's reasoning is correct and its decision should be followed here.

STATEMENT

A. Statutory Background

The Medicaid program, which was enacted in 1965 as Title XIX of the Social Security Act, "is a cooperative federal-state program through which the Federal Government provides financial assistance to States so that they may furnish medical care to needy individuals." *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990). "Although participation in the program is voluntary, participating States must comply" with the requirements imposed by the Medicaid Act and by HHS in its administration of the Act. *Ibid.*; *see also Collins v. Hamilton*, 349 F.3d 371, 374 (7th Cir. 2003). Within specified limits, the Medicaid Act "gives the States substantial discretion to choose the proper mix of amount, scope, and duration limitations on coverage, as long as care and services are provided in 'the best interests of the recipients.'" *Alexander v. Choate*, 469 U.S. 287, 303 (1985) (quoting 42 U.S.C. § 1396a(a)(19)).

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[1] *See* Brief for the United States as *Amicus Curiae*, *L.F. v. Olszewski*, Nos. 04-2479 & 05-1047, 2005 WL 5917922, at *22-30.

To qualify for federal funds, a participating State must submit to HHS and receive approval of a "plan for medical assistance" that describes the nature and scope of the State's Medicaid program and demonstrates compliance with the Act. *See* 42 U.S.C. § 1396a(a), (b); *Wilder*, 496 U.S. at 502. For example, the plan must show that the state Medicaid program will cover specified categories of individuals and provide specified benefits (such as physician and hospital services). *See* 42 U.S.C. § 1396a(a)(10). In addition, under the "free choice of providers" requirement that is at issue here, the state plan must

> provide that (A) any individual eligible for medical assistance . . . may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required, . . . who undertakes to provide him such services, and (B) an enrollment of an individual eligible for medical assistance in a [managed care plan] shall not restrict the choice of the qualified person from whom the individual may receive [family planning services] . . . .

42 U.S.C. § 1396a(a)(23).

Longstanding HHS regulations implement this requirement. Under the regulations, a state plan must provide that a Medicaid "recipient may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is . . . (i) qualified to furnish the services; and

(ii) willing to furnish them to that particular recipient." 42 C.F.R. § 431.51(b)(1) (capitalization omitted). At the same time, the regulations allow States to set "reasonable standards relating to the qualifications of providers." *Id.* § 431.51(c)(2).

Authority to disapprove a state plan or plan amendment is vested in the Administrator of HHS's Centers for Medicare & Medicaid Services, who may disapprove a plan or plan amendment after consultation with the Secretary. *See id.* § 430.15(c). The disapproval of a plan or plan amendment is subject to reconsideration, *see* 42 U.S.C. § 1316(a)(2), and direct review in the court of appeals for the circuit in which the State is located, *see id.* § 1316(a)(3).

B. Factual Background and Prior Proceedings

1. "The State of Indiana participates in the Medicaid program and is therefore bound by its requirements." *Collins v. Hamilton*, 349 F.3d 371, 374 (7th Cir. 2003). The federal government pays more than half of the costs of Medicaid benefits in Indiana; the percentage of medical assistance that is paid with federal funds in Indiana is currently 66.52%. *See* 74 Fed. Reg. 62315, 16 (Nov. 27, 2009).

On May 13, 2011, Indiana submitted to CMS a proposed amendment to its Medicaid plan that reflected the provisions of a new Indiana statute. *See* App. 138. As relevant here, that statute prohibits state agencies from contracting with or making grants to entities that perform abortions. *See* Indiana Code § 5-22-17-5.5(b). The statute also cancels any past state appropriations to pay for existing contracts with or grants made to entities that perform abortions. *See id.* § 5-22-17-5.5(c), (d). The funding restrictions do not apply to licensed hospitals or ambulatory surgical centers. *See id.* § 5-22-17-5.5(a). There is no dispute that the statute encompasses Medicaid funding.

