

IN THE
UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS, INDIANA

PLANNED PARENTHOOD OF INDIANA,)	
INC., <i>et al.</i> ,)	
Plaintiffs,)	
)	
v.)	No. 1:11-cv-0630-TWP-DKL
)	
COMMISSIONER OF THE INDIANA STATE)	
DEPARTMENT OF HEALTH, <i>et al.</i> ,)	
Defendants.)	

DEFENDANTS' RESPONSE
TO STATEMENT OF INTEREST OF THE UNITED STATES

The federal government's Statement of Interest says nothing to advance Planned Parenthood's cause. It cites no federal court precedent affording deference to an initial CMS rejection of a State plan amendment that remains subject to rehearing and judicial review, and it directs the Court to no statutory text or case law supporting the view that the Medicaid free choice statute trumps the Medicaid provider qualifications statute, particularly in light of the State's compelling interest in preventing indirect subsidy of abortion. Indeed the federal government's position in this case is in tension with its own regulations, which specifically acknowledge state authority over provider qualifications.

I. The Statement of Interest Provides No Additional Law Supporting Planned Parenthood's Position

The federal government has identified no new statutory text or history bearing on the provider qualifications and free choice issues, and like the CMS letter denying Indiana's plan amendment, the federal government's brief provides no law supporting its position.

1. The United States argues that 42 U.S.C. § 1396a(p)(1) is not implicated here because 1396a(a)(23) constrains State disqualifications of Medicaid providers. This argument,

however, ultimately fails to come to grips with the fact that *every* provider disqualification deprives some Medicaid beneficiary of choice. The United States never explains why, in light of the free choice doctrine, the State has the authority to impose some qualifications, such as those relating to licensure and billing, U.S. Br. 10, but not others. All one can infer from the federal government's brief is the idea that CMS is free to approve the qualifications it likes and disapprove those it does not. Affording such unconstrained, non-textual discretion would be contrary to law, and in fact would implicitly negate the complex and detailed Medicaid statutes that in so many ways constrain CMS discretion.

More specifically for this case, Senate Report 100-109 shows that Congress intended to protect the State's right to exclude providers for reasons other than those granted to the Secretary. *See* Defs.' Memo in Opp. Mot. Prelim. Inj. 10-11. Rather than identify contrary authority, the federal government merely asserts that the State has read Senate Report 100-109 "too broadly." U.S. Br. 20. According to the United States, 1396a(p)(1) grants States authority over qualifications, but only to prevent "fraud and abuse" and "to protect the beneficiaries . . . from incompetent practitioners and from inappropriate or inadequate care." U.S. Br. 20 (quoting S. Rep. 100-109, at 2). The Senate Report did indeed cite those grounds for disqualifying providers, but it unambiguously added that 1396a(p)(1) "is not intended to preclude a State from establishing, under State law, *any other bases for excluding individuals or entities* from its Medicaid program." S. Rep 100-109, at 20 (emphasis added). Thus, the section both protects the ability of a State to exclude providers for reasons it deems necessary and explicitly gives the State the power (regardless of additional authorization from the State's legislature) to exclude providers for any of the reasons that the Secretary can exclude them.

What is more, federal regulations back the State's position here. *See* 42 C.F.R. 1002.2

“(a) In addition to any other authority it may have, a State may exclude an individual or entity from participation in the Medicaid program for any reason for which the Secretary could exclude that individual or entity from participation . . . (b) Nothing contained in this part should be construed to limit a State’s own authority to exclude an individual or entity from Medicaid for any reason or period authorized by State law.”). Accordingly, the Ninth Circuit has held that section 1396a(p)(1) “plainly 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. Were such not the case, this subsection would not vest the Secretary with any authority not already provided elsewhere in the statute, and its inclusion would be redundant.” *Guzman v. Shewry*, 552 F.3d 941, 949 (9th Cir. 2009).

