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6 IN THE UNITED STATES DISTRICT COURT
7 FOR THE DISTRICT OF ARIZONA

8
9 Planned Parenthood Arizona, Inc.; Jane
10 Doe #1; Jane Doe #2; Jane Doe #3; Eric
Reuss, M.D.,

11 Plaintiffs,

12 v.

13 Tom Betlach, Director, Arizona Health
14 Care Cost Containment System; Tom
Horne, Attorney General,

15 Defendants.

No. CV-12-01533-PHX-NVW

ORDER

AND

**FINDINGS OF FACT AND
CONCLUSIONS OF LAW**

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1 Before the Court is Plaintiffs' Motion for Preliminary Injunction (Doc. 6) and
2 Defendants' Motion to Dismiss Counts I and II (Doc. 37). For the reasons below, the
3 Plaintiffs' Motion for Preliminary Injunction will be granted, and the Defendants' Motion
4 to Dismiss will be denied. This Order states the Court's findings of fact and conclusions
5 of law under Fed. R. Civ. P. 52(a)(2).

6 **I. BACKGROUND**

7 **A. The Challenged Arizona Act**

8 Plaintiffs brought this action to enjoin the enforcement of Arizona Legislature HB
9 2800, 2nd Regular Session, 50th Legislature (2002) ("the Arizona Act"), which prohibits
10 any health care provider who performs elective abortions from receiving Medicaid
11 funding. A.R.S. § 35-196.05. The challenged portion of the Arizona Act provides:

12 This state or any political subdivision of this state may not enter into a
13 contract with or make a grant to any person that performs nonfederally
14 qualified abortions or maintains or operates a facility where nonfederally
qualified abortions are performed for the provision of family planning
services.

15 A.R.S. § 35-196.05(B). For the purposes of the Arizona Act, "nonfederally qualified
16 abortion" is defined as "an abortion that does not meet the requirements for federal
17 reimbursement under title XIX of the social security act." A.R.S. § 35-196.05(F)(4). In
18 turn, an abortion that does not meet the requirements for federal reimbursement is any
19 abortion except where the pregnancy is the result of rape or incest, or threatens the life or
20 health of the mother. Exec. Order No. 13,535, 75 Fed. Reg. 15, 599 (Mar. 24, 2010).
21 The Arizona Act therefore prohibits any person or entity that performs abortions, outside
22 of those exceptions, from participating in Medicaid. On May 4, 2012, Governor Jan
23 Brewer signed the Arizona Act into law after the Act passed by wide margins in both
24 houses of the Arizona Legislature. Though the Arizona Act was scheduled to take effect
25 on August 2, 2012, the parties in this case stipulated to a temporary restraining order that
26 delayed implementation and enforcement of the Act pending the Court's ruling on
27 Plaintiffs' Motion. (Doc. 26.)
28

B. The Medicaid Program

The Medicaid program, established by Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.*, is a cooperative federal-state program created to provide medical assistance to needy families and individuals. Under the Medicaid program, the federal government provides funds to states to offset some of the expense of furnishing medical services to low-income persons. The program is jointly financed by the federal and state governments, and states administer the program according to federal guidelines. 42 U.S.C. § 1396 *et seq.*; 42 C.F.R. § 430.0. States are not required to participate in the federal Medicaid program. Once a state elects to participate in Medicaid, however, it must do so in accordance with federal statutes and regulations. 42 U.S.C. §§ 1396a(a)(1)-(83); *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990).

States that participate in the Medicaid program are required to develop a comprehensive plan for the provision of services that must be approved by the Secretary of Health and Human Services (“the Secretary”). 42 U.S.C. § 1396a(a); *Wilder*, 496 U.S. at 502. The Secretary delegates power to review and approve plans to Regional Administrators of the Centers for Medicare and Medicaid Services (“CMS”). 42 C.F.R. § 430.15(b). CMS reviews the state plan to determine whether its provisions are consistent with federal policy. 42 C.F.R. § 430.14. CMS then exercises its delegated authority either to approve the state plan or to disapprove the plan after consulting with the Secretary. 42 C.F.R. § 430.15(b)-(c).

1. Freedom of Choice Provision

Central to the dispute in this case, among the requirements for states to participate in the Medicaid program, “[a] State plan for medical assistance must – provide that:”

(A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services, and

(B) an enrollment of an individual eligible for medical assistance in a primary care case-management system . . . a Medicaid managed care

organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive services under section 1396d(a)(4)(C) of this title.

42 U.S.C. § 1396a(a)(23). The Supreme Court has interpreted this freedom of choice provision to give Medicaid recipients “the right to choose among a range of qualified providers, without government interference.” *O'Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773, 785 (1980).

Subparagraph (B) of § 1396a(a)(23) expands that protection in the context of family planning services. The services described in 42 U.S.C. § 1396d(a)(4)(C) are “family planning services and supplies furnished . . . to individuals of child-bearing age . . . who are eligible under the State plan and who desire such services and supplies.” Section 1396a(a)(23)(B) therefore provides an additional guarantee of an individual’s free choice of providers of family planning services; the guarantee applies even in the context of managed care organizations, where free choice of providers otherwise can be limited by a state. 42 U.S.C. § 1396a(a)(23)(B); *see also* 42 U.S.C. § 1396n(b) (providing that the Secretary may waive free choice of providers in some circumstances to permit a state to set up a managed care delivery system, but that “[n]o waiver under this subsection may restrict the choice of the individual” in receiving family planning services).

Though participating states must comply with all of the requirements of Title XIX, including the freedom of choice provision, states retain some autonomy and flexibility in devising Medicaid plans. Specifically, a state may establish “reasonable standards relating to the qualifications of providers” 42 C.F.R. § 431.51(c)(2). A state may also exclude health care providers under certain circumstances: “[i]n addition to any other authority, a State may exclude an individual or entity . . . for any reason for which the Secretary could exclude the individual or entity from participation.” 42 U.S.C. § 1396a(p)(1).