Federal law prohibits the use of Medicaid funding for abortions except where the pregnancy results from rape or incest or the life of the pregnant woman is at stake. *See Harris v. McRae*, 448 U.S. 297, 302 (1980) (discussing the Hyde Amendment). The effect of the new Indiana statute is to prevent Medicaid recipients from obtaining from providers such as PPIN services that are unrelated to abortion, including cervical Pap smears, HIV testing, treatment of sexually transmitted disease, and contraceptive pills and supplies. *See* Short App. 3. In the past year, PPIN

provided services to more than 9,300 Medicaid recipients in Indiana. *See id.* at 4. Only a small percentage of the services that PPIN provides involve abortion. *See id.* at 3.

On June 1, 2011, the Administrator of CMS, Donald M. Berwick, M.D., sent a letter advising the State of Indiana that he was unable to approve the proposed amendment to Indiana's Medicaid plan because the amendment does not comply with the requirements of 42 U.S.C. § 1396a(a)(23). *See* App. 142. The letter explained that the proposed amendment "would eliminate the ability of Medicaid beneficiaries to receive services from specific providers for reasons not related to their qualifications to provide such services." *Ibid.* It noted that Medicaid funding of abortion services is "not permitted under federal law except in extraordinary circumstances (such as in cases of rape or incest)." *Ibid.* It explained that, "[a]t the same time, 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." *Ibid.* The letter further explained that "[s]uch a restriction would have a particular effect on beneficiaries' ability to access family planning providers, who are

subject to additional protections under" § 1396a(a)(23)(B). *Ibid.* Accordingly, the CMS Administrator advised the State that the plan amendment could not be approved. *See ibid.* The Administrator noted that his decision should not be unexpected because Indiana's own Legislative Services Agency had warned that "'restricting freedom of choice with respect to providers of family planning services is prohibited.'" *Ibid.* (citation omitted).

On June 23, Indiana submitted a request for reconsideration of the CMS Administrator's decision, which is pending. *See* App. 147.[2]

2. Plaintiffs in this lawsuit are PPIN, two PPIN employees, and two Medicaid beneficiaries who receive annual examinations and other health services at their local PPIN health centers. As relevant here, the complaint alleged that the exclusion of providers imposed by the new Indiana statute violates the Medicaid Act's free choice of providers requirement. Plaintiffs moved for a preliminary injunction, and the United States filed a Statement of Interest in support of the motion for a preliminary injunction.

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[2] A hearing on the reconsideration request is scheduled for December 15.

The district court issued a preliminary injunction. The court concluded that § 1396a(a)(23) is subject to private enforcement in an action brought under 42 U.S.C. § 1983; that plaintiffs are likely to succeed on the merits; and that the balance of harms warrants injunctive relief.

ARGUMENT

I. The Indiana Statute Violates the Medicaid Act's Free Choice of Providers Requirement.

Indiana's new statute excludes providers that perform abortions from the Medicaid program for reasons that bear no relation to the providers' qualifications to render services. The exclusion violates the Medicaid Act's free choice of providers requirement.

A. States Do Not Have Unfettered Discretion To Exclude Providers from the Medicaid Program.

1. Under the free choice of providers requirement, a state plan must provide that "any individual eligible for medical assistance . . . may obtain such assistance 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). "The same 'free choice of providers' is also guaranteed by" longstanding HHS

regulations. *O'Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773, 779 n.8 (1980) (citing 42 C.F.R. § 431.51 (1979)). Under the regulations, a state plan must provide that a Medicaid recipient "may obtain Medicaid services from any institution, agency, pharmacy, or organization that is . . . (i) qualified to furnish the services; and (ii) willing to furnish them to that particular recipient." 42 C.F.R. § 431.51(b)(1) (capitalization omitted). At the same time, the regulations allow States to set "reasonable standards relating to the qualifications of providers." *Id.* § 431.51(c)(2).

