No. 12-17558

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Planned Parenthood Arizona, Inc.; Jane Doe #1; Jane Doe #2;
Jane Doe #3; Eric Reuss, M.D.,
Plaintiffs-Appellees,

v.

Tom Betlach, Director, Arizona Health Care Cost Containment System;
Tom Horne, Attorney General,
Defendants- Appellants.

Appeal from the United States District Court for the District of Arizona
Civil Case No. 2:12-cv-01533-NVW (Honorable Neil V. Wake)

PRELIMINARY INJUNCTION APPEAL

DEFENDANTS-APPELLANTS' OPENING BRIEF

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OTHER AUTHORITIES

Defendants-Appellants Tom Betlach, Director of the Arizona Health Care Cost Containment System, and Tom Horne, Attorney General, submit this opening brief in their appeal from the United States District Court for the District of Arizona's ("District Court") Order and Findings of Fact and Conclusions of Law (Excerpts of Record ["ER"] at 1-28, District Court Docket Number ["Doc."] 78; "Order").

INTRODUCTION

This action challenges certain provisions of Arizona House Bill 2800, 2nd Regular Session, 50th Legislature (2012) (A.R.S. § 35-196.05), which provides:

> [T]his State or any political subdivision of this State may not enter into a contract with or make a grant to any person that performs nonfederally qualified abortions [defined as an abortion that is ineligible for federal Medicaid reimbursement] or maintains or operates a facility where nonfederally qualified abortions are performed for the provision of family planning services.[1]

[1] HB 2800, passed by wide margins and signed into law by Governor Brewer on May 4, 2012, *see* http://www.azleg.gov/FormatDocument.asp?inDoc=/legtext/ 50leg/2r/bills/ hb2800o.asp&Session_ID=107 (Arizona State Legislature Bill Status Overview site reflecting passage 42-17 in the House and 18-8 in the Senate), is consonant with a number of other provisions that limit allocation of public funds for purposes that contravene Arizona public policy. *Cf.* A.R.S. § 35-196.02, which prohibits the use of State or local funds, as well as federal funds passing through state or local treasuries, for abortion under most circumstances and the use of state or local funds to "directly or indirectly" pay for insurance coverage for abortion in most circumstances; and A.R.S. § 35-196.04, which prohibits the use of State or local funds and federal funds passing through State or local

Plaintiff-Appellee Planned Parenthood of Arizona ("PPAZ"), along with three Jane Doe Plaintiffs-Appellees ("the Does"), who assert that they are Medicaid patients who contend they wish to obtain family planning services at PPAZ, and Dr. Reuss, who is a member of PPAZ's board and a doctor who asserts that he performs nonfederally qualified abortions but still wants to receive Medicaid funding, challenge this provision on constitutional and statutory grounds.

Defendants-Appellants filed a Motion to Dismiss Counts I and II (Doc. 37) of Plaintiffs-Appellees' Complaint (Doc. 1), asserting that Plaintiffs-Appellees have no standing under either the Medicaid Act or the Supremacy Clause of the U.S. Constitution because the "choice criterion" of the Medicaid Act is too vague for the Court to enforce, and so Plaintiffs-Appellees lack a private right of action under the Medicaid Act; and further, because A.R.S. § 35-196.05 does not conflict with the Medicaid Act's

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treasuries for human cloning under most circumstances. The Courts of the State of Arizona have likewise held that "[T]he state has a 'justifiably strong interest' in 'preserving life,'" *Planned Parenthood Arizona, Inc. v. American Ass'n of Pro-Life Obstetricians & Gynecologists*, 227 Ariz. 262, 269, 257 P.3d 181, 188 (Ariz. App. Div. 1 2011) (quoting *Rassmussen by Mitchell v. Fleming*, 154 Ariz. 207, 216, 741 P.2d 674, 683 (1987)), and that abortion is "inherently different from other medical procedures, because no other procedure involves the purposeful termination of a potential life." *Id*. at 270 n.5 (citing *Harris v. McRae*, 448 U.S. 297, 324-26 (1980) (upholding federal statute prohibiting use of Medicaid funding for some medically necessary abortions)).

"choice criterion" and so does not violate the Supremacy Clause. The District Court denied the Motion to Dismiss (ER 1-28, Doc. 78).

PPAZ, which provides an extremely small percentage of family planning services to Arizona Medicaid patients statewide also performs nonfederally qualified abortions at five of its fourteen locations in the State, asserted that absent preliminary relief, it will face imminent and irreparable injury by virtue of losing its eligibility to be reimbursed for treating Medicaid patients once A.R.S. § 35-196.05 is implemented. The District Court granted Plaintiffs-Appellees' motion for a preliminary injunction (Motion, Doc. 6; ER 1-28, Doc. 78).

The District Court erred in granting preliminary relief. As an initial matter, the District Court had no jurisdiction over Plaintiffs-Appellees' Complaint (Doc. 1; First Amended Complaint filed as Doc. 59) because the "choice criterion" of the Medicaid Act is too vague for that court to enforce, and so Plaintiffs-Appellees lack a private right of action.

Further, injunctive relief should not have been granted. "A plaintiff seeking a preliminary injunction must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest." *Winter v. Natural Res. Def. Council, Inc.*,

555 U.S. 7, 20 (2008). Injunctive relief is always an "extraordinary and drastic remedy." *Mazurek v. Armstrong*, 520 U.S. 968, 972 (1997) (citation omitted). "[A]s *Winter* plainly demonstrates, . . . plaintiffs seeking a preliminary injunction face a difficult task in proving that they are entitled to this 'extraordinary remedy.'" *Earth Island Institute v. Carlton*, 626 F.3d 462, 469 (9th Cir. 2010) (quoting *Winter*, 555 U.S. at 22). Plaintiffs-Appellees cannot demonstrate that they are likely to succeed on the merits of their constitutional and statutory claims because Arizona enjoys broad authority under the Medicaid statute to establish provider qualifications that reflect State law and policy, and because Medicaid patients have no statutory or constitutional right to access Medicaid-subsidized services from a provider that is determined not to be qualified pursuant to State law. Further, whatever "harm" that may flow to Plaintiff-Appellee PPAZ is strictly pecuniary, and hence not cognizable as "irreparable" because a temporary loss of public funds can be legally remediated after a determination of its claims on the merits. For the reasons set forth below, the District Court's grant of a preliminary injunction should be reversed.

STATEMENT OF JURISDICTION

The District Court lacked subject matter jurisdiction under 28 U.S.C. § 1331 because Plaintiffs-Appellees have no right of action to enforce 42

U.S.C. § 1396a(a)(23), and because A.R.S. § 35-196.05 does not conflict with the Medicaid Act's "choice criterion" and so does not violate the Supremacy Clause. This Court, in contrast, may hear this appeal pursuant to 28 U.S.C. § 1291 in order to evaluate the District Court's order granting Plaintiffs-Appellees' preliminary injunction (Doc. 78), which is an interlocutory order appealable as of right. The District Court entered its order on Oct. 19, 2012, and Defendants-Appellants timely filed a notice of appeal on Nov. 16, 2012. *See* FED. R. APP. P. 4(a)(2), 4(a)(1)(A).