Even if one were to accept, as a limit on 1396a(p)(1) authority, the proposition that disqualifications must relate to providers’ “fitness to provide or properly bill for Medicaid services[,]” U.S. Br. 10, HEA 1210 still survives. Neither the United States nor PPIN has refuted Indiana’s grounds for enacting HEA 1210—to prevent indirect taxpayer subsidy for abortion and carry out the policies behind the Hyde Amendment. *See* Pub. L. No. 111-8, §§ 507-08, 123 Stat. 524 (2009); Ind. Code § 12-15-21-2; 405 IAC § 5-28-7. It is not, as the United States suggests, the exclusion of a “provider based on an ideological objection to the scope of services the provider offers[.]” U.S. Br. 14. It is instead a measure designed to ensure that the people’s money does not fund, even indirectly through shared staff salaries or overhead, the practice of abortion. Accordingly, HEA 1210 fits comfortably even within the federal government’s non-textual restrictions on the use of 1396a(p)(1).

Further, the notion that Medicaid qualifications may relate solely to the ability to provide medical services or billing is contradicted by still other federal regulations. Under 42 C.F.R. §

1001.1501, the Office of the Inspector General may disqualify providers from participation in Medicare and Medicaid solely on the basis that they have defaulted on health education loan and scholarship obligations. Such disqualification in no way relates to ability to provide or bill for services, nor does it relate to any rules broken in the course of providing care.

2. The United States insists that *Kelly Kare, Ltd. v. O'Rourke*, 930 F.2d 170 (2d Cir. 1991), does not suggest that New York could “design provider ‘qualifications’ wholly unrelated to the ability of providers to perform services or bill properly[.]” U.S. Br. 19. The significance of *Kelly Kare*, however, is not what it says about 1396a(p)(1), but what it says about the limits of the free choice rule. Regardless of the reason for the county’s refusal to execute a provider agreement (*i.e.*, regardless whether it related to provider “qualifications” or some other barrier to entry), Medicaid recipients in Westchester County, New York were not, in fact, able to obtain Medicaid-reimbursed services from Kelly Kare. *Kelly Kare*, 930 F.2d at 178. Yet such lost choice was only an “incidental burden on their right to choose.” *Id.* The point is that the free choice statute does not constitute an absolute right to obtain Medicaid-reimbursed services from whatever provider one chooses. *See id.* at 177 (“Medicaid’s freedom of choice provision is not absolute.”). It only means the right to choose among those who have been able to enter the market. *See id.* at 178; *O’Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773, 785 (1980) (holding that freedom of choice entails “the right to choose among a range of *qualified* providers”) (emphasis in original).

II. The United States Has Failed to Show that *Chevron* Deference is Appropriate

A. No deference is owed to an agency interpretation that is not final

The federal government argues that finality is not a requirement to grant *Chevron* deference, advancing an apparently novel argument that a non-final agency interpretation is

sufficient so long as it has “force of law.” U.S. Br. 14. There are at least two fundamental problems with this argument.

First, it is not clear what the federal government means by “force of law” in this context. If it means to suggest that CMS’s rejection of Indiana’s plan amendment has the “force of law” because it is a self-enforcing requirement that Indiana not enforce HEA 1210, it is plainly incorrect. U.S. Br. 21-22 (acknowledging that the State is able to continue to operate its Medicaid program according to Ind. Code § 5-22-17-5.5). If it means that CMS’s letter has “force of law” in some duty-creating sense, that theory is at odds with the Medicaid statute, under which only the Secretary of Health and Human Services is *required* to do anything, namely, to determine if a State is in substantial compliance with its Medicaid plan, and to withhold funds if it is not. *See* 42 U.S.C. § 1396c. In that vein, if the federal government means that CMS’s interpretation has “force of law” because the Secretary might later use it to reduce or eliminate Indiana’s Medicaid funding, it is plainly premature since Indiana has not yet exhausted its agency appeal rights or its judicial review rights, much less has CMS actually moved to deny funding to Indiana. Whatever else might be said of CMS’s ruling, it has not yet ripened into a decision with actual consequences (which is why the federal government has now voiced its support for injunctive relief in this Court).