It is common ground that § 1396a(a)(23) does not give Medicaid recipients the right to obtain services from providers that are not "qualified to perform the service or services required." The Supreme Court explained, in discussing a nursing home that was decertified for failure to meet federal standards, that § 1396a(a)(23) "gives recipients the right to choose among a range of *qualified* providers, without government interference." *O'Bannon*, 447 U.S. at 785 (emphasis in original). The Court stated that, "[b]y implication, it also confers an absolute right to be free from government interference with the choice to remain in a home that continues to be qualified." *Ibid.* The provision does not, however,

"confer a right on a recipient to enter an unqualified home and demand a hearing to certify it, nor does it confer a right on a recipient to continue to receive benefits for care in a home that has been decertified." *Ibid.*; *see also Bruggeman v. Blagojevich*, 324 F.3d 906, 911 (7th Cir. 2003) (observing that "the aim" of § 1396a(a)(23) "is to give the recipient a choice among available facilities, not to require the creation or authorization of new facilities") (citing *O'Bannon*, 447 U.S. at 785-86; *Kelly Kare, Ltd. v. O'Rourke*, 930 F.2d 170, 177 (2d Cir.1991); *Catanzano v. Wing*, 103 F.3d 223, 231 (2d Cir.1996)).

Indiana does not contend that its statute excludes providers from participation in the Medicaid program on the ground that they are "unqualified" in any conventional sense. Instead, Indiana asserts that States are free to exclude providers from Medicaid on the basis of any "practices of which States disapprove," to avoid an "indirect subsidy" of the disapproved practices. State Br. 12.

That is not a tenable interpretation of the Medicaid Act. The State's assertion of "carte blanche" authority "to expel otherwise competent Medicaid providers" (Short App. 22) would render illusory the "absolute

right" that § 1396a(a)(23) affords Medicaid beneficiaries to choose among qualified providers without government interference. *O'Bannon*, 447 U.S. at 785. Furthermore, Indiana's position would render superfluous the specific statutory exceptions to the free choice of providers requirement. For example, § 1396a(a)(23) states 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 which the State agency determines is inconsistent with the best interests of beneficiaries under the State plan." If, as Indiana asserts, a State had unfettered authority to exclude providers from Medicaid, Congress would not have specified that a State may exclude a provider convicted of a felony for an offense that is inconsistent with the best interests of Medicaid beneficiaries.

The regulations that implement § 1396a(a)(23) similarly recognize, consistent with *O'Bannon*, that a State may set "reasonable standards" relating to the qualifications of providers. 42 C.F.R. § 431.51(c)(2). On Indiana's theory, by contrast, a State could exclude providers regardless of whether the exclusion bears a "reasonable" relationship to their ability

to perform the services or furthers any other objective of the Medicaid program, such as its financial integrity.

Indiana's position is particularly implausible with respect to providers of family planning services such as PPIN, because Congress singled out recipients of family planning services for additional protection in the free choice of providers requirement. Under § 1396a(a)(23)(B), a Medicaid recipient's enrollment in a managed care program "shall not restrict the choice of the qualified person from whom the individual may receive services under section 1396d(a)(4)(C)," *i.e.*, "family planning services." Thus, even in the managed care setting — where a State generally may limit a Medicaid recipient's free choice of providers — Medicaid recipients are free to choose their provider of family planning services. Accordingly, Indiana's own Legislative Services Agency recognized that "'restricting freedom of choice with respect to providers of family planning services is prohibited.'" App. 142 (quoting the state agency's April 19, 2011 fiscal impact statement).

2. Indiana's principal contention is that a 1987 amendment to the Medicaid statute gave States carte blanche authority to exclude providers

from the Medicaid program. But that provision, 42 U.S.C. § 1396a(p)(1), provides no support for the State's position. Section 1396a(p)(1) states: "In addition to any other authority, a State may exclude any individual or entity for purposes of participating under the State plan under this subchapter for any reason for which the Secretary could exclude the individual or entity from participation in a program under [Medicare] under section 1320a-7, 1320a-7a, or 1395cc(b)(2) of this title." The referenced sections address the Secretary's authority to exclude providers for reasons such as criminal offenses related to the delivery of services or abuse or neglect of patients (42 U.S.C. § 1320a-7); submission of false claims or acceptance of kickbacks (*id.* § 1320a-7a); and failure to comply with regulations or corrective action requirements (*id.* § 1395cc(b)(2)). A State's authority to exclude providers for the reasons listed in § 1396a(p)(1) is not at issue here.