2. Waivers for Demonstration Projects

1 In addition to the state plans approved by CMS, 42 U.S.C. § 1315 authorizes the
 2 Secretary to approve experimental or demonstration projects with the goal of encouraging
 3 states to adopt innovative programs that promote the objectives of Medicaid. *Portland*
 4 *Adventist Med. Ctr. v. Thompson*, 399 F.3d 1091, 1093 (9th Cir. 2005). To that end, the
 5 Secretary may waive certain Medicaid mandates generally applicable to state plans to
 6 allow a state to participate in these “demonstration projects.” 42 U.S.C. § 1315(a). The
 7 Secretary may approve such a project when it “is likely to assist in promoting the
 8 objectives” of the Medicaid program. To do so, the Secretary may waive compliance
 9 with any of the requirements of § 1396a, which governs state plans for Medicaid, “to the
 10 extent and for the period [the Secretary] finds necessary to enable [a State] to carry out
 11 such a project.” 42 U.S.C. §§ 1315(a)-(a)(1).

12 C. Arizona’s Medicaid Program

13 Arizona participates in the Medicaid program through both an approved state plan
 14 under § 1396a and a demonstration project under § 1315. Arizona is therefore bound by
 15 the requirements of § 1396a unless CMS expressly waives a requirement. The state plan
 16 and the demonstration project together authorize the Arizona Health Care Cost
 17 Containment System (“AHCCCS”), the agency responsible for Arizona’s Medicaid
 18 program. AHCCCS operates a managed care system in which health care providers
 19 contract with managed care organizations rather than directly with the State. To facilitate
 20 this demonstration program, CMS waived § 1396a(a)(23)(A) only “[t]o the extent
 21 necessary to enable the State to restrict freedom of choice of providers through
 22 mandatory enrollment of eligible individuals in managed care organizations and/or
 23 Prepaid Inpatient Health Plans.” (Doc. 51 at 6.) CMS did not waive the additional
 24 guarantee of an individual’s free choice of providers of family planning services in
 25 § 1396a(a)(23)(B).

26 II. PLAINTIFFS’ MOTION FOR PRELIMINARY INJUNCTION

27 Plaintiffs seek a preliminary injunction that would enjoin the implementation of
 28 the A.R.S. § 35-196.05(B). A preliminary injunction is an extraordinary equitable

remedy which seeks to “preserve the relative positions of the parties until a trial on the merits can be held.” *Univ. of Tex. v. Camenisch*, 451 U.S. 390, 395 (1981). To be entitled to injunctive relief, a movant must demonstrate that: (1) the movant is likely to succeed on the merits; (2) the movant is likely to suffer irreparable harm in the absence of preliminary relief; (3) the balance of equities tips in the movant’s favor; and (4) an injunction is in the public interest. *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). The burden of persuasion is on the movant, who must make “a clear showing” that each of the four prongs is satisfied. *Mazurek v. Armstrong*, 520 U.S. 968, 972 (1997) (per curiam).

A. Plaintiffs Are Likely to Succeed on the Merits.

Plaintiffs’ first argument is that the Arizona Act violates a Medicaid patient’s right – derived from the § 1396a(a)(23) freedom of choice provision – to receive care from the provider of his or her choice. Defendants contend in response that Plaintiffs do not have a right of action under 42 U.S.C. § 1983 to enforce the Medicaid freedom of choice provision, and that the State cannot violate Medicaid provisions because Medicaid is a voluntary program.

1. Plaintiffs Have a Right to Sue Under 42 U.S.C. § 1983.

Under § 1983, persons are liable if they act under color of law to deprive individuals of “any rights, privileges, or immunities secured by the Constitution and laws” of the United States. 42 U.S.C. § 1983. Although § 1983 authorizes lawsuits to enforce federal statutory rights, *Maine v. Thiboutot*, 448 U.S. 1, 4 (1980), it “does not provide an avenue for relief every time a state actor violates a federal law,” *City of Rancho Palos Verdes v. Abrams*, 544 U.S. 113, 119 (2005). To sue under § 1983, then, a plaintiff must allege a violation of an individual right, not merely a violation of a federal law. See *Blessing v. Freestone*, 520 U.S. 329, 340 (1997). Moreover, Plaintiffs bear the burden of showing that Congress intended for the statute at issue to create an enforceable right. *Gonzaga Univ. v. Doe*, 536 U.S. 273, 283–84 (2002). It is only “rights, not the broader or vaguer ‘benefits’ or ‘interests’ that may be enforced under the authority of

1 [§ 1983].” *Id.* at 283. The Supreme Court established a three-factor test in *Blessing* to
 2 determine whether a particular federal statute creates an enforceable right. That test
 3 instructs courts to evaluate whether:

4 (1) “Congress intended that the provision in question benefit the plaintiff”;
 5 (2) the plaintiff has “demonstrated that the right assertedly protected by the
 6 statute is not so ‘vague and amorphous’ that its enforcement would strain
 7 judicial competence”; and (3) “the statute unambiguously imposes a
 binding obligation on the States,” such that “the provision giving rise to the
 asserted right is couched in mandatory, rather than precatory terms.”

8 *Ball v. Rodgers*, 492 F.3d 1094, 1104 (9th Cir. 2007) (quoting *Blessing*, 520 U.S. at 340-
 9 41). If all three elements of the *Blessing* test are satisfied, a federal right is
 10 “presumptively enforceable by § 1983, subject only to a showing by the state that
 11 Congress specifically foreclosed a remedy under § 1983.” *Ball*, 492 F.3d at 1116
 12 (internal quotation marks and citation omitted).

13 In *Gonzaga*, the Supreme Court directed courts to evaluate the first *Blessing* prong
 14 by examining whether Congress used “rights-creating” language to create individual
 15 rights that were “unambiguously conferred.” *Gonzaga*, 536 U.S. at 283-84. As
 16 exemplars of statutory provisions that create § 1983 rights, the Court discussed Title VI
 17 of the Civil Rights Act of 1964 and Title IX of the Education Amendments of 1972, both
 18 of which use the wording “[n]o person . . . shall . . . be subjected to discrimination.” *Id.*
 19 at 284.