STATEMENT OF ISSUES PRESENTED FOR REVIEW

1. Whether Plaintiffs-Appellees lack a private right of action to sue under the Medicaid Act.

2. Whether Plaintiffs-Appellees lack a private right of action to sue under the Supremacy Clause of the U.S. Constitution.

3. Whether Plaintiffs-Appellees demonstrated that the balance of likelihood of success on the merits, harm, and the public interest weighed in favor of a preliminary injunction.

STATEMENT OF THE CASE

On July 16, 2012, Plaintiffs-Appellees Planned Parenthood Arizona, Inc. ("PPAZ"), and Jane Does #1-3 filed a Complaint in the District of Arizona against State of Arizona officials Tom Betlach, Director, Arizona

Health Care Cost Containment System; and Tom Horne, Attorney General, under 42 U.S.C. § 1983 and the United States Constitution seeking a declaratory judgment and preliminary and permanent injunctions against Defendants-Appellants with regard to A.R.S. § 35-196.05, signed into law on May 4, 2012, which updated Medicaid provider qualifications to provide that eligible providers must not perform elective abortions. (Doc. 1).

Defendants-Appellants filed a Motion to Dismiss Counts I and II (Doc. 37) of Plaintiffs-Appellees' Complaint (Doc. 1), asserting that Plaintiffs-Appellees have no standing under either the Medicaid Act or the Supremacy Clause of the U.S. Constitution because the "choice criterion" of the Medicaid Act is too vague for the Court to enforce, and so Plaintiffs-Appellees lack a private right of action under the Medicaid Act; and further, because A.R.S. § 35-196.05 does not conflict with the Medicaid Act's "choice criterion" and so does not violate the Supremacy Clause. The District Court denied the Motion to Dismiss (ER 1-28, Doc. 78).

PPAZ, which provides an extremely small percentage of family planning services to Arizona Medicaid patients statewide and performs nonfederally qualified abortions at five of its fourteen locations in the State, asserted that absent preliminary relief, it will face imminent and irreparable injury by virtue of losing its eligibility to be reimbursed for treating

Medicaid patients once A.R.S. § 35-196.05 is implemented. Plaintiffs-Appellees' motion for a preliminary injunction (Doc. 6) was granted by the District Court (ER 1-28, Doc. 78).

Defendants-Appellants Tom Betlach, Director of the Arizona Health Care Cost Containment System, and Tom Horne, Attorney General, timely filed a notice of appeal (Doc. 92) on Oct. 19, 2012, from the United States District Court for the District of Arizona's ("District Court") Order and Findings of Fact and Conclusions of Law (ER 1-28, Doc. 78; "Order").

Additionally, Plaintiffs-Appellees filed a Motion for Summary Judgment (Doc. 85) as to Count I only of their First Amended Complaint (Doc. 59) on Nov. 15, 2012,[2] claiming that A.R.S. § 35-196.05 violates the Medicaid Act as a matter of law and that Plaintiffs-Appellees are thus entitled to summary judgment on Count I, their Medicaid Act claim, which they represent would resolve the case.

STATEMENT OF FACTS

Arizona law prohibits the State from expending public funds, state tax monies, or federal funds for the performance of any abortion unless the

[2] The parties have stipulated to a stay of discovery on the issues related to the Motion for Summary Judgment (Count I of the First Amended Complaint). Counts II through V of Plaintiffs' First Amended Complaint remain; as to these, Defendants do not waive their right to discovery, but reserve the right to conduct discovery if and when Plaintiffs determine to move forward on these remaining claims (Doc. 94; Order at Doc. 95).

abortion is necessary to save the life or health of the mother.[3] The State is also banned from directly or indirectly expending public or state tax monies to pay the costs associated with a health insurance policy, contract, or plan that provides coverage, benefits, or services related to the performance of any abortion unless the abortion is necessary to avert irreversible impairment of a major bodily function of the woman having the abortion or to save the woman's life. A.R.S. § 35-196.02.

Arizona's managed care system has been a model for other states to follow to effectively deliver public assistance for medical services in an innovative and cost-efficient fashion. Under managed care, individual providers such as Plaintiff-Appellee PPAZ do not ordinarily seek reimbursement from AHCCCS directly on a fee-for-service ("FFS") basis, and are not under contract with AHCCCS. (ER 79, Declaration of Kim Elliott, Ph.D., C.P.H.Q. at 2, ¶ 6-7). Instead, providers contract with health plans known as "Managed Care Organizations" ("MCOs"), which provide a range of health care services within a specific Geographic Service Area ("GSA"); Plaintiff-Appellee PPAZ contracts with approximately ten MCOs. (ER 34 Declaration of Steven H. Aden at 1, ¶ 3; ER 50, Excepts of Tr. of Dep. of Bryan Howard at 34). AHCCCS annually negotiates with MCOs a

[3] *See* A.R.S. § 35-196.02; *Simat Corp. v. Arizona Health Care Cost Containment System*, 203 Ariz. 454, 56 P.3d 28 (2004).

"capitation" [i.e., per patient per month] rate to be paid to MCOs for patient care, and makes "capitation payments" monthly to MCOs for services to be performed in furtherance of the MCO contract. (ER 79, Elliott Dec. at 2, ¶ 6). MCOs, in turn, negotiate with providers for reimbursement rates on a fee-for-service basis. (*Id.*)

Although AHCCCS does not have a direct contract for patient services with providers, AHCCCS executes a Provider Participation Agreement ("PPA") with each provider in the MCO system pursuant to federal Medicaid law (*see* 42 C.F.R. § 431.107; A.R.S. § 36-2901). *Id.* at 2, ¶ 7. The PPA registers the provider in the AHCCCS system, thus enabling the provider to participate and deliver health care services to eligible persons enrolled with the MCO. (*Id.*, ER 89, Ex. A, Current PPAs for PPAZ, at 1, ¶ B.1). Payment may not be made to a provider for services rendered absent a current PPA. (*Id.*; ER 38, Howard Dep. at 17-18 (acknowledging negotiation process with MCOs)).

Pursuant to the PPA agreement, "With respect to any services furnished by the Provider to an AHCCCS eligible person enrolled with a Contractor [i.e., MCO], the terms and conditions of payment shall be as set forth in the contract between the Provider and the Contractor . . . . The Provider agrees to hold AHCCCS harmless, and agrees not to seek

reimbursement from AHCCCS, for services rendered to an enrolled member pursuant to a contract between the Provider and a Contractor." (ER 91, Current PPAs for PPAZ at 3 ¶ B.15).

AHCCCS reserves the right to voluntarily terminate a PPA upon thirty days' written notice, or in the case of a "cancellation, termination or material modification in the Provider's qualifications to provide," upon 24 hours' written notice. (ER 92, Current PPAs for PPAZ at 4, ¶ B.31). In the event of termination, "Provider shall assist in providing for the orderly transition of care for members assigned to the Provider." (*Id*., ¶ B.32).