There is no doubt that § 1396a(p)(1) "contemplates that states have the authority to suspend or to exclude providers from state health care programs for reasons other than those upon which the Secretary of HHS has authority to act." *Guzman v. Shewry*, 552 F.3d 941, 949 (9th Cir.

2009). As discussed above, HHS regulations issued nearly a decade before the 1987 amendments allowed States to set "reasonable standards relating to the qualifications of providers." 43 Fed. Reg. 45176, 45189 (Sept. 29, 1978) (42 C.F.R. § 431.51(d)(2)). Accordingly, the 1987 Senate Report explained that § 1396a(p)(1), "by expressly granting States the authority to exclude individuals or entities from participation in their Medicaid programs for any of the reasons that constitute a basis for an exclusion from Medicare under sections 1128, 1128A, or 1866(b)(2) of the Social Security Act," was "not intended to preclude a State from establishing, under State law, any other bases for excluding individuals or entities from its Medicaid program." S. Rep 100-109, at 19 (1987).

Thus, the authority of a State to set reasonable qualifications for providers was specifically left unaltered by § 1396a(p)(1). But nothing in § 1396a(p)(1) suggests that a State has *unfettered* authority to exclude providers from the Medicaid program. To the contrary, the 1987 amendments to the Social Security Act were generally designed to "protect beneficiaries under the health care programs of [the Social Security Act] from unfit health care practitioners, and otherwise to improve the

antifraud provisions relating to those programs." S. Rep. No. 100-109, at 1 (1987). Section 1396a(p)(1) addressed that goal by allowing States to exclude providers for reasons that constitute a basis for exclusion from Medicare. Indiana's position would render superfluous that specific grant of authority. Indeed, if, as Indiana asserts, States had unconstrained discretion to exclude providers from Medicaid for whatever reasons they see fit, Congress would have had no reason to enact § 1396(p)(1) in the first place.[3]

3. The cases on which Indiana relies (State Br. 29-30) underscore the absence of support for the State's position. For example, *First Medical Health Plan, Inc. v. Vega-Ramos*, 479 F.3d 46 (1st Cir. 2007), involved actions taken by Puerto Rico, which is exempt from the free choice of providers requirement. *See* 42 U.S.C. § 1396a(a)(23) ("this paragraph shall not apply in the case of Puerto Rico, the Virgin Islands, and Guam").

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[3] Indiana notes that, under 42 C.F.R. § 1001.1501, the Office of the Inspector General may disqualify providers from Medicare and Medicaid if they have defaulted on health education loan and scholarship obligations. *See* State Br. 31. The cited regulation implements a specific grant of statutory authority that permits the Secretary to exclude any individual "who the Secretary determines is in default on repayments of scholarship obligations or loans in connection with health professions education[.]" 42 U.S.C. § 1320a-7(b)(14).

Moreover, the regulation upheld by the First Circuit was designed to prevent a provider from engaging in "self-dealing" and thus to "protect the integrity of the Puerto Rico Medicaid system." *First Medical Health Plan*, 479 F.3d at 49, 52.

Other decisions cited by Indiana involved the exclusion from Medicaid of physicians involved in malpractice or providers under criminal investigation. *See Triant v. Perales*, 491 N.Y.S.2d 486, 488 (N.Y. App. Div. 1985) (physician was barred from the Medicaid program in light of "monumental deficiencies" in record-keeping that left him unable to recall the reason for prescribing medication, ordering tests, or referring Medicaid patients to specialists); *Guzman v. Shewry*, 552 F.3d 941 (9th Cir. 2009) (physician was under investigation for Medicaid fraud); *Plaza Health Laboratories, Inc. v. Perales*, 878 F.2d 577, 579 (2d Cir. 1989) (provider was indicted for a felony offense that the State determined "relat[ed] to the furnishing or billing for medical care, services or supplies").