20 The Medicaid freedom of choice provision at issue here reveals congressional
 21 intent to create an individualized right. Section 1396a(a)(23) is phrased in terms of the
 22 individual’s right to select among qualified providers and is unmistakably focused on the
 23 specific individuals the provision is intended to benefit. “A State plan for medical
 24 assistance *must* . . . provide that *any individual eligible for medical assistance* (including
 25 drugs) may obtain . . .” 42 U.S.C. § 1396a(a)(23)(A) (emphasis added). Further, in the
 26 family planning context, “[a] State plan for medical assistance *must* . . . provide that an
 27 enrollment of *an individual* eligible for medical assistance in a primary care case-
 28 management system . . . *shall not* restrict the choice of the qualified person from whom

1 *the individual* may receive services” 42 U.S.C. § 1396a(a)(23)(B) (emphasis
2 added). The language Congress used in these provisions includes paradigmatic “rights-
3 creating terms” that evince congressional intent to confer individual rights. *Gonzaga*,
4 536 U.S. at 284. Indeed, it is “difficult, if not impossible, as a linguistic matter, to
5 distinguish the import of the relevant Title XIX language – ‘A State plan must provide’ –
6 from the ‘No person shall’ language of Titles VI and IX,” that the Supreme Court
7 identified as an exemplar. *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 190 (3d Cir.
8 2004) (citing *Blessing*, 520 U.S. at 341); *see also Watson v. Weeks*, 436 F.3d 1152, 1161
9 (9th Cir. 2006) (endorsing the *Sabree* court’s reasoning). The language of the freedom of
10 choice provision focuses on individuals and provides clear instructions for what the states
11 must do to ensure that eligible individuals receive services to which they are entitled
12 under the statute. The provision does not, therefore, focus on the “aggregate services
13 provided by the State, rather than the needs of any particular person.” *See Gonzaga*, 536
14 U.S. at 282. Instead, § 1396a(a)(23) confers on eligible individuals the “right to choose
15 among a range of qualified providers [] without government interference.” *O’Bannon*,
16 447 U.S. at 785. The text of the freedom of choice provision therefore guarantees
17 individual patients the right to make health care choices using mandatory, rights-creating
18 language. *See Planned Parenthood of Ind., Inc. v. Comm’r of Ind. State Dep’t of Health*,
19 794 F. Supp. 2d 892, 902 (S.D. Ind. 2011).

20 But the inquiry into congressional intent to create rights does not end with the text
21 of the particular provision at issue. In addition to the plain text, the structure of the
22 statute in its entirety must be considered to determine whether Congress intended to
23 confer individual rights. *Gonzaga*, 536 U.S. at 286. Defendants contend that Title XIX
24 of the Social Security Act, understood as a whole, does not reflect congressional intent to
25 create individual rights because Congress was concerned with systemic rather than
26 individual compliance. The best evidence of this purported congressional intent is 42
27 U.S.C. § 1396c, which empowers the Secretary to suspend payments to a state when the
28 state’s Medicaid plans fails to “comply substantially” with the requirements of Title XIX.

1 Arizona is therefore obligated, Defendants argue, only to comply substantially with the
2 requirements of § 1396a(a)(23), and the only remedy for its failure to comply
3 substantially would be for the Secretary to withhold payments.

4 Congress has, however, expressly rejected Defendants' interpretation of the
5 Medicaid Act. In *Suter v. Artist M.*, 503 U.S. 347 (1992), the Supreme Court accepted
6 Defendants' argument and held a Medicaid Act provision unenforceable under § 1983
7 because it could be "read to impose only a rather generalized duty on the State, to be
8 enforced not by private individuals, but by the Secretary." *Id.* at 363. Congress
9 superseded that interpretation and responded directly to *Suter* by enacting 42 U.S.C.
10 § 1320a-2, known as the "*Suter* fix." The *Suter* fix clarified that a provision of the Social
11 Security Act "is not to be deemed unenforceable because of its inclusion in a section of
12 this chapter requiring a State plan or specifying the required contents of a State plan." By
13 enacting 42 U.S.C. § 1320a-2, Congress decreed that the statutory structure of the
14 Medicaid Act, which requires states to submit plans to the Secretary for approval,
15 "cannot detract from or override the otherwise clear 'rights-creating language' Congress
16 used in enacting the free choice provisions." *Ball*, 492 F.3d at 1112 (finding "like the
17 language of . . . [§] 1396a(a)(23) . . . the language of §§ 1396n(c)(2)(C) and (d)(2)(C)
18 satisfies the 'rights-creating' standard set forth in *Gonzaga*"). Congress has therefore
19 foreclosed Defendants' argument that § 1396a(a)(23) was "enacted simply to set forth a
20 policy or practice upon which the receipt of federal funds is conditioned." *Id.*; *see also*
21 *Harris v. Olszewski*, 442 F.3d 456, 461 (6th Cir. 2006) (holding § 1396a(a)(23) "creates
22 enforceable rights that a Medicaid beneficiary may vindicate through § 1983").

23 This conclusion is supported by the fact that Defendants' interpretation of § 1396c
24 would prohibit enforcement of *any* provision of the Medicare Act through § 1983.
25 Binding Ninth Circuit precedent precludes that interpretation. *Ball*, 492 F.3d 1094; *see*
26 *also Watson v. Weeks*, 436 F.3d 1152, 1161 (9th Cir. 2006) (holding § 1396a(a)(10)
27 enforceable under § 1983). And, in addition to the Ninth, Sixth, and Third Circuit cases
28 already cited, other circuits have applied *Gonzaga* and concluded that a variety of

1 Medicaid provisions create enforceable rights that plaintiffs can vindicate under § 1983.
2 See *Doe v. Kidd*, 501 F.3d 348 (4th Cir. 2007); *Rabin v. Wilson-Coker*, 362 F.3d 190 (2d
3 Cir. 2004); *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 604 (5th Cir. 2004). Therefore,
4 the Court finds that § 1396a(a)(23) unambiguously evinces Congress's intent to create
5 individual rights that can be enforced under § 1983. Plaintiffs have satisfied the first
6 prong of the *Blessing* test.