Second, the United States cites no cases that support its “force of law” theory of applying *Chevron* deference to a CMS denial of a State plan amendment still subject to appeal. It cites *Association of International Automobile Manufacturers, Inc. v. Commissioner, Massachusetts Department of Environmental Protection*, 208 F.3d 1, 6 (1st Cir. 2000), which observed that both parties agreed that the opinion letter at stake was “neither binding nor intended to be binding on the parties,” but this dictum in no way vitiates the finality rule applied by the court in that very

case or creates a new “force of law” doctrine governing *Chevron* deference. *See id.* (“Given our conclusion that the [EPA’s] opinion letter is not final agency action . . . the opinion does not command any particular deference under *Chevron* or comparable doctrines.”). In addition, the federal government cites 42 U.S.C. § 1316(c) and 42 C.F.R. § 430.18(e)(1), which indicate that an initial determination shall not be stayed pending reconsideration, but says nothing about *Chevron* deference. Regardless, CMS’s initial rejection of Indiana’s plan amendment has not bound Indiana to do anything; it merely serves as a warning shot that the Secretary may later, if upheld at all levels, reduce or eliminate Indiana’s Medicaid match.

Moreover, the First Circuit is not the only Court of Appeals to invoke agency finality as the touchstone for affording *Chevron* deference. *Cf. LeBlanc v. E.P.A.*, 310 Fed. App’x 770, 773 (6th Cir. 2009) (“A *final agency action* is subject to a deferential standard of judicial review under the APA.”) (emphasis added); *Shell Oil Co. v. F.E.R.C.*, 47 F.3d 1186, 1197 (D.C. Cir. 1995) (“[A] court must uphold a *final agency action* unless that action is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.”) (citation omitted) (emphasis added). The CMS letter, still subject to agency rehearing and judicial review, is not final.¹

B. The federal government has failed to show a relevant longstanding interpretation of the freedom of choice provision

To support its argument that CMS’s initial rejection of Indiana’s plan amendment is final and entitled to deference, the United States cites three “prior interpretations” of the free choice statute that it claims limit State provider qualifications to only two areas: ability to provide services, and ability to bill for services. U.S. Br. 9. None, however, rejected State plan amendments disqualifying abortion clinics from Medicaid; none even held that the free choice doctrine trumps all provider qualifications. Rather, each rejection arose from the idiosyncratic

¹ The State has now filed its formal petition for rehearing with the Commission. *See Ex. 1.*

circumstances and particular statutes and regulations that applied in each case (none of which apply here), and indeed two convey principles supporting Indiana’s decision to prevent indirect funding of a non-Medicaid-covered-service.

1. Interpretations of case manager qualifications are not analogous to provider qualifications

Curiously, as support for its argument concerning limits on State authority to establish Medicaid provider qualifications, the federal government cites the State Medicaid Manual and its particular guidance concerning qualifications for *case managers*—*i.e.*, that qualifications for case managers “must be reasonably related” to performance of the case management function. Manual § 4302.2(E). CMS included such guidance apparently out of concern that “[t]he statute does not set minimum standards for the provision of case management services.” *See id.* Yet the very existence of guidance in the Manual purporting to trim State authority to set qualifications for case managers, without similar guidance for providers generally, suggests no intention to trim State authority over qualifications *except as to case managers*.

What is more, even if the “reasonably related” standard of Manual section 4302.2(E) applied to providers generally, HEA 1210 would fit within it as a safeguard against funding a provider’s services specifically excluded by Congress from Medicaid. By way of analogy, government agencies typically prohibit employees from performing outside work on government time or using government resources in order to ensure that taxpayer money does not finance anything but the people’s work. *See* 40 IAC § 2-1-9(f) (State employees “shall not make use of state materials, funds, property, personnel, facilities, or equipment for any purpose other than for official state business”); *see also* 5 C.F.R. § 2635.704(a) (federal employees “shall not use [Government] property, or allow its use, for other than authorized purposes.”). Surely such protections against indirect government funding of outside work are “reasonably related” to

employees' rendering of government services. HEA 1210 is equally related to providing medical services financed by the government: it is a qualification that effectively restricts medical practice that the State does not wish to fund indirectly by subsidizing shared personnel, rent and overhead.