In *Kelly Kare, Ltd. v. O'Rourke*, 930 F.2d 170, 177 (2d Cir. 1991) (cited at State Br. 34), a county terminated a provider's Medicaid contract without giving a reason. *See id.* at 173. In rejecting a constitutional

challenge to the termination, the Second Circuit stressed that the county's termination did "not bear on Kelly Kare's status as a qualified provider." *Id.* at 176. The court concluded that "[t]here is a critical difference between being declared a qualified health-care provider and being awarded a contract to furnish health-care services," and noted that the "refusal by a social services district to enter a contract with a qualified provider in no way affects the status of the provider," which "remains free to seek a contract with a different social services district." *Id.* at 176. Assuming *arguendo* that the premises of the constitutional holding were correct, the decision addressed only the termination of a single county contract rather than a statewide exclusion from the Medicaid program.[4]

[4] As the district court noted, this Court cited *Kelly Kare* in its *Bruggeman* decision for the "non-controversial proposition that the aim of the 'freedom of choice' provision is 'to give the recipient a choice among available facilities, not to require the creation or authorization of new facilities.'" Short App. 14 n.4 (quoting *Bruggeman*, 324 F.3d at 911).

B. The CMS Administrator's Determination Is Entitled to Deference.

For the reasons discussed above, the State's position should be rejected even without regard to the deference that is owed to the CMS Administrator's disapproval of Indiana's proposed plan amendment. The Administrator's determination is also entitled to deference.

The CMS Administrator, in disapproving Indiana's proposed plan amendment, exercised authority delegated by the Secretary of Health and Human Services. *See* 42 C.F.R. § 430.15(c). The Secretary's authority, in turn, derives from an express delegation of authority by Congress. As the D.C. Circuit has explained, Congress explicitly granted the Secretary authority to review and approve state Medicaid plans for medical assistance. *See Pharmaceutical Research & Mfrs. of America v. Thompson*, 362 F.3d 817, 822 (D.C. Cir. 2004). "In carrying out this duty, the Secretary is charged with ensuring that each state plan complies with a vast network of specific statutory requirements." *Ibid.* "Through this 'express delegation of specific interpretive authority,' . . . the Congress manifested its intent that the Secretary's determinations, based on interpretation of the relevant statutory provisions, should have the force

of law." *Ibid.* (quoting *United States v. Mead*, 533 U.S. 218, 229 (2001)). "The Secretary's interpretations of the Medicaid Act are therefore entitled to *Chevron* deference." *Ibid.*

The Sixth Circuit in *Harris v. Olszewski*, 442 F.3d 456, 467-68 (6th Cir. 2006), expressly followed the D.C. Circuit's reasoning, and other courts of appeals likewise have held that HHS's denial or approval of a state plan amendment is entitled to *Chevron* deference. *See ibid.* (citing *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 596 (5th Cir. 2004); *Alaska Dep't of Health & Soc. Servs. v. Ctrs. for Medicare & Medicaid Servs.*, 424 F.3d 931, 939 (9th Cir.2005); *Georgia, Dep't of Medical Assistance ex rel. Toal v. Shalala*, 8 F.3d 1565, 1572-73 (11th Cir.1993)). Indiana cites no contrary authority.

Indiana nonetheless asserts that "*Chevron* deference is inappropriate here because Congress has legislated extensively in creating a system of cooperative federalism, and because harmonizing Sections 1396a(a)(23) and 1396a(p)(1) is central to how Medicaid functions." State Br. 38-39. The Sixth Circuit correctly recognized, however, that "'reliance on [the] Secretary's significant expertise [is] particularly appropriate in the context

of a complex and highly technical regulatory program' like Medicaid." *Harris*, 442 F.3d at 468 (quoting *Wis. Dep't of Health & Family Servs. v. Blumer*, 534 U.S. 473, 497 (2002)).