AHCCCS covers family planning services when provided by physicians or practitioners to members who voluntarily choose to delay or prevent pregnancy. *See* Chapter 400 of the Medical Policy for Maternal and Child Health, Policy 420, "Family Planning," at 420-1, available at 222.azahcccs.gov/shared/MedicalPolicyManual/MedicalPolicyManual.aspx.

Family planning services include covered medical, surgical, pharmacological, and laboratory benefits, as well as the provision of accurate information and counseling to allow members to make informed decisions about specific family planning methods available. *Id*. However, AHCCCS excludes from coverage "pregnancy terminations [including

Mifepristone (Mifeprex or RU 486)] and hysterectomies" as well as "pregnancy termination counseling." *Id*. at 420-3.

Pursuant to AHCCCS policy, "[M]embers may choose to obtain family planning services and supplies from any appropriate provider within the Contractor's network." *Id*. Contractors must ensure that family planning services are "[a]vailable and easily accessible for members…." *Id*. There are over 2,000 providers who deliver family planning services registered with AHCCCS in the State of Arizona. (ER 82, Elliot Dec. at 5, ¶ 16).

Pursuant to their contract with AHCCCS, MCOs provide information on patient visits, known as "encounters," to AHCCCS to document patient services rendered in consideration of the capitation payments made pursuant to the contract. Encounter data reported to AHCCCS includes AHCCCS participant information, procedure codes (e.g., "CPT" codes), amounts billed, and amounts paid. (ER 80-81, Elliott Dec. at 3 – 4, ¶ 12).

Payment amounts per year for family planning services over the four-year period from 2008 to 2012 ranged from $247,047 to $340,981. (ER 83, Elliott Dec. at 6, ¶ 21). Corresponding members served ranged from 2,127 to 3,207. 1,119,056 AHCCCS members received family planning services system-wide, for a total of $352,184,827 in payments. (*Id*.) For PPAZ alone, 2,112 members received services for a total of $241,910 in payments. (ER

84, Elliott Dec. at 7, ¶ 26). Consequently, PPAZ last year served only .19% of AHCCCS members receiving those services. (*Id*., ¶ 27).

SUMMARY OF ARGUMENT

Plaintiffs-Appellees misconstrue the application of § 1396a(a)(23), the "choice criterion" of the Medicaid Act, to A.R.S. § 35-196.05(b). Section 1396a(a)(23) states that a State plan for medical assistance must provide that: "[A]ny 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" (emphasis added). The use of the term "qualified" in § 1396a(a)(23) renders the statute "so 'vague and amorphous' that its enforcement . . . strain[s] judicial competence," *Blessing v. Freestone*, 520 U.S. 329, 340-41 (1997), and so Plaintiffs-Appellees lack a private right of action under the Medicaid Act.[4]

Similarly, Plaintiffs-Appellees lack a private right of action under the Supremacy Clause. "[A]n allegation of incompatibility between federal and state statutes and regulations does not, in itself, give rise to a claim 'secured by the Constitution' within the meaning of § 1343(3)." *Chapman v. Houston Welfare Rights Org*., 441 U.S. 600, 615 (1979). Even if a preemption claim

[4] Although Defendants-Appellants are not challenging the first and third *Blessing* factors at this juncture, they do not waive their right to do so.

generally does afford a right of action enforceable under § 1983 via the Supremacy Clause, regardless of whether the federal law in question secures individual rights, that doctrine would nonetheless be inapposite because PPAZ's claims do not establish federal preemption. There is no state law in conflict with § 1396a(a)(23).

"A plaintiff seeking a preliminary injunction must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest." *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). However, injunctive relief is always an "extraordinary and drastic remedy," *Mazurek v. Armstrong*, 520 U.S. 968, 972 (1997) (citation omitted). Plaintiffs-Appellees cannot demonstrate that they are likely to succeed on the merits of their constitutional and statutory claims because Arizona enjoys broad authority under the Medicaid statute to establish provider qualifications that reflect State law and policy, and Medicaid patients have no statutory or constitutional right to access Medicaid-subsidized services from a provider that is determined not to be qualified under State law.[5] Further, whatever

[5] Defendants-Appellants note that although Plaintiffs-Appellees assert that "every court faced with th[e] issue" presented in this action has held that the standard for issuance of a preliminary injunction was met, two of the

"harm" that may flow to Plaintiff-Appellee PPAZ is strictly pecuniary, and hence not cognizable as "irreparable" because a temporary loss of public funds can be remediated after a determination of its claims on the merits.

The pertinent statutory provisions are:

A.R.S. § 35-196.05:

> [T]his State or any political subdivision of this State may not enter into a contract with or make a grant to any person that performs nonfederally qualified abortions [defined as an abortion that is ineligible for federal Medicaid reimbursement] or maintains or operates a facility where nonfederally qualified abortions are performed for the provision of family planning services.

42 U.S.C. § 1396a(a)(23):

> [A]ny 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(p)(1):

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authorities cited (Memo. in Supp. at 7) – *Planned Parenthood v. Comm'r*, 794 F. Supp. 2d 892 (S. D. Ind. 2011) and *Planned Parenthood of Kan. v. Brownback*, 799 F. Supp. 2d 1218 (D. Kan. 2011) - are pending decisions on appeal, and another was recently overturned on appeal. *See Planned Parenthood Ass'n of Hidalgo Cty., Tex., Inc. v. Suehs*, --- F.3d ----, 2012 WL 3573642 (5th Cir. Aug. 21, 2012) (reversing injunction ordered in *Suehs*, 828 F. Supp. 2d 872 (W. D. Tex. 2012)). Moreover, Plaintiffs-Appellees' statement is factually inaccurate, as preliminary relief against a similar funding statute was reversed in *Planned Parenthood v. Sanchez*, 403 F.3d 324, 329, 342-43 (5th Cir. 2005).

> 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 . . . .

ARGUMENT

I. STANDARD OF REVIEW.

The Court of Appeals reviews a district court's interpretation of the Federal Rules of Civil Procedure *de novo*. *Barabin v. AstenJohnson, Inc.*, 700 F.3d 428, 431 (9th Cir. 2012). This includes the standard of review for determinations of subject matter jurisdiction, *Cook Inlet Region, Inc. v. Rude*, 690 F.3d 1127, 1130 (9th Cir. 2012) (citing *Puri v. Gonzales*, 464 F.3d 1038, 1040 (9th Cir. 2006)). "Once challenged, the party asserting subject matter jurisdiction has the burden of proving its existence." *Robinson v. United States*, 586 F.3d 683, 685 (9th Cir. 2009) (citation omitted).

The Court of Appeals also uses a *de novo* standard of review to determine whether a district court has authority to issue a preliminary injunction, *Meyer v. Portfolio Recovery Associates, LLC*, 696 F.3d 943, 946 (9th Cir. 2012), including its interpretation of the underlying legal principles related to a preliminary injunction, *McCormack v. Hiedeman*, 694 F.3d 1004, 1010 (9th Cir. 2012).

Finally, a District Court's interpretation and construction of a federal statute, such as 42 U.S.C. § 1396a(a)(23), is reviewed *de novo*. *Holmes v. Merck & Co., Inc*., 697 F.3d 1080, 1082 (9th Cir. 2012).