The United States also cites, as evidence of a supposed "longstanding policy" applicable to HEA 1210, two instances, one from Maryland and one from South Dakota, when CMS rejected State plan amendments related to qualifications for case managers. U.S. Br. 10. But as CMS apparently treats case managers differently from providers generally, *see* Manual § 4302.2(E), it is not clear why these examples are even superficially relevant.

Moreover, these particular Maryland and South Dakota rejections cited by the federal government do not establish that CMS rejects all State provider qualifications. Indeed, the qualifications at issue in those two instances were radically and materially different from HEA 1210. First, the Maryland SPA would have permitted *only* "employees of [State] public welfare agencies" to be case managers. U.S. Br. Ex. A, at 27. Permitting recipients no choice whatever among providers is exactly what the free-choice statute targets. *See, e.g., Chisholm v. Hood*, 110 F. Supp. 2d 499, 506-07 (E.D. La. 2000); *Bay Ridge Diagnostic Lab., Inc. v. Dumpson*, 400 F. Supp 1104, 1106-1108 (E.D.N.Y. 1975). Accordingly, CMS's rejection of the Maryland plan does nothing to cast doubt on HEA 1210, under which there remains patient choice from some 800 certified Medicaid providers around the State who have offered family planning services in the past. *See* Decl. of Michael A. Gargano, Doc. 56-1.

Second, and perhaps more significant, the reasons given by CMS for rejecting the Maryland proposal as illegitimate actually *support* the legitimacy of HEA 1210. There, the Administrator did not simply reject Maryland's case manager qualifications outright as a

restriction on free choice, but instead examined Maryland's proposed government-only qualification and found it troubling as an "attempt to find alternative funding for a State mandated function . . . in contravention of explicit Congressional intent." U.S. Br. Ex. A, at 27. That is, Maryland's case management qualification would have created an indirect Medicaid subsidy of its non-Medicaid social services program, which was not a legitimate objective that could justify the accompanying incidental restriction on free choice. The implication for free-choice doctrine is that, even if States may not directly target free choice as such, they may incidentally burden free choice with restrictions aimed at other, legitimate objectives. *See generally Kelly Kare*, 930 F.2d at 177-78. And while creating an indirect subsidy of non-Medicaid State services falls short, surely preventing indirect subsidy of non-Medicaid medical services is a legitimate (even compelling) choice-neutral objective.

The disapproval of the South Dakota SPA is unhelpful to the federal government's position for similar reasons. In that case, South Dakota proposed to qualify as case managers only "private non-profit" organizations that could "provide court-appointed guardianship"; it would also have required the case managers either to assume guardianship of patients or choose guardians for them. South Dakota SPA, 53 FR 8699-03, 8700 (Mar. 16, 1988) (notice of hearing). Such an amendment would not merely have restricted the range of available providers, but would also effectively have placed the choice of provider in the hands of the case manager acting as guardian. This is a free-choice restriction of a wholly different stripe: HEA 1210 does not authorize anyone to choose among qualified providers for the patients.

Furthermore, like the Maryland proposal rejected by CMS, the South Dakota plan would have channeled federal Medicaid funds to non-Medicaid State services, there "the provision of guardianship services under the guise of case management services." *Id.* Again, just because it

is not permissible to limit provider choice for the sake of *creating* an indirect Medicaid subsidy for non-Medicaid services, that does not foreclose a State from *preventing* indirect Medicaid subsidies for non-Medicaid services such as abortion, even where there might be an incidental impact on recipient choice.