There is no conflict between §§ 1396a(a)(23) and 1396a(p)(1); neither provision supports Indiana's position here for reasons discussed above. If, however, there were a need to harmonize different Medicaid Act provisions, that would be the responsibility of the Secretary, who is charged by Congress with administering the Medicaid Act.

II. The Free Choice of Providers Requirement Confers Individual Rights That Medicaid Recipients May Enforce in a § 1983 Action.

A. Section 1396a(a)(23) Uses Individually Focused Terminology That Establishes Privately Enforceable Rights.

The State also contends, as a threshold matter, that § 1396a(a)(23) does not confer individual rights that a Medicaid recipient may enforce in an action brought under § 1983. The district court correctly rejected that contention. For the reasons discussed at length by the Sixth Circuit in *Harris v. Olszewski*, 442 F.3d 456 (6th Cir. 2006), the free choice of providers requirement meets the standard established by the Supreme

Court for determining that a provision of Spending Clause legislation may be enforced in a § 1983 action.

"First, in giving 'any individual eligible for medical assistance' a free choice over the provider of that assistance, the statute uses the kind of 'individually focused terminology' that 'unambiguously confer[s]' an 'individual entitlement' under the law." *Id.* at 461 (quoting *Gonzaga University v. Doe*, 536 U.S. 273, 287 (2002)). Moreover, by stating that "'[a] State plan . . . must . . . provide' this free choice, the statute uses the kind of 'rights-creating,' . . . mandatory language, . . . that the Supreme Court . . . [has] held establishes a private right of action." *Id.* at 461-62 (quoting *Gonzaga*, 563 U.S. at 287) (other citations omitted).

"It is also clear that the right is vested 'in the class of beneficiaries to which [plaintiffs] belong[ ],' namely individuals eligible for Medicaid coverage." *Id.* at 462 (quoting *City of Rancho Palos Verdes v. Abrams*, 544 U.S. 113, 120 (2005)). The Supreme Court has expressly recognized that § 1396a(a)(23) "gives recipients the right to choose among a range of qualified providers, without government interference." *O'Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773, 785 (1980) (emphasis omitted).

"Nor do other provisions of the Medicaid Act explicitly or implicitly foreclose the private enforcement of this statute through § 1983 actions." *Harris*, 442 F.3d at 462. "That the Federal Government may withhold federal funds to non-complying States is not inconsistent with private enforcement." *Id.* at 463. In *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498 (1990), the Supreme Court rejected the contention that the Secretary's authority to "curtail federal funds to States whose plans are not in compliance with the Act" warrants the inference that Congress precluded any private enforcement of Medicaid Act requirements under § 1983. *Id.* at 521-22. The Supreme Court held that the administrative scheme "cannot be considered sufficiently comprehensive to demonstrate a congressional intent to withdraw the private remedy of § 1983.'" *Ibid.* (quoted in *Harris*, 442 F.3d at 463).

B. Indiana's Contention That None of the Medicaid Act's Requirements Is Subject to Private Enforcement Is Foreclosed by Supreme Court Precedent and Specific Legislation.

Indiana does not dispute that § 1396a(a)(23) uses the type of individually focused terminology that has been held to confer rights enforceable under § 1983. Instead, the State urges this Court to reject the

Supreme Court's reasoning in *Wilder* and to hold that *none* of the Medicaid Act's requirements can be the subject of private enforcement because they are embodied in a state plan for medical assistance. *See* State's Br. 18-19. Indiana asserts that the Medicaid Act does "nothing more than supply criteria for federal reimbursement," and that the only means of enforcement is for the Secretary to "turn off the funding spigot." *Id.* at 14. Indeed, Indiana suggests that no statute enacted pursuant to Congress's spending power may be enforced through an injunction. It asserts that, because "conditional funding is optional for a State, the appropriate action in dealing with State noncompliance is to reduce funding, not to enjoin the State from enforcing legislation that fails to meet the conditions of funding." *Id.* at 24.