II. THE DISTRICT COURT ERRED IN HOLDING THAT PLAINTIFFS-APPELLEES HAVE A PRIVATE RIGHT OF ACTION UNDER THE MEDICAID ACT.

Plaintiffs-Appellees cannot prevail as a matter of law because the "choice criterion" of the Medicaid Act is too vague for the court to enforce, and so Plaintiffs-Appellees lack a private right of action under the Medicaid Act. Plaintiffs-Appellees misconstrue the application of § 1396a(a)(23), the "choice criterion" of the Medicaid Act, to A.R.S. § 35-196.05(b). Section 1396a(a)(23) states that a State plan for medical assistance must provide that: "[A]ny 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" (emphasis added). The State and the Secretary are authorized to determine which individuals and entities are qualified to perform such services. 42 U.S.C. § 1396a(p)(1) ("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 order to determine whether a statutory provision gives rise to a federal right and thus a private right of action under § 1983: (1) Congress must have "intended that the provision in question benefit the plaintiff;" (2) the right allegedly protected by the statute must not be "so 'vague and amorphous' that its enforcement would strain judicial competence;" and (3) the provision giving rise to the right must be stated in "mandatory, rather than precatory terms." *Blessing v. Freestone*, 520 U.S. 329, 340-41 (1997).[6]

The second *Blessing* prong, necessary to enforce a "right" under § 1983, requires that Plaintiffs-Appellees bear the burden of demonstrating that the right they claim is not so "vague" that it would "strain judicial competence" to enforce it. *Blessing*, 520 U.S. at 340. As this Court recognized, there is "legitimate debate about the scope of medical care covered by § 1396a(a)(23)," Order and Findings of Fact and Conclusions of Law (Doc. 78); however, even more vagueness arises from a(a)(23)'s use of the term "qualified."

Blessing stands for the proposition that each subsection must be viewed on its own merits when it comes to a right of action under § 1983.

[6] Although Defendants-Appellants are not challenging the first and third *Blessing* factors at this juncture, they do not waive their right to do so.

520 U.S. at 342-43. Thus, for example, *Ball v. Rogers*, 492 F.3d 1094 (9th Cir. 2007), upon which Plaintiffs-Appellees rely heavily, held that §§ 1396n(c)(2)(C) and (d)(2)(C) do give rise to a private right of action, while § a(a)(30)(A) does not.

Sections 1396n(c)(2)(C) and (d)(2)(C), which the Ninth Circuit held do create a private right of action, are both notice requirements. They require, respectively, that the State ensure as to "certain disabled patients," and as to "home and community-based services for elderly," that:

> n(c)(2)(c): "such individuals who are determined to be likely to require the level of care provided in a hospital . . . are *informed* of the feasible alternatives, if available under the waiver, at the choice of such individuals . . . ."
>
> n(d)(2)(c): "such individuals who are determined to be likely to require the level of care provided in a skilled nursing facility . . . are *informed* of the feasible alternatives . . . which such individuals may choose if available under the waiver . . . ."

These requirements are clear, not amorphous, as it is plainly evident whether or not a notice requirement has been fulfilled. Further, the *Ball* plaintiffs sought specific, objective injunctive relief in the form of home- and community-based care, which included being "lift[ed] . . . out of bed and into a motorized wheelchair," "constant supervision," and "assistance with

all activities of daily living, including feeding[,] toileting," dressing, bathing, eating, cooking, housekeeping, and shopping. *Ball*, 492 F.3d at 1099 n.6.

In contrast, § a(a)(30)(A), which *Ball* held (following *Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005)) yields no private right of action enforceable under §1983, requires that the State plan:

> Provide such methods and procedures . . . as may be necessary to safeguard against *unnecessary* utilization of such care and services and to assure that payments are consistent with *efficiency*, economy, and quality of care and are *sufficient* to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

Id. (emphasis added).

Section a(a)(23) is clearly more analogous to § a(a)(30)(A), which provides no private right of action, than to §§ 1396n(c)(2)(C) and (d)(2)(C). Not only is a(a)(23) in the same vicinity of the statute as a(a)(30)(a), its "qualified" language is much more similar to the "unnecessary," "efficiency," and "sufficient" language of a(a)(30)(A), than to the objective requirement of "informing" beneficiaries of §§ 1396n(c)(2)(C) and (d)(2)(C). Both are, indeed, so vague that it would be difficult for courts to enforce them. *See Harris v. Olszewski*, 442 F.3d 456, 462 (6th Cir. 2006). Therefore,

this case is more analogous to *Sanchez* and to the a(a)(30)(A) holding of *Ball* than to the n(c)(2)(C) and (d)(2)(C) holding of *Ball*.

Plaintiffs-Appellees urge this Court to resort to a dictionary definition of the term "qualified" in its discussion of the second *Blessing* prong, which definition attempts to define "qualified" by using the term "qualifications": A medical service provider that is "qualified" is one "[p]ossessing the necessary qualifications; capable or competent, [e.g.] a qualified medical examiner." BLACK'S LAW DICTIONARY (9th ed. 2009). But this definition is inherently circular, because it "defines" the term "qualified" with reference to "qualifications" without further explicating that term. Moreover, by its terms, this definition does not preclude the State of Arizona from qualifying would-be providers for reasons based on state law and policy. The State of Arizona is well able to determine if a provider is, for reasons of state law and policy, qualified, and it would be a usurpation of this delegated power for a court to second-guess Arizona's determination.

The Seventh Circuit engaged in this improper resort to BLACK'S LAW DICTIONARY in an attempt to define by common usage what is in fact a term of law. *Planned Parenthood of Ind., Inc. v. Comm'r of Ind. State Dep't of Health*, --- F.3d ----, 2012 WL 5205533 (7th Cir. Oct. 23, 2012). That court held that because a State's right to establish "standards relating to the

qualifications of providers," 42 C.F.R. § 431.51(c)(2), is limited by the requirement that they be "reasonable," the "reasonableness" requirement somehow eviscerates the State's inherent reserved right to set provider qualifications, i.e., to write the list of eligible providers from whom patients may exercise their right to choose. The ability to qualify providers based on State law and policy, contrary to the Seventh Circuit's holding, is not a meaning "'entirely strange to those familiar with its ordinary usage.'" *Planned Parenthood of Ind.*, --- F.3d ---- (quoting *United States v. Little Lake Misere Land Co.*, 412 U.S. 580, 596 (1973)). Rather, it is the Seventh Circuit's attempt to pull a definition of "qualified" out of thin air ("Read in context, the term 'qualified' as used in § 1396a(a)(23) unambiguously relates to a provider's fitness to perform the medical services the patient requires. . . . To be "qualified" in the relevant sense is to be capable of performing the needed medical services in a professionally competent, safe, legal, and ethical manner," *id.*) that is "entirely strange to those familiar with its ordinary usage."