Notably, the United States makes no assertion that CMS has *never* approved a provider qualification that would restrict recipient choice. This is significant because CMS rulings on plan amendments are not publicly available, which makes it impossible for the State to do its own national research as to whether any such instances have arisen. As it happens, however, CMS has indeed approved an *Indiana* plan amendment related to provider qualifications that would incidentally restrict recipient choice among otherwise qualified providers. In 2006, CMS allowed the State to refuse to qualify additional beds for Medicaid in nursing facilities in certain circumstances. *See Ex. 2.* That change did not involve the provider's ability to perform covered services or billing, and it would undoubtedly force some patients who would otherwise choose the affected nursing facilities to choose another provider, yet CMS approved it anyway. It is hard to understand why Indiana can restrict recipient choice for the sake of limiting nursing home capacity but not for the sake of preventing indirect Medicaid subsidy of such non-Medicaid services as abortion. In any event, that approval demonstrates that CMS does approve State decisions about Medicaid qualifications that may restrict recipients' free choice.

In short, the CMS precedents cited by the United States do not stand for the proposition that the free-choice rule precludes all State provider qualifications that may have an incidental impact on recipient choice (which is to say, all provider qualifications). And they certainly do not address qualifications aimed at preventing indirect subsidy of non-Medicaid services, such as abortion. Thus, the United States provides no "longstanding interpretation" entitled to deference.

2. The need for special statutes and rules prohibiting States from disqualifying Indian health care facilities implies no *general* limit on State provider qualifications

For its “longstanding interpretation” argument, the federal government also relies on a 1977 regulation (42 FR 64345) (Nov. 16, 1977) (codified at 42 C.F.R. § 449.10, now 42 C.F.R. § 431.110) implementing the 1976 Indian Health Care Improvement Act (IHCIA), a statute enacted to make quality health care accessible to the American Indian community, a historically underserved population. Pub. L. No. 94-437 (codified at 25 U.S.C. § 1601). It is not clear how a federal statute specially authorizing Indian health facilities to be Medicaid providers, and a corresponding rule precluding disqualification of them as such, applies here, where no federal statute specially authorizes abortion clinics to be Medicaid providers. Indeed, the only logical inference to draw from ICHIA and its implementing regulations is that it requires a separate act of Congress to withdraw from States the power to determine Medicaid provider qualifications.

Furthermore, insofar as the United States cites the IHCIA regulation as authority for the proposition that it is not “proper and efficient admin[istration] to *arbitrarily* refuse to enter into provider agreements” (emphasis added), that too has no relevance here. The State has not enacted an arbitrary provider qualification. Rather, it has disqualified abortion clinics from Medicaid as part of a policy to eliminate indirect subsidy of abortion—an objective the United States never criticizes as illegitimate.

C. *Chevron* deference is inappropriate because the CMS interpretation involves a non-interstitial question

The United States fails to address the argument that *Chevron* deference is inappropriate because CMS’s initial ruling involves a central aspect of the Medicaid statutory scheme—the interplay between 42 U.S.C. §§ 1396a(p)(1) and 1396a(a)(23). Determining the relationship between these sections is central to the functioning of Medicaid, as it defines the roles of the

State and federal government in administering Medicaid. The United States tacitly acknowledges the centrality of this issue when it argues that 1396a(a)(23) must by its nature limit State discretion under 1396a(p)(1), lest States have too much power to erode the free choice doctrine. U.S. Br. 19-20. There is nothing interstitial about this debate. Congress did not intend for the Secretary to sort out such a fundamental question. *Chevron* deference is inappropriate when such core issues arise. See *Food and Drug Admin. v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 159-60 (2000); *MCI Telecommunications Corp. v. AT&T*, 512 U.S. 218, 231 (1994).