These assertions reflect a fundamental misunderstanding of the nature of Spending Clause legislation and of the Supreme Court's private right of action jurisprudence. Requirements imposed pursuant to Congress's spending power have the full force of federal law.[5] "A state's

[5] *See, e.g.*, *Townsend v. Swank*, 404 U.S. 282, 285 (1971); *Carleson v. Remillard*, 406 U.S. 598, 604 (1972); *Blum v. Bacon*, 457 U.S. 132, 145-46 (1982); *Bennett v. Arkansas*, 485 U.S. 395, 397 (1988) (per curiam); *Dalton v. Little Rock Family Planning Servs.*, 516 U.S. 474, 476 (1996) (per

participation in the Medicaid program is completely voluntary. However, once a state elects to participate, it must abide by all federal requirements and standards as set forth in the Act." *Collins v. Hamilton*, 349 F.3d 371, 374 (7th Cir. 2003) (citing *Wilder,* 496 U.S. at 502). "The State of Indiana participates in the Medicaid program and is therefore bound by its requirements." *Ibid.*; *see also*, *e.g.*, *Atkins v. Rivera*, 477 U.S. 154, 157 (1986) ("States participating in the Medicaid program must provide coverage to the 'categorically needy.'") (citing 42 U.S.C. § 1396a(a)(10)(A)).

Withholding funds is one means to enforce Spending Clause legislation, but it is not the only means. To the contrary, a "funding recipient is generally on notice that it is subject not only to those remedies explicitly provided in the relevant legislation, but also to those remedies traditionally available in suits for breach of contract," including "injunction." *Barnes v. Gorman*, 536 U.S. 181, 187 (2002). "Even in the absence of statutory authority, the United States has the inherent power to sue to

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curiam); *Missouri Child Care Ass'n v. Cross*, 294 F.3d 1034, 1041 (8th Cir. 2002); *Westside Mothers v. Haveman*, 289 F.3d 852, 859-60 (6th Cir. 2002); *Antrican v. Odom*, 290 F.3d 178, 188 (4th Cir. 2002); *Frazar v. Gilbert*, 300 F.3d 530, 550-51 (5th Cir. 2002), *reversed on other grounds*, 540 U.S. 431 (2004).

enforce conditions imposed on the recipients of federal grants." *United States v. Miami University*, 294 F.3d 797, 808 (6th Cir. 2002); *accord Indiana Protection & Advocacy Services v. Indiana Family & Social Services Admin.*, 603 F.3d 365, 384 (7th Cir. 2010) (en banc) (Posner, J., concurring) ("[t]he state's acceptance created a contract and the federal government, if it sought specific performance of the state's obligation, would be enforcing a federal common law contractual right") (citing cases); *id.* at 388 (Easterbrook, C.J., dissenting) (federal government "can end the funding or sue if the state does not keep its part of the bargain"); *see also*, *e.g.*, *Henke v. Department of Commerce*, 83 F.3d 1445, 1450 (D.C. Cir. 1996); *United States v. Marion County School District*, 625 F.2d 607, 609 (5th Cir. 1980). Thus, the governing precedent makes clear that Spending Clause legislation is susceptible to enforcement by means other than "turning off the funding spigot."

The availability of a *private* remedy under § 1983 is a question of congressional intent, determined by reference to the particular statutory provision at issue. Contrary to Indiana's contention, "*Gonzaga University* did not overrule *Wilder*." *Bertrand ex rel. Bertrand v. Maram*, 495 F.3d

452, 456-57 (7th Cir. 2007). Thus, the courts of appeals have repeatedly held in post-*Gonzaga* decisions that certain Medicaid Act requirements may be enforced in a § 1983 action. *See, e.g., Doe v. Kidd*, 501 F.3d 348, 355-57 (4th Cir. 2007) (§ 1396a(a)(8)); *Watson v. Weeks*, 436 F.3d 1152, 1159-62 & n.8 (9th Cir. 2006) (§ 1396a(a)(10)); *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 602-07 (5th Cir. 2004) (§ 1396a(a)(10)); *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 190-93 (3d Cir. 2004) (§§ 1396a(a)(8), 1396a(a)(10), 1396d(a)(15)); *Rabin v. Wilson-Coker*, 362 F.3d 190, 201-02 (2d Cir. 2004) (§ 1396r-6); *Gean v. Hattaway*, 330 F.3d 758, 772-73 (6th Cir. 2003) (§ 1396a(a)(3)).