In fact, it is this illogical "free choice of [] provider" argument that would make the scope of the provision illimitable and eviscerate State authority to set reasonable provider qualifications, by prohibiting every qualification unrelated to competency that incidentally reduced the pool of

qualified providers. Plaintiffs-Appellees would have this Court believe that what they mistakenly label as the "free choice of provider" provision (deleting "qualified" *sub silentio*) grants Medicaid recipients *carte blanche* to determine which providers are, in fact, "qualified," and what "qualified" (i.e., allegedly 'capable and competent') provider they will utilize. Under this theory, any patient could select any licensed physician and file suit to force their eligibility. The "choice" intended in the Medicaid Act is instead the free choice of qualified providers as determined by the state and thus on the state list – not the unbridled ability to add names to that list. It is substantial, not incidental, restrictions on freedom to choose among qualified providers that the statute is designed to address. *See, e.g.*, *Kelley Kare, Ltd. v. O'Rourke*, 930 F.2d 170 (2d Cir. 1991) (disqualification of a single provider was only an "incidental burden on [beneficiaries'] right to choose"); *O'Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773, 785 (1980) (freedom of choice entails "the right to choose among a range of *qualified* providers," who "continue[] to be qualified") (emphasis in original).[7]

Further, the legislative history cited by plaintiffs in their

[7] As noted in Defendant Horne's Memorandum in Opposition to Motion for Preliminary Injunction (Docket No. 44), at 16, n.7, CMS has approved Arizona State Plan Amendments (SPAs) that have the unintended but obvious effect of restricting access to providers that would be otherwise qualified.

Memorandum in Opposition to Defendants' Motion to Dismiss Claims I and II of Plaintiffs' Complaint (Doc. 61), at 4, adds nothing that is not apparent on the face of the statute. It simply states that the provision was intended to:

> (1) "[a]llow recipients free choice of *qualified* providers of health services"; (2) provide that "people covered under the Medicaid program would have free choice of *qualified* medical facilities and practitioners"; and (3) require that "recipients of medical assistance under a State Title XIX program . . . have freedom in their choice of medical institution or medical practitioner."

S. Rep. No. 90–744 at 5, 19, 122 (1967), reprinted in 1967 U.S.C.C.A.N. 2834, 2838, 2868, 3021 (emphasis added). Whether "qualified" means "qualified as a doctor and able to perform a procedure" – i.e., whichever medical professional Plaintiffs-Appellees wish to be qualified – or "meeting requirements and so qualified by the state," as supported by § 1296a(p)(1), is determinative yet too "vague" to be administered equitably by this Court. Thus, a(a)(23)'s "qualified" language introduces a level of "vagueness" that bars it from meeting the second *Blessing* prong. Consequently, Plaintiffs-Appellees cannot be held to possess a right of action to enforce it.

III.

THE DISTRICT COURT ERRED IN HOLDING THAT PLAINTIFFS-APPELLEES HAVE STANDING UNDER THE SUPREMACY CLAUSE, WHICH AFFORDS NO DIRECT RIGHT OF ACTION TO ENFORCE A FEDERAL STATUTE THAT CONFERS NO INDIVIDUAL RIGHTS.

Plaintiffs-Appellees likewise lack a private right of action to challenge Medicaid disqualification through a preemption claim. "[T]he Supremacy Clause, of its own force, does not create rights enforceable under § 1983." *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 107 (1989). "[A]n allegation of incompatibility between federal and state statutes and regulations does not, in itself, give rise to a claim 'secured by the Constitution' within the meaning of § 1343(3)." *Chapman v. Houston Welfare Rights Org.*, 441 U.S. 600, 615 (1979).

Even if a preemption claim generally does afford a right of action enforceable under § 1983 via the Supremacy Clause, regardless of whether the federal law in question secures individual rights, that doctrine would nonetheless be inapposite because PPAZ's claims are not preemption claims. There is no state law that actually conflicts with § 1396a(a)(23). Again, § 1396a(a)(23) merely establishes one criterion for federal reimbursement of state payments. A state Medicaid plan that does not comport with the provision may not qualify for federal reimbursement, but it does not conflict with federal law. As discussed above, states may, consistent with federal law, maintain Medicaid plans that do not qualify for federal reimbursement. And again, as discussed above, this is all the more true when it comes to legislation, such as Medicaid, enacted under the Spending Clause.

It is undisputed "that there is no statutory private right of action to enforce 42 U.S.C. § 1396a(a)(30)(A), either under 42 U.S.C. § 1983 or directly under the Medicaid Act." Brief for the United States as *Amicus Curiae* Supporting Petitioner at 9, *Douglas v. Independent Living Ctr. of S. Cal., Inc.*, 131 S.Ct. 992 (No. 09-958), 2011 WL 2132705 at *9. Furthermore, the United States added, "the relevant features of the [Medicaid] statutory scheme counsel against recognizing a nonstatutory cause of action for Medicaid providers and beneficiaries to enforce Section 1396a(a)(30)(A)." *Id.* at *10. This is equally true for § 1396a(a)(23), which like § 1396a(a)(30)(A) merely describes what a Medicaid plan must include for the Secretary to approve it and does not require states to do anything.

IV. THE DISTRICT COURT ERRED IN GRANTING INJUNCTIVE RELIEF TO PLAINTIFFS-APPELLEES.

Even if this Court finds that Plaintiffs-Appellees have standing, injunctive relief is inappropriate. A party seeking a preliminary injunction must demonstrate: (1) a likelihood of success on the merits; (2) that he is likely to suffer irreparable harm in the absence of preliminary relief; (3) that the balance of equities tips in his favor; and (4) that an injunction is in the public interest. *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). However, injunctive relief is always an "extraordinary and drastic remedy." *Mazurek v. Armstrong*, 520 U.S. 968, 972 (1997) (citation omitted).

"[A]s *Winter* plainly demonstrates, . . . plaintiffs seeking a preliminary injunction face a difficult task in proving that they are entitled to this 'extraordinary remedy.'" *Earth Island Institute v. Carlton*, 626 F.3d 462, 469 (9th Cir. 2010) (quoting *Winter*, 555 U.S. at 22). Plaintiffs-Appellees cannot demonstrate that they are likely to succeed on the merits of their constitutional and statutory claims because Arizona enjoys broad authority under the Medicaid statute to establish provider qualifications that reflect State law and policy, and Medicaid patients have no statutory or constitutional right to access Medicaid-subsidized services from a provider that is not qualified under State law. Further, whatever "harm" that may flow to Plaintiff-Appellee PPAZ is strictly pecuniary, and hence not cognizable as "irreparable" because a temporary loss of public funds can be remediated after a determination of its claims on the merits. For the reasons set forth below, the District Court's granting of a preliminary injunction should be reversed.

A. Plaintiffs-Appellees Cannot Succeed on the Merits Because A.R.S. § 35-196.05 Is Consistent with Medicaid's Protection for Freedom of Choice Among Qualified Healthcare Providers.

The plain language of A.R.S. § 35-196.05 and its implementing regulation provide that State authority to determine the "qualifications" inherent in a "free choice of *qualified* providers" (emphasis added) is

retained under the statutory scheme. Relying on a subjective reading of the provisions at issue rather than the "plain statement" required to impose statutory conditions on a State sovereign would turn federalism on its head and seeks to usurp the proper role of Arizona in furthering its own State public policy relating to the health and welfare of its citizens.