The United States does not dispute this general proposition, or explain how the statutory interpretation at issue here somehow presents interstitial, rather than central, questions of Medicaid interpretation. It does cite to a number of cases applying *Chevron* deference to the disapproval of State plans, but it does not demonstrate how the issues in those cases were as central to the functioning of Medicaid as the issue here. See *West Virginia v. Thompson*, 475 F.3d 204, 212-14 (4th Cir. 2007) (deferring to an interpretation as to whether a homestead exemption was too broad to constitute an “undue hardship” exception under 42 U.S.C. § 1396p(b)(3), which permits criteria to be “established by the Secretary”); *Harris v. Olszewski*, 442 F.3d 458, 466-69 (6th Cir. 2006) (deferring to an interpretation of whether incontinence products fall under the term “medical devices”); *Alaska Dep’t of Health and Soc. Servs. v. CMS*, 424 F.3d 931, 938-40 (9th Cir. 2005) (deferring to an interpretation of the words “efficiency” and “economy,” as applied to a State Plan Amendment); *Texas v. U.S. Dep’t of Health and Human Servs.*, 61 F.3d 438, 440-42 (5th Cir. 1995) (deferring to an interpretation as to whether “rehabilitative services” includes room and board expenses); *Indiana Ass’n of Homes for Aging Inc. v. Indiana Office of Medicaid Policy and Planning*, 60 F.3d 262, 265-70 (7th Cir. 1995)

(deferring to an interpretation of whether a legislative change to single certification of nursing facilities created a need for single-form reimbursement).

What matters for *Chevron* deference is not simply that CMS reviews State plans, but whether in doing so CMS is exercising authority bestowed by Congress to make law covering some interstitial question. Whether the free-choice statute trumps State provider qualifications is an issue of fundamental importance, and Congress did not delegate it to CMS.

D. Other cases cited by the United States show that *Chevron* deference is not appropriate here

Much of the authority that the federal government cites actually demonstrates that *Chevron* deference is not appropriate in this case. In *Indiana Association of Homes for Aging Inc. v. Indiana Office of Medicaid Policy and Planning*, 60 F.3d 262, 264-65 (7th Cir. 1995), for example, private parties challenged the approval of an Indiana SPA. The United States cites this case as holding that courts “should defer” to the administrator’s decision to approve a SPA. U.S. Br. 12. The court, however, actually said that the administrator’s decision was entitled only to “a presumption of regularity,” not a presumption of correctness, and that in any event the court would perform “a thorough, probing, in-depth review.” *Homes for Aging*, 60 F.3d at 266.

Similarly, in *Wisconsin Department of Health & Family Services v. Blumer*, 534 U.S. 473, 497 (2002), the Court accorded the Secretary’s view only “respectful consideration,” even though both the State and the HHS Secretary were advocating for the same interpretation of the statute. And in *Urnikis-Negro v. American Family Property Services*, 616 F.3d 665, 674-76 (7th Cir. 2010), the court granted a Department of Labor bulletin only a “measure of respect,” even though it was promulgated in response to (and in accord with) Supreme Court precedent on the subject. *See also Estate of Landers v. Leavitt*, 545 F.3d 98, 107 (2d Cir. 2008) (applying only

Skidmore deference to a CMS policy manual).² These cases plainly do not support affording *Chevron* deference here, and for the reasons explained in the State’s earlier brief, Defs.’ Supplemental Br. at 6-7, CMS’s initial denial of the Indiana plan amendment is not only wholly unpersuasive, but arbitrary and capricious and contrary to law.

III. The Statement of Interest Underscores the Need to Reject A Private Right of Action for Planned Parenthood

The remedy that Congress has expressly provided for State Medicaid non-compliance is for CMS, if approved by the HHS Secretary, to withhold federal matching grants. *See* 42 U.S.C. § 1396c. With such a direct, self-help remedy available to the federal government (subject to judicial review), there would seem to be no need for federal court injunctions to carry out Medicaid policy. The federal government’s extraordinary decision to urge private injunctive relief, therefore, only underscores why it is important for the Court to conclude that there is no private right of action. Even assuming HEA 1210 violates the free-choice rule—and it does not—to afford PPIN a claim for injunction, particularly at the urging of the federal government, would effectively preempt the *politically accountable* remedial process enacted by Congress.