7 Under the second *Blessing* prong, a plaintiff must demonstrate that the conferred
8 right at issue is not so "vague" that it would "strain judicial competence" to enforce the
9 right. 520 U.S. at 340. Though there may be legitimate debate about the scope of
10 medical care covered by § 1396a(a)(23), the mandate itself is not so vague that it would
11 be difficult for courts to enforce. *Harris*, 442 F.3d at 462. Rather, the provision sets
12 forth an explicit right that guarantees individuals eligible for medical assistance the
13 ability to choose from among a range of qualified providers without government
14 interference. "A court can readily determine whether a state is fulfilling these statutory
15 obligations by looking to sources such as a state's Medicaid plan, agency records and
16 documents, and the testimony of Medicaid recipients and providers." *Ball*, 492 F.3d at
17 1115. By reviewing this readily available evidence, a court can determine without
18 difficulty whether a state provides an individual with the free choice guaranteed in the
19 provision. Plaintiffs have met their burden of demonstrating the freedom of choice
20 provision satisfies the second *Blessing* prong.

21 The third prong of the *Blessing* test requires consideration of whether the statute
22 "unambiguously impose[s] a binding obligation on the States." 520 U.S. at 347. By
23 using the language "a State plan . . . must . . . provide" and "shall not restrict the choice,"
24 Congress framed the rights it created in § 1396a(a)(23) in mandatory terms. The relevant
25 terms in the freedom of choice provision are therefore "mandatory rather than precatory."
26 *Sabree*, 367 F.3d at 190 (quoting *Blessing*, 520 U.S. at 341). As a result, the final
27 *Blessing* factor "is perhaps most obviously met by the free choice provisions." *Ball*, 492
28 F.3d at 1116.

1 Defendants argue that the mandatory language of the provision should not control
2 because no provision of the Medicaid Act could be mandatory on states that voluntarily
3 participate in the program. If a state program is not compliant with Medicaid
4 requirements, Defendants contend, the state may lose federal funding but cannot be in
5 violation of any federal law. The Supreme Court has considered and rejected this
6 argument. The capacity of the Secretary to curtail funding when states are noncompliant
7 does not foreclose private remedies. *Wilder v. Wilder*, 496 U.S. 498 (1990). Although a
8 state's participation in Medicaid is voluntary, once a state elects to participate it "*must*
9 comply with certain requirements imposed by the Act and regulations promulgated by
10 [the Secretary]." *Id.* at 502 (emphasis added). As a result, "the power of [the Secretary]
11 to reject state Medicaid plans or to withhold federal funding to States whose plans did not
12 comply with federal law cannot foreclose a § 1983 remedy." *Ball*, 492 F.3d at 117
13 (internal quotation marks and citations omitted). Because the language of the freedom of
14 choice provision is a binding obligation for all states that elect to participate in the
15 Medicaid program, the third *Blessing* prong is satisfied. All three prongs of the *Blessing*
16 test are therefore met, and § 1396a(a)(23) confers an individual right that is
17 presumptively enforceable by § 1983.

18 But even where a right is unambiguously conferred, a state may rebut the
19 presumption that § 1983 is available by showing that "Congress specifically foreclosed a
20 remedy under § 1983." *Gonzaga*, 536 U.S. at 284 n.4 (citation omitted). Title XIX does
21 not explicitly preclude individual actions and, as discussed above, the majority of circuits
22 have found provisions of the Medicaid Act enforceable under § 1983. The remedial
23 component of the Medicaid Act – allowing the Secretary to cut federal funds – "cannot
24 be considered sufficiently comprehensive to demonstrate a congressional intent to
25 withdraw the private remedy of § 1983." *Ball*, 492 F.3d at 1117 (citing *Wilder*, 496 U.S.
26 at 521-22). Therefore, nothing in the statute could foreclose a § 1983 remedy. Medicaid
27 beneficiaries thus enjoy individual rights under § 1396a(a)(23) that can be properly
28 enforced through a § 1983 cause of action.

1 **2. Plaintiffs Are Likely to Succeed on Their Claim that the**
2 **Arizona Act Violates the Freedom of Choice Provision.**

3 Because Plaintiffs have a right to sue under § 1983, the Court must consider the
4 merits of their claim that A.R.S. § 35-196.05 (“the Arizona Act”) violates the freedom of
5 choice provision in § 1396a(a)(23). Plaintiffs contend that the Arizona Act disqualifies
6 otherwise qualified providers of medical care from Medicaid solely because of the range
7 of services they provide, which violates a Medicaid patient’s right to receive care from
8 the provider of his or her choice. Defendants argue that the Medicaid Act gives Arizona
9 the authority to determine provider qualifications and that the Arizona Act is merely an
10 expression of that authority.

11 Section 1396a(a)(23) “gives recipients the right to choose among a range of
12 *qualified* providers, without government interference.” *O’Bannon*, 447 U.S. at 785. That
13 right also entails “an absolute right to be free from government interference with the
14 choice to [receive services from a provider] that continues to be qualified.” *Id.* at 785.
15 The emphasis on the term “qualified” in *O’Bannon* presages the central conflict between
16 the parties in this case: whether Arizona can limit the range of qualified Medicaid
17 providers to those providers that do not provide abortions without violating the freedom
18 of choice provision.