A.R.S. § 35-196.05 is not preempted by the Medicaid Act, either by the express terms of the "freedom of choice of among qualified providers" provision or implicitly via the purpose and framework of the statute. The Tenth Amendment guarantees that Arizona retains its sovereign police power authority to regulate the health and welfare of its citizens even when acting in partnership with the federal government, and that where Congress has not already spoken through the terms of a Spending Clause statute, State authority to legislate in the area occupied jointly by the federal and State government is reserved to the State.[8] Any purported surrender of Arizona's sovereignty must be interpreted strictly in favor of the State. "[T]he powers delegated to the United States, being in derogation of the rights of sovereign States, must be construed strictly." *Anderson v. Dunn*, 19 U.S. 204, 213

[8] "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people." U.S. CONST. AMEND. X.

(1821)[9]; *see also Sossamon v. Texas*, 131 S. Ct. 1651, 1658 (2011) (quoting *Lane v. Pena*, 518 U.S. 187 (1996)) (for the same reasons that a State's surrender of its sovereign immunity from suit "'will be strictly construed, in terms of its scope, in favor of the sovereign,'" all other surrenders of a State's sovereign authority to the federal government must also be read narrowly and in deference to the sovereign said to be surrendering its authority).

In consequence of this guiding principle of the federal system, "courts may not find state measures pre-empted in the absence of clear evidence that Congress so intended . . . ." *California v. FERC*, 495 U.S. 490, 497 (1990). "Only a demonstration that complete ouster of state power including state power to promulgate laws not in conflict with federal laws was 'the clear and manifest purpose of Congress' would justify th[e] conclusion" that States could not act in the absence of federal legislation. *DeCanas v. Bica*, 424 U.S. 351, 357 (1976) (quoting *Florida Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132, 146 (1963)).

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[9] *See also* Kurt Lash, *Leaving the Chisholm Trail: The Eleventh Amendment and the Background Principle of Strict Construction*, 50 WILLIAM & MARY L. REV. 1577, 1597-98 (2009) ("[T]he attendees of the state conventions were assured that all delegated power would be strictly construed in order to preserve the retained sovereignty of the people in the states.").

The State's case is made by the complete paucity of authority for the proposition that the Centers for Medicaid Services ("CMS") has had a "longstanding" interpretation of the Medicaid Act that precludes State authority to define provider qualifications by the scope of their services. No CMS decision turns upon the "scope of services" of a provider, or even employs that term. The truth is, the position that States may not establish provider qualifications that restrict providers based on the "scope of services" they perform – uniquely in this case, meaning elective abortion – is an *ad hoc* pronouncement cobbled together out of whole cloth in reaction to Indiana's similar measure, passed in 2011. But politically driven policy positions taken by a federal agency cannot override the sovereign authority of the States where that authority has been reserved to the States, both by operation of the Tenth Amendment (because authority over provider qualifications was not expressly delegated to the federal government) and by an explicit statutory reservation of that authority to the States. *See* 42 U.S.C. § 1396a(p)(1) ("In addition to *any other authority* . . . .") (emphasis added). Congressional intent to preempt State law should not lightly be inferred in the absence of an actual conflict with federal law. *California Fed. Sav. & Loan Ass'n v. Guerra*, 479 U.S. 272, 281 (1987).

> In all pre-emption cases, and particularly in those in which Congress has legislated in a field which the States have traditionally occupied, we start with the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.

Wyeth v. Levine, 555 U.S. 555, 565 (2009).

The States' ability to set reasonable provider qualifications thus inheres in their sovereignty, and not in any authorization to do so by a federal statute. Recognizing this, § 1396a(p)(1) is a dual statement that State authority is co-extensive with the Secretary's authority in acting upon certain enumerated grounds for discretionary exclusion, *and* an explicit reservation of existing and inherent State authority to exclude providers for reasons germane to State law and policy. Contrary to Plaintiffs-Appellees' assertion, this express grant of co-equal authority and acknowledgment of retained inherent State authority applies without any distinction between initial qualifications and disqualifications or exclusions. *See* 42 U.S.C. § 1396a(p)(3) ("As used in this subsection, the term 'exclude' includes the refusal to enter into or renew a participation agreement or the termination of such an agreement.").

Because States contract at arms' length with the federal government as co-equal sovereigns to implement federal programs, "states accepting funds from the federal government must be aware of the conditions attached

to the receipt of those funds so that they can be said to have 'voluntarily and knowingly accept[ed] the terms of the 'contract.'" *Sanchez v. Johnson*, 416 F.3d 1051, 1057 (9th Cir. 2005) (quoting *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 17 (1981)). This is known as the "*Pennhurst* clear statement rule."[10] "Accordingly, if Congress intends to impose a condition on the grant of federal monies, it must do so unambiguously . . . [and] speak with a clear voice [in order to] enable the States to exercise their choice knowingly, cognizant of the consequences of their participation." *Pennhurst, ibid.*; *Will v. Mich. Dep't of State Police*, 491 U.S. 58, 65 (1989) (describing as an "ordinary rule of statutory construction" the principle that "if Congress intends to alter the 'usual constitutional balance between the States and the Federal Government,' it must make its intention to do so 'unmistakably clear in the language of the statute.'")

This is a particularly important principle under the Medicaid program, because it *guarantees* States "*flexibility in designing plans* that meet their

[10] The United States Supreme Court vigorously reiterated this principle of federalism and reaffirmed the continuing vitality of the *Pennhurst* "clear statement" rule this past session in *Nat'l Fed. of Indep. Businesses ("NFIB") v. Sebelius*, 132 S.Ct. 2566 (2012), stating, "The legitimacy of Congress's exercise of the spending power "rests on whether the State voluntarily and knowingly accepts the terms of the 'contract.'" *NFIB*, 132 S.Ct. at 2602 (quoting *Pennhurst*, 451 U.S. at 17). Thus, the Supreme Court admonished, "Respecting this limitation is critical to ensuring that Spending Clause legislation does not undermine the status of the States as independent sovereigns in our federal system." *Id.*

individual needs" and "*considerable latitude* in formulating the terms of their own medical assistance plans." *Addis v. Whitburn*, 153 F.3d 836, 840 (7th Cir. 1998) (citing *Dandridge v. Williams*, 397 U.S. 471, 487 (1970)) (emphasis added). This flexibility and wide latitude is a reflection of the fact that when a State acts within its core or natural sphere of operation,[11] or expends its own funds,[12] attention to the *Pennhurst* "clear statement rule" is all the more heightened. *Gregory v. Ashcroft*, 501 U.S. 452, 460 (1991) ("[Where] [c]ongressional interference [with a core state function] would upset the usual constitutional balance of federal and state powers[,] ... 'it is incumbent upon the federal courts to be certain of Congress' intent before finding that federal law overrides' this balance." (quoting *Atascadero State Hosp. v. Scanlon*, 473 U.S. 234, 243 (1985)).