In *Collins v. Hamilton*, 349 F.3d 371 (7th Cir. 2003), Indiana did not contest the district court's determination that a class of Medicaid beneficiaries may bring suit under § 1983 to enforce the requirements of § 1396a(a)(10). *See Collins v. Hamilton*, 231 F. Supp. 2d 840, 846-47 (S.D. Ind. 2002). This Court affirmed an injunction that required Indiana to provide specified services to the plaintiff class. *See* 349 F.3d at 376.

Nonetheless, Indiana now contends that *none* of the Medicaid Act's requirements may be enforced under § 1983 because the requirements

concern the contents of a state plan. *See* State Br. 17-18. That argument is foreclosed not only by *Wilder*, but also by the Social Security Act amendments that Congress enacted in response to *Suter v. Artist M.*, 503 U.S. 347 (1992), where the Supreme Court had suggested Congress might not have intended to allow private enforcement of state plan requirements. To negate that inference, Congress provided: "In an action brought to enforce a provision of [the Social Security Act], 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." 42 U.S.C. §§ 1320a-2, 1320a-10.[6] The Conference Report explained that

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[6] In full, these amendments to the Social Security Act provide:

> In an action brought to enforce a provision of [the Social Security Act], 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.

"[t]he intent of this provision is to assure that individuals who have been injured by a State's failure to comply with the Federal mandates of the State plan titles of the Social Security Act are able to seek redress in the federal courts to the extent they were able to prior to the decision in *Suter v. Artist M.*" H.R. Conf. Rep. No. 761, 103d Cong., 2d Sess. 926 (1994).

As the Second Circuit explained, "Section 1320a-2 precludes [a State] from relying on the plan requirement language" of Medicaid to urge that enforcement under § 1983 is precluded. *Rabin v. Wilson-Coker*, 362 F.3d 190, 201-02 (2d Cir. 2004). Indiana's brief does not discuss this statutory amendment, although it is quoted in the Supreme Court *amicus* brief on which the State relies. *See* State Br. 27 (discussing the Brief for the United States as *Amicus Curiae* Supporting Petitioner, *Douglas v. Independent Living Center of S. Cal., Inc.*, No. 09-958, 2011 WL 2132705).

Moreover, the State mistakenly suggests that the position urged by the United States in *Douglas* would preclude private enforcement of § 1396a(a)(23). There is no dispute that the particular Medicaid Act provision before the Court in *Douglas*, § 1396a(a)(30), does not confer individuals rights enforceable in a § 1983 action. The question in *Douglas*

is whether the Court should recognize a nonstatutory cause of action for Medicaid providers and beneficiaries to enforce that provision. The United States has urged that the Court should not recognize such a nonstatutory cause of action. Here, by contrast, Medicaid recipients may enforce the free choice of providers requirement in a § 1983 action for the reasons discussed above.

CONCLUSION

The judgment of the district court should be affirmed.

Respectfully submitted.

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CERTIFICATE OF COMPLIANCE WITH FEDERAL RULE OF APPELLATE PROCEDURE 32(a)(7)(B)

I hereby certify that this brief complies with the type-face and volume limitations set forth in Federal Rule of Appellate Procedure 32(a)(7)(B) as follows: the type face is fourteen-point Century font, and number of words is 6,033.

s/Alisa B. Klein

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CERTIFICATE OF SERVICE

I hereby certify that on this 6th day of September, 2011, I caused the foregoing brief to be filed and served through the ECF system.

s/Alisa B. Klein

Alisa B. Klein