19 According to Defendants, the inclusion of the term “qualified provider” in
20 § 1396a(a)(23) demonstrates that a state retains the authority to limit access to providers
21 it deems unqualified. The freedom of choice provision grants Medicaid patients the right
22 to choose, Defendants contend, only among those providers that the State has determined
23 are qualified for any reason consistent with state law. And the Arizona Act merely
24 reflects the State’s considered judgment that providers who perform abortions as defined
25 in the Arizona Act are not qualified to receive Medicaid funding.

26 In response, Plaintiffs – and the United States in its statement of interest – argue
27 that the term “qualified” refers only to a provider’s ability to perform and bill properly
28 for services. Congress has specified several narrow exceptions to the freedom of choice

1 mandate that Plaintiffs contend represent the only permissible limits a state can place on
2 an individual's access to a qualified provider. Congress could not have intended,
3 Plaintiffs argue, to allow states to subvert the freedom of choice provision simply by
4 labeling providers as unqualified; such an interpretation would render the specific
5 exceptions to the provision in the statute superfluous.

6 After considering these arguments, the Court finds that a state's determination of
7 whether a provider is qualified must relate to its ability to deliver Medicaid services. The
8 Court's conclusion is based on an independent review of the plain meaning of the
9 statutory language, a review of the exceptions Congress has delineated to the freedom of
10 choice provision, cannons of statutory construction, and a measure of deference accorded
11 to the relevant agency's considered interpretation of the provision.

12 **a. The Plain Meaning of the Phrase "Qualified to Perform the**
13 **Service" Refers to the Ability of the Provider to Perform**
14 **Medicaid Services.**

15 The plain language of § 1396a(a)(23) connects the limitation on an individual's
16 free choice of providers to those providers that are "qualified" to the ability of the
17 provider "to perform the service or services required." 42 U.S.C. § 1396a(a)(23)(A).
18 That plain language does not support the Defendants' claim that by using the term
19 "qualified" Congress intended for states to have the authority to exclude whole groups of
20 providers for any state policy reason. A medical service provider that is "qualified" is
21 one "[p]ossessing the necessary qualifications; capable or competent, [e.g.] a qualified
22 medical examiner." Black's Law Dictionary (9th ed. 2009). The plain meaning of the
23 phrase "[providers that are] qualified to perform the service or services required" thus
24 limits freedom of choice to those providers that are competent to provide the needed
25 services. Implementing regulations give the states the authority to limit freedom of
26 choice under the provision by "[s]etting reasonable standards relating to the qualifications
27 of the providers." 42 C.F.R. § 431.51(c)(2). So states unquestionably retain the authority
28 to set qualification standards, but only reasonable standards related to the ability of the

1 provider to perform the Medicaid services in question. Defendants do not contend that
 2 the Plaintiff providers are unfit to perform family planning services under Arizona's
 3 Medicaid plan; indeed, Defendants argue that the providers could continue providing
 4 these services if they would stop performing abortions or create a separate entity. Within
 5 the plain meaning of the term, the Plaintiff providers are therefore "qualified" to perform
 6 Medicaid services. As a result, the plain meaning of the text of § 1396a(a)(23) supports
 7 Plaintiffs' argument that the provision guarantees Medicaid recipients the right to select
 8 Plaintiff providers for those services, unless an exception to the provision applies.

9 **b. Section 1396a(p)(1) Does Not Give States Authority to**
 10 **Disqualify Providers for Reasons Unrelated to the Purposes**
 11 **of the Medicaid Act.**

12 The inquiry is not limited to the text of § 1396a(a)(23), however, because other
 13 provisions of Title XIX create exceptions to the general mandate that Medicaid patients
 14 have free choice of qualified providers. These exceptions allow both the Secretary and
 15 the states to exclude providers in a variety of situations. Within § 1396a(a)(23) itself, for
 16 example, Congress clarified that "nothing in this paragraph shall be construed as
 17 requiring a State to provide medical assistance for such services furnished by a person or
 18 entity convicted of a felony under Federal or State law for an offense which the State
 19 agency determines is inconsistent with the best interests of beneficiaries under the State
 20 plan." And the Secretary has discretion to allow states to restrict a Medicaid recipient's
 21 choice of providers to those providers who "meet, accept, and comply with the
 22 reimbursement, quality, and utilization standards under the State plan." 42 U.S.C.
 23 § 1396n(b)(4). Most central to this dispute, § 1396a(p)(1) allows states to exclude
 24 providers for a number of enumerated reasons "[i]n addition to any other authority." 42
 25 U.S.C. § 1396a(p)(1). Section 1396a(p)(1) provides:

26 In addition to any other authority, a State may exclude any individual or
 27 entity for purposes of participating under the State plan under this
 28 subchapter for any reason for which the Secretary could exclude the
 individual or entity from participation in a program under subchapter XVIII
 of this chapter under section 1320a-7, 1320a-7a, or 1395cc(b)(2) of this
 title.

1 Defendants argue that § 1396a(p)(1) gives states the authority to determine
2 provider qualifications for any reason that advances state law and policy. Plaintiffs argue
3 that § 1396a(p)(1) does not give states sweeping authority to determine qualification
4 standards; rather, it specifies narrowly drawn exceptions to the freedom of choice
5 guarantee, all of which are related to excluding providers for fraudulent or illegal
6 activities. Both sides cite to the legislative history of § 1396a(p)(1) to support their
7 proposed interpretations. Defendants note the Senate report accompanying the bill states
8 that § 1396a(p)(1) “is not intended to preclude a State from establishing, under State law,
9 any other bases for excluding individuals or entities from its Medicaid program.” S. Rep.
10 No. 100-109, at 20 (1987), reprinted in 1987 U.S.C.A.N. 682, 700. Plaintiffs highlight
11 that the same Senate report indicates that Congress intended § 1396a(p)(1) to protect
12 Medicaid programs “from fraud and abuse, and to protect the beneficiaries of those
13 programs from incompetent practitioners and from inappropriate or inadequate care.” *Id.*
14 at 1-2, 682. And the United States argues that the phrase “[i]n addition to any other
15 authority” is merely a savings clause at the beginning of a specific authorization to the
16 states to exclude providers in a narrow set of circumstances involving fraud and abuse.
17 Whether the Arizona Act violates the freedom of choice provision therefore turns
18 primarily on the scope of the § 1396a(p)(1) exception.