Plaintiffs-Appellees' interpretation of the "free choice among qualified providers" rule is contrary to the "clear statement" rule of *Pennhurst*. The "free choice among qualified providers" provision does not

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[11] Establishing qualifications for medical providers is a traditional State function. *Pennsylvania Medical Soc'y v. Marconis*, 942 F.2d 842, 847 (3d Cir. 1991) ("The licensing and regulation of physicians is a state function . . . . Thus, the state regulation is presumed valid. To rebut this presumption, appellants must show that Congress intended to displace the state's police power function.").

[12] Participation in the Medicaid program requires States to expend their own funds as well as administer the federal share. The State share for family planning services is ten percent, resulting in a substantial outlay of State funds.

explicitly preclude States from imposing qualifications based on scope of practice; it guarantees free choice among "qualified" providers, and elsewhere the implementing regulation explicitly acknowledges retained State authority to define such qualifications. Section 1396a(p)(1) codifies States' plenary (though *not* arbitrary or unreasonable) authority to set qualification standards. Such authority may be and has been exercised broadly for many reasons that advance State law and policy, including fraud (*Guzman v. Shewry*, 552 F.3d 941, 950 (9th Cir. 2009)); conflicts of interest (*First Medical Health Plan, Inc. v. Vega-Ramos*, 479 F.3d 46 (1st Cir. 2007)); engaging in industrial pollution (*Plaza Health Laboratories, Inc. v. Perales*, 878 F.2d 577, 578-79 (2d Cir. 1989)); and inadequate record-keeping (*Triant v. Perales*, 491 N.Y.S.2d 486, 488 (N.Y. App. Div. 1985)).

As argued above, to derive the meaning of "qualified" for purposes of the "free choice among qualified providers" provision from a common dictionary definition would ignore the fact that the Medicaid statute itself and its implementing regulations recognize that States retain the authority to define what makes a provider "qualified" in the first place, for any reason supplied by State law. *See* 42 U.S.C. § 1296a(p)(1) ("*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 . . . .") (emphasis added); S. Rep. No. 100-109, at 20 (1987), 1987 WL 61463 (express authority to exclude providers for fraud and abuse "is not intended to preclude a State from establishing, *under State law, any other bases for excluding individuals or entities* from its Medicaid program") (emphasis added); and 42 C.F.R. § 1002.2 ("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*.") (emphasis added). Nor would Defendants-Appellants' textually derived construction do harm to the statutory scheme, because the exercise of this authority is cabined – by the Medicaid statute and federal and State constitutional provisions - to "reasonable" (i.e., not arbitrary or capricious) qualifications.[13]

The Court's well-reasoned analysis in *Guzman, supra*, demonstrates the proper approach to statutory interpretation where preemption by the terms of the Medicaid statute is claimed. Dr. Guzman claimed that a provision of the California welfare law allowing temporary suspension of a

[13] Approval of an SPA that is arbitrary or capricious or otherwise incongruous with applicable law is subject to review under the Administrative Procedure Act. *See Arizona Cattle Growers' Ass'n v. U.S. Fish and Wildlife, Bureau of Land Management*, 273 F.3d 1229, 1236 (9th Cir. 2001) (citing 5 U.S.C. § 706(2)(A)).

physician under investigation for fraud or abuse was preempted by federal law. 552 F.3d at 949. "In preemption cases, we begin with the presumption that the 'historic police powers of the States' are not superseded by federal law unless such result was the 'clear and manifest purpose of Congress.'" *Id*. (quoting *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996)) (internal quotation marks and citation omitted). Dr. Guzman argued that the state statute was preempted because federal law prohibited states from suspending providers from a state health care program simply because the provider is "under investigation" for fraud or abuse.

After pausing to note that the Medicaid program "exemplifies what is often referred to as cooperative federalism," and thus "the case for federal preemption becomes a less persuasive one," *id*. (quoting *Wash. Dep't of Soc. & Health Servs. v. Bowen*, 815 F.2d 549, 557 (9th Cir. 1987)) (internal quotation marks and citations omitted), the Court looked first for "explicit pre-emptive language" limiting the grounds upon which a state may suspend a provider from a state health care program. *Id*. Finding none,[14] the court then turned to the question of whether the Medicaid scheme is so pervasive as to make reasonable the inference that Congress left no room for the States

[14] The Court properly observed that the Social Security Act requires states to exclude providers if directed to do so by the Secretary, "but it does not expressly prohibit states from excluding or suspending providers in other circumstances." *Id*. at 949, n.7 (citing 42 U.S.C. § 1396a(a)(39)).

to supplement it, or whether compliance with the California statute "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Id*. at 949 (quoting *Wisconsin Public Intervenor v. Mortier*, 501 U.S. 597, 605 (1991)) (interior quotation omitted).

To do so, the Court examined the language of the statute to ascertain whether State authority and federal authority to exclude providers could coexist side-by-side in the Medicaid statutory scheme. It first noted that Section 1128 of the Social Security Act lists certain grounds upon which the federal Secretary *must* exclude providers, as well as certain other grounds for discretionary exclusion. *Id*. (citing 42 U.S.C. § 1320a–7). In listing the discretionary grounds for suspension, the Court observed, "[O]ne subsection of the Act explains that the Secretary may exclude or suspend '[a]ny individual or entity which has been suspended or excluded from participation . . . [in] a State health care program, for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity.'" *Id*. (citing 42 U.S.C. § 1320a–7(b)(5)). Because the provision referred to other authority to exclude retained by the States in the statutory scheme, the Court concluded:

> This provision 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.

Id. at 949-50 (citing *Spencer Enters., Inc. v. United States*, 345 F.3d 683, 691 (9th Cir. 2003) ("[I]t is ... a 'cardinal rule of statutory interpretation that no provision should be construed to be entirely redundant.'") (quoting *Kungys v. United States*, 485 U.S. 759, 778 (1988))).

Finally, the Court surveyed the applicable regulations and found that they confirmed this view. *Id*. at 950. The pertinent regulation provided that "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." *Id*. (citing 42 C.F.R. § 1002.2(a)). It further instructed that "nothing [in the regulations] 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*." *Id*. (citing 42 U.S.C. § 1002.2(b)) (emphasis added). "Thus," the court concluded, "[N]ot only does the applicable federal statute fail to prohibit states from suspending providers from state health care programs for reasons other than those upon which the Secretary of HHS may act, the governing regulation specifically instructs that states have such authority." *Id*. Here, the same analysis compels the conclusion that Arizona's preclusion of elective abortion providers is not

prohibited by the terms or intent of the Medicaid statute, and thus, the State retains its authority to enact the statute.

Finally, A.R.S. § 35-196.05 does not offend the "free choice among qualified providers" provision because Plaintiff-Appellee PPAZ remains able to create a separate entity to provide nonfederally qualified abortion services at its five facilities that do so, and thereby remain eligible to provide Medicaid family planning services. Moreover, implementation of A.R.S. § 35-196.05 would result only in an incidental loss of family planning services. Even with this restriction on elective abortion providers, Medicaid beneficiaries seeking family planning services could choose from among approximately 2,000 Medicaid providers that have historically billed for family planning services. (*See* ER 82, Elliott Dec. at 5, ¶ 16.) In light of this, and in view of the fact that PPAZ provides a miniscule portion of the total Medicaid family planning services in Arizona, (ER 72-73, Epps Dec. at 2-3, ¶ 16(b)), Plaintiffs-Appellees cannot claim that A.R.S. § 35-196.05 deprives Medicaid beneficiaries of the opportunity to obtain family planning services from a qualified provider.[15] *See Kelley Kare, supra*; *O'Bannon, supra*.