IV. Indiana has Demonstrated its Legitimate and Compelling Objectives in Passing this Law and the United States does not Criticize those Objectives

The United States does not dispute that, absent HEA 1210, abortion services in Indiana would be indirectly subsidized by Medicaid. Instead, it argues that injunctive relief here is in the public interest because federal policy favoring free choice trumps. U.S. Br. 21. But that

² The federal government makes passing reference to deference accorded an agency’s interpretation of its own regulations. U.S. Br. 17 n.5 (citing *Auer v. Robbins*, 519 U.S. 452, 461 (1997)). But CMS made no pretense of interpreting any regulations. Besides, *Auer* spoke in the context of resolving interstitial questions, not questions of fundamental statutory interpretation and, as such, does not imply the power of an agency to bootstrap policymaking authority already delegated elsewhere, such as through 42 U.S.C. § 1396a(p)(1). *Also compare* 42 C.F.R. 1002.2(b) (“Nothing contained in this part should be construed to limit a State’s own authority to exclude an individual or entity from Medicaid for any reason or period authorized by State law.”) with *Arkansas Dep’t of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 292 (2006) (rejecting a CMS interpretation of Medicaid that “couples internal inconsistency with a conscious disregard for the statutory text.”).

argument proves too much. If the free-choice policy prevails here, it must prevail over any State qualification interest, such as (for example) in disqualifying polluters, *see, e.g., Plaza Health Labs., Inc. v. Perales*, 878 F.2d 577 (2d Cir. 1989). And preventing taxpayer funding of abortion generally is as much a part of federal Medicaid policy as free choice. *See Harris v. McRae*, 448 U.S. 297, 302 (1980) (“Congress has prohibited . . . the use of any federal funds to reimburse the cost of abortions under the Medicaid program except under certain specified circumstances.”).

The United States also mentions that Congress specifically protects recipient choice with respect to family planning services in managed care organizations. U.S. Br. 3. HEA 1210, however, is not targeted at managed care organizations, nor is it directed at family planning choice. It is targeted at preventing indirect subsidy of abortions, which Congress expressly *excludes* as a form of “family planning” payable by Medicaid. *See* Pub. L. No. 111-8, §§ 507-08, 123 Stat. 524 (2009). To be eligible for Medicaid provider status, medical care entities, whether they provide family planning *or any other* services, must not perform abortions, just as they must not mistreat patients or commit an infinite variety of other transgressions. Indeed, targeting “entities” that perform abortions, while permitting some level of affiliation between providers and abortion clinics (with safeguards against subsidy) keeps the law focused on preventing abortion subsidy rather than unnecessarily excluding family planning service providers. *See* Ex. 3, Notice of Proposed Rulemaking.

Conclusion

The motion for preliminary injunction should be denied.

Respectfully submitted,

GREGORY F. ZOELLER
Attorney General of Indiana

By: /s/ Thomas M. Fisher

Thomas M. Fisher
Solicitor General

Heather Hagan McVeigh
Deputy Attorney General

Ashley Tatman Harwel
Deputy Attorney General

Adam Clay
Deputy Attorney General

CERTIFICATE OF SERVICE

I hereby certify that on June 24, 2011, a copy of the foregoing Defendants' Response to Statement of Interest of the United States was filed electronically. Notice of this filing will be sent to the following parties by operation of the Court's CM/ECF system:

Kenneth J. Falk
Gavin M. Rose
Jan P. Mensz
ACLU OF INDIANA
kfalk@aclu-in.org
grose@aclu-in.org
jmensz@aclu-in.org

Talcott Camp
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION
tcamp@aclu.org

Tamra T. Moore
Ethan P. Davis
Joseph W. Mead
UNITED STATES DEPARTMENT OF
JUSTICE
Tamra.Moore@usdoj.gov
Joseph.W.Mead@usdoj.gov
Ethan.P.Davis@usdoj.gov

Notice of this filing will be sent to the following parties by U.S. Mail:

Roger Evans
Planned Parenthood Federation of America
434 W. 33rd Street
New York, NY 10001

/s/ Thomas M. Fisher
Thomas M. Fisher
Solicitor General

Office of the Attorney General
Indiana Government Center South 5th Floor
302 W. Washington St.
Indianapolis, IN 46204-2770
Phone: (317) 232-6255
Fax: (317) 232-7979
Email: Tom.Fisher@atg.in.gov