19 The Court is not persuaded that Congress intended § 1396a(p)(1) to be a sweeping
20 grant of authority to the states that would allow them to disqualify any provider from
21 participating in Medicaid for nearly any reason, or for reasons unrelated to the purposes
22 of the Medicaid Act. As an initial matter, Congress’s use of the term “qualified” in
23 § 1396a(a)(23) is distinct from the term “exclude” as used in § 1396a(p)(1). “Exclude”
24 has a specific meaning as defined in this statute: “the refusal to enter into or renew a
25 participation agreement or the termination of such an agreement.” 42 U.S.C.
26 § 1396a(p)(3). In order to “exclude” a provider under the statute, a state must give the
27 provider to be excluded notice of the state’s intent to exclude, 42 C.F.R. § 1002.212, and
28 an opportunity to appeal the exclusion before it is imposed, 42 C.F.R. § 1002.213. A

1 state's authority to exclude providers is not, therefore, coextensive with the state's
2 authority to set generally applicable provider qualifications. Rather, the state's power to
3 exclude focuses on individual providers who are excluded on a case-by-case basis after
4 notice and opportunity to appeal.

5 Defendants' conflation of a state's power to exclude an individual provider with
6 the state's authority to set reasonable qualifications for all providers permeates
7 Defendants' argument. All of the provisions on which Defendants rely for their
8 contention that states have authority to define a "qualified" provider however they see fit
9 set forth a state's authority to "exclude" providers. None discusses a provider's
10 qualifications. Indeed, at oral argument Defendants' counsel repeatedly referred to
11 § 1396a(p)(1) as the "qualification provision of the Medicaid statute" despite the fact that
12 Congress did not use the word "qualified" or "qualification" anywhere in that provision.
13 If Congress had intended § 1396a(p)(1) to establish states' authority to determine
14 provider qualifications, it knew how to say so by using the word "qualified" as it did in
15 § 1396a(a)(23). Therefore, even if the Court were to accept the Defendants' argument
16 that § 1396a(p)(1) permits a state to *exclude* a provider for any reason established by state
17 law, the power to exclude would not translate directly to the power to *disqualify* an entire
18 class of providers based on services it offers outside the Medicaid program.

19 Further, the interpretation of § 1396a(p)(1) that Defendants advance is not
20 plausible because it renders the remainder of the exceptions to the freedom of choice
21 provision superfluous. If a state could rely on § 1396a(p)(1) to exclude a class of
22 providers for any non-arbitrary reason, then the remainder of the exceptions, which
23 carefully set forth circumstances under which the Secretary and states have authority to
24 exclude providers, would be unnecessary. Such an interpretation undermines "the
25 cardinal rule of statutory interpretation that no provision [of a statute] should be
26 construed to be entirely redundant." *Kungys v. United States*, 485 U.S. 759, 778 (1988);
27 *see also Colautti v. Franklin*, 439 U.S. 376, 392 (1979) ("[It is an] elementary canon of
28 statutory construction that a statute should be interpreted so as not to render one part

1 inoperative.”). Rather, “it is our duty to give effect, if possible, to every clause and word
2 of a statute.” *Khatib v. County of Orange*, 639 F.3d 898, 904 (9th Cir. 2011) (quoting
3 *Duncan v. Walker*, 533 U.S. 167, 174 (2001)).

4 The exceptions to the freedom of choice provision are narrow and specific. For
5 example, Congress carefully circumscribed the Secretary’s own authority, set forth in
6 § 1396n(b)(4), to waive the general requirements of §1396a and allow states to restrict
7 Medicaid beneficiaries’ choice of provider. The Secretary may only grant such a waiver
8 when a state uses standards to limit choice that “are consistent with access, quality, and
9 efficient and economic provision of covered care and services.” 42 U.S.C. § 1396n(b)(4).
10 Further, the Secretary may only allow states to limit choice if “such restriction does not
11 discriminate among classes of providers on grounds unrelated to their demonstrated
12 effectiveness and efficiency in providing those services.” *Id.* Even when the Secretary
13 has limited the freedom of choice requirement, in other words, a state may not restrict a
14 beneficiary’s choice of provider for reasons unrelated to the provider’s ability to provide
15 Medicaid services. If § 1396a(p)(1) gave states the independent authority to restrict
16 choice of providers for any reason, both the Secretary’s authority to grant states waivers
17 of the freedom of choice requirement and the limitation on that authority in § 1396n(b)(4)
18 would be rendered inoperative. Because Congress would not have drafted the statute to
19 make the specific instances in which the Secretary and a state could restrict choice of
20 providers redundant, Defendants’ proposed interpretation of § 1396a(p)(1) is in error.

21 Finally, if a state’s exclusion authority allowed the state to disqualify an entire
22 class of providers for any reason supplied by state law, the freedom of choice guarantee
23 of § 1396a(a)(23) would be greatly weakened. The guarantee would be subject to state
24 policies and politics having nothing to do with the Medicaid program. It is unlikely that
25 Congress would have included a broad guarantee of free choice among qualified
26 providers, subject to enumerated and well-defined exceptions, and then created in the
27 states authority to circumvent that guarantee for nearly any reason. The legislative
28 history of § 1396a(p)(1) does not, therefore, override the statutory guarantee of free

1 choice in § 1396a(a)(23). Indeed, the Senate report as a whole serves to clarify that the
2 overarching purpose of § 1396a(p)(1) is to grant authority to exclude a provider based on
3 the provider's quality of services – not to disqualify a provider based on its scope of
4 services outside Medicaid. S. Rep. No. 100-109; *see also Planned Parenthood of Ind.*,
5 794 F. Supp. 2d at 904.