[15] As discussed in Defendants' Response to the United States Statement of Interest at 12-16 (Docket No. 62), no deference is owed to CMS' interpretation of the "freedom of choice among qualified providers" provision based on *Chevron* or *Skidmore* deference.

B. Plaintiffs-Appellees Failed to Demonstrate Irreparable Harm, and a Remedy at Law Exists Presuming They Prevail.

PPAZ complains that access to health service will be substantially diminished if it is precluded from offering Medicaid services. Mem. in Supp. at 17-19. To the contrary, the Medicaid statute requires the State to have "methods and procedures . . . to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. § 1902(a)(30)(A). AHCCCS data for the last five years, set out in the agency's "Access to Care May 2012" report,[16] reflects that despite a large expansion in AHCCCS population during that period, "there were no access to care issues," AHCCCS reported. *Id*. at 2. In fact, "Overall, the number of AHCCCS providers has increased in the past few years." *Id*. at 7. Eighty percent of Arizona practicing physicians are actively enrolled to provide services to Medicaid members. *Id*. at 8. "[T]he AHCCCS network is robust and will be more than adequate in the coming

[16] Avail. at www.azahcccs.gov/commercial/.../rates/AccessToCare 2012_Web.pdf.

year." *Id* at 2.[17] And while PPAZ also asserts that Medicaid patients will have to travel farther to access services in its absence, AHCCCS requirements for network adequacy standards (time and distance as well as minimum provider/facility requirements) far exceed CMS-established standards for Medicare Advantage Plans. Provider data reflects that there are qualified family planning providers in every geographic area served by PPAZ that are more than adequate to make up for the relatively insignificant proportion of services provided by PPAZ. (ER 71-73, Epps Dec. at ¶¶ 2 - 3, 14 – 16). Thus, it cannot be said that either PPAZ or its patients would suffer any harm if PPAZ chose not to divest itself of abortion services and thereby remain eligible for participation as an AHCCCS provider.

C. The Balance of Harms Favored the State, Not Plaintiffs-Appellees.

PPAZ bears the burden to show that the balance of equities tips in its favor. *Stormans v. Selecky*, 586 F.3d 1109, 1138 (9th Cir. 2009) (citing *Winter*, 555 U.S. at 20). It is the judgment of the legislature, confirmed by

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[17] Planned Parenthood estimates its cost of providing Medicaid services by a "relative value unit" that is unique to PPPAZ. (ER 56-59, Howard Dep. at 22-25.) But AHCCCS rates are set by objective market data in consultation with the Medicare Indexed National Resource-Based Relative Value Scale's ("RBRVS) data for the State of Arizona. (*See* ER 82, Elliot Dec. at 5, ¶ 17). AHCCCS' practitioner reimbursement rates are currently 84% of Medicare in aggregate. "Access to Care" Report at 8. Last year, the number of providers who left for rate-related reasons was a mere 0.14% of total providers. *Id*. at 7.

the unrebutted declarations of Mr. Epps and Dr. Elliott, that PPAZ is in fact subsidizing abortions with AHCCCS funds. Arizona taxpayers, acting through their elected representatives, have a strong interest in ending these taxpayer subsidies of abortion. PPAZ serves only a tiny percentage of AHCCCS members and receives relatively little AHCCCS family planning funding. (ER 85, Elliott Dec. ¶¶ 27-28). Without the requested injunctive relief the Doe Plaintiffs-Appellees would remain free to receive AHCCCS services from other providers. Moreover, PPAZ would remain free to simply create a separate entity to provide abortion services, devoid of any cross-subsidization with PPAZ, and thereby continue to fully participate in the AHCCCS program. PPAZ does not explain why it cannot or will not take this step and eliminate any need for injunctive relief. Plaintiffs-Appellees thus have demonstrated no actual harm from the Act at all and the balance of equities favors the taxpayers' interest in ensuring that Arizona's scarce resources are not used to subsidize abortions.

D. The Public Interest Was Not Served by the Issuance of an Injunction.

Any public interest in ensuring continued access to health services would not be served by issuing the injunction. Rather, the public interest has been identified by the legislative enactment, and signed by the Governor.

Even of the services PPAZ most commonly provides, PPAZ serves only a small fraction of Arizona patients, less than .02% (1 out of every 5000), of all of the patients provided those services through AHCCCS. (ER 85, Elliott Dec., ¶¶ 27-28, Ex. D (PPAZ served 2,112 AHCCCS patients in FY2011 of the 1,119,056 members served by Arizona providers). PPAZ provides no contrary evidence that its exclusion from AHCCCS would have any detrimental effect on public health whatsover. To the contrary, the issuance of the injunction would frustrate the public's interest, expressed through its elected representatives, in ensuring that taxpayer dollars do not directly or indirectly support abortions.[18]

CONCLUSION

For the reasons set forth above, the District Court's decision to deny Defendants-Appellants' motion to dismiss Plaintiffs-Appellees' complaint,

[18] Additionally, any injunctive relief should be tailored to the limits of PPAZ's successful claims. Appropriate relief in those situations would involve enjoining only the unconstitutional applications of the statute while leaving other applications in force, *Ayotte v. Planned Parenthood of Northern New England*, 546 U.S. 320, 328-29 (2006), or severing its problematic portions while leaving the remainder intact. *Id.* at 329; *see also Cincinnati Women's Services, Inc. v. Taft*, 468 F.3d 361, 371 (6th Cir. 2006) (adopting the *Ayotte* standard). A.R.S. § 35-196.05 refers to contracts generally while making no mention of Medicaid or any other specific funding source. Therefore, even if A.R.S. § 35-196.05 is invalid with respect to Medicaid funding, Plaintiffs would not be entitled to facial invalidation, but only to relief for Medicaid participation.

and to grant a preliminary injunction to Plaintiffs-Appellees, should be reversed.

Respectfully submitted this 28th day of December, 2012.

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Statement of Related Cases

There are no cases deemed to be related to this matter in this Court.

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Dated this 28th day of December, 2012.

s/ Thomas M. Collins
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CERTIFICATE OF SERVICE
When All Case Participants are Registered for the Appellate CM/ECF System

I hereby certify that I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system on (date) .

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

Signature (use "s/" format)

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CERTIFICATE OF SERVICE
When Not All Case Participants are Registered for the Appellate CM/ECF System

I hereby certify that I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system on (date) .

Participants in the case who are registered CM/ECF users will be served by the appellate CM/ECF system.

I further certify that some of the participants in the case are not registered CM/ECF users. I have mailed the foregoing document by First-Class Mail, postage prepaid, or have dispatched it to a third party commercial carrier for delivery within 3 calendar days to the following non-CM/ECF participants:

Signature (use "s/" format)