6 At the preliminary injunction stage, the Court need not define the precise contours
7 of a state's authority to set reasonable standards for provider qualifications. A state's
8 power to determine qualifications may not be as narrowly drawn as Plaintiffs suggest.
9 But for the Court to determine that Plaintiffs are likely to succeed on the merits, it is
10 enough to find that a state's power to set reasonable qualification standards cannot be as
11 broad as Defendants claim. Simply put, a state's determination of whether a provider is
12 qualified to perform Medicaid services must at least be related to Medicaid services. The
13 fact that the Plaintiff providers perform legally protected abortions does not affect their
14 ability to perform family planning services for Medicaid patients. The language of the
15 Medicaid Act, basic canons of statutory construction, and the legislative history of the
16 provisions involved therefore compel the conclusion that Arizona lacks the authority to
17 disqualify providers from the Medicaid program based solely on their provision of lawful
18 abortion services. Because the Arizona Act would disqualify providers for reasons
19 unrelated to Medicaid, Plaintiffs are likely to succeed on their claim that the Act violates
20 the freedom of choice provision of § 1396a(a)(23).

21 **c. Agency Interpretations of § 1396a(a)(23) Are Entitled to**
22 **Some Deference.**

23 To the extent that there is remaining ambiguity about the meaning of
24 § 1396a(a)(23) in light of § 1396a(p)(1), persuasive agency interpretations of these
25 provisions further demonstrate that Plaintiffs are likely to succeed on the merits. The
26 Department of Health and Human Services ("HHS"), the agency charged with
27 administering the Medicaid program through its delegee Centers for Medicare and
28 Medicaid Services ("CMS"), has interpreted the statutes and implementing regulations at

1 issue in this case as this Court does. The most important implementing regulation creates
2 a narrow exception to the freedom of choice provision that permits a state to establish
3 “reasonable standards relating to the qualifications of providers.” 42 C.F.R.
4 § 431.51(c)(2). The Agency has interpreted “reasonable standards relating to the
5 qualifications of providers” to refer to standards that are relevant to providers’ ability to
6 render Medicaid services and to properly bill for those services.

7 Most recently, CMS reviewed in 2011 Indiana’s state Medicaid plan, which
8 included a restriction very similar to the Arizona Act. Indiana’s plan proposed to
9 disqualify health care providers that performed abortions from state contracts and grants,
10 including those that distributed federal Medicaid funds. In its initial review, the CMS
11 Administrator, after consulting with the Secretary, refused Indiana’s plan because the
12 restriction violated § 1396a(a)(23) and its guarantee of free choice of providers. (Doc.
13 51-3.) Following that decision, CMS issued an informational bulletin to all states in
14 which the agency reiterated its interpretation in a “review of longstanding federal law.”
15 (Doc. 51-4.) The bulletin advised the states that they were “not . . . permitted to exclude
16 providers from the program solely on the basis of the range of medical services they
17 provide.” (*Id.*) CMS further clarified its interpretation that “Medicaid programs may not
18 exclude qualified health care providers . . . from providing services under the program
19 because they separately provide abortion services” (*Id.*)

20 Planned Parenthood of Indiana filed an action in the district court seeking a
21 preliminary injunction to prevent Indiana from enforcing its defunding law. In that case
22 Indiana argued, as Defendants do here, that CMS’s interpretation should be accorded no
23 deference by the district court because the CMS decision letter was not final and because
24 there was no statutory gap for the agency to fill in interpreting § 1396a(a)(23). *Planned*
25 *Parenthood of Ind., Inc. v. Comm’r of Ind. State Dep’t of Health*, 794 F. Supp. 2d 892,
26 907 (S.D. Ind. 2011). The court rejected Indiana’s argument, finding that “some level of
27 deference is warranted” without deciding whether heightened deference under *Chevron v.*
28 *NRDC*, 467 U.S. 837 (1984), was warranted. The court reasoned that “in cases such as

1 those involving Medicare or Medicaid, in which CMS, a highly expert agency,
2 administers a large complex regulatory scheme in cooperation with many other
3 institutional actors, the various possible standards for deference – namely, *Chevron* and
4 *Skidmore* – begin to converge.” *Id.* at 908 (quoting *Estate of Landers v. Leavitt*, 545 F.3d
5 98, 107 (2d Cir. 2008)).

6 Since the Southern District of Indiana issued its opinion, additional administrative
7 proceedings have further strengthened the case for awarding some deference to the
8 agency’s interpretation. Indiana sought reconsideration of CMS’s initial disapproval of
9 its Medicaid plan, which CMS denied. In its letter of denial, CMS emphasized that
10 Indiana’s restriction was impermissible because it would particularly affect access to
11 family planning providers, which were subject to additional protection for beneficiary
12 choice of providers under § 1396a(a)(23)(B). (Doc. 7-1 at 10.) Indiana then sought an
13 administrative hearing regarding the denial, a hearing which included full briefing and
14 oral argument before two CMS hearing officers. (*Id.*) Following the argument, the CMS
15 Presiding Officer issued a detailed proposed decision on June 20, 2012. The Officer
16 concluded that Indiana’s restriction was “contrary to the plain language of the freedom of
17 choice provision” and that § 1396a(p)(1) “[did] not apply because it addresses
18 exclusionary powers over specific individuals or entities” rather than provider
19 qualifications. (*Id.* at 25.)

20 Defendants argue that the Court should award no deference to these interpretations
21 because there is no gap to fill in interpreting § 1396a(a)(23) or § 1396a(p)(1) and because
22 there has been no adjudicatory process resulting in an informed determination of the
23 statute’s meaning. The Court disagrees. Even though the proposed decision of the CMS
24 presiding officer (Doc. 7-1) is subject to final review by the CMS administrator, it is
25 entitled to some deference. It is not necessary to decide at this stage whether full
26 *Chevron* deference is appropriate because the agency’s interpretation is persuasive
27 authority “upon the thoroughness evident in its consideration, the validity of its
28 reasoning, its consistency with earlier and later pronouncements, and all those factors

1 which give it power to persuade, if lacking power to control.” *Skidmore v. Swift & Co.*,
2 323 U.S. 134, 140 (1944). The Court finds that CMS’s interpretation was carefully
3 reasoned, decided after thorough consideration of arguments from both sides, and
4 consistent with both prior and subsequent agency pronouncements. Indeed, the agency’s
5 interpretation is persuasive independent of the level of deference it is owed.

6 In addition, ascribing some level of deference to the expert agency’s thoroughly
7 considered interpretation of the Medicaid Act is “squarely in line with a thorough body of
8 case law.” See *Planned Parenthood of Ind.*, 794 F. Supp. 2d at 906 (collecting cases
9 where courts apply *Chevron* deference to CMS approval or denial of state Medicaid
10 plans). After the agency has further considered the denial, held trial-like proceedings,
11 and issued a carefully reasoned proposed decision, the case for that deference is even
12 stronger. The agency’s persuasive interpretation of the statutes at issue here – consistent
13 with the Court’s independent interpretation – weighs heavily in favor of granting
14 injunctive relief in this case.

15 For all of these reasons, the Court finds that Plaintiffs are likely to succeed on the
16 merits of their claim that the Arizona Act violates the freedom of choice provision of the
17 Medicaid Act. Because Plaintiffs would be successful at trial if they were successful on
18 any one of their claims, the Court need not evaluate whether Plaintiffs are likely to
19 succeed on the merits of their other claims at the preliminary injunction stage.

20 **B. Plaintiffs Will Suffer Irreparable Harm Without Injunctive Relief.**

21 If Defendants are permitted to implement the Arizona Act, Plaintiffs Planned
22 Parenthood of Arizona (“PPAZ”) and Dr. Reuss will be unable to provide healthcare
23 services to their patients who are Medicaid beneficiaries, including Doe Plaintiffs, and
24 will lose revenue from those services. Both harms are irreparable.

25 First, PPAZ patients who are also Medicare beneficiaries, including the three Doe
26 Plaintiffs in this case, will be denied their choice of qualified health care providers for
27 family planning services. Should the Court fail to issue a preliminary injunction and later
28 be reversed, these Medicaid patients are virtually certain to be denied the ability to

1 continue to seek care from the provider they have selected because, as a practical matter,
2 PPAZ will be forced to give up its Medicaid services. The denial of that freedom of
3 choice is exactly the injury that Congress sought to avoid when it enacted § 1396a(a)(23).
4 The purpose of the freedom of choice provision is to allow Medicaid recipients the same
5 opportunities to choose among available providers of covered health care services as are
6 normally offered to the general population. A preliminary injunction to preserve the
7 status quo properly avoids the risk that Doe Plaintiffs will needlessly suffer that
8 irreparable injury while this case is pending.

9 Second, PPAZ and Dr. Reuss will immediately lose revenue from Medicaid
10 funding, around \$350,000 annually in PPAZ's case. Plaintiff providers would be unable
11 to recover this lost revenue as damages after a judgment on the merits in their favor
12 because of the Eleventh Amendment's bar to seeking damages from a state. Therefore,
13 Plaintiffs have met their burden of demonstrating that it is likely they will suffer
14 irreparable harm in the absence of a temporary injunction. *Winter*, 555 U.S. at 22.

15 **C. The Balance of Equities Favors Plaintiffs.**

16 Defendants argue that prohibiting health care providers who perform elective
17 abortions from receiving Medicaid funding will serve the State's interest by preventing
18 public funding of abortions. As a result, Defendants claim that the State will be harmed
19 by a preliminary injunction as taxpayer funds will be used to subsidize abortions while it
20 is in force. This argument ignores evidence that PPAZ complies with all federal and state
21 requirements to ensure that public funds are not used for abortion services – evidence
22 supported by the fact that PPAZ has participated in Arizona's Medicaid program without
23 incident for more than twenty years. Because PPAZ is a fee for service provider, PPAZ
24 bills Arizona's Medicaid program only for the specific services it has provided Medicaid
25 patients. PPAZ does not bill Medicaid for most of the abortion services it provides
26 because federal law prohibits the use of federal funds to pay for most abortions.

27 In order to support their claim that state taxpayer funds are being used by PPAZ to
28 subsidize abortions, Defendants argue that any Medicaid funds paid to PPAZ for other

1 medical services indirectly subsidize abortions by supporting the operation as a whole.
2 Defendants contend that taxpayer money that goes to PPAZ for other services is used to
3 subsidize abortions because the money covers overhead and other shared expenses that
4 allow PPAZ to perform abortions. But the Medicaid reimbursements PPAZ receives
5 cover only about half the cost of providing Medicaid services. As a result, after the
6 Medicaid services that PPAZ provides are paid for, there is no excess funding that could
7 be used to subsidize abortions.

8 Further, if the harm the Arizona Act sought to avoid was indirect subsidization of
9 abortions, the injury could be prevented by reducing the state funding that PPAZ receives
10 for Medicaid services to ensure no excess funds were available to pay for the alleged
11 shared expenses. But at oral argument, Defendants' counsel contended that even if the
12 reimbursement PPAZ received for Medicaid services were only ten percent of the current
13 rate, the State would still be harmed by subsidizing abortions. By taking this position,
14 Defendants reveal their argument to be untenable; at that rate, PPAZ would lose so much
15 money offering Medicaid services that it would approach the absurd to say that Medicaid
16 funds were used to "subsidize" abortions. The core remaining of Defendants' argument
17 that the State would be harmed is thus that money is fungible, and that any amount of
18 funding, no matter how small, could be theoretically used by PPAZ to fund abortion
19 services. At that level of abstraction, Defendants' alleged harm is too tenuous to be given
20 weight in the balancing of equities. If there were any merit – and there is none – to
21 Defendants' argument that the State suffers some abstract harm from indirectly
22 supporting abortion services, that harm would be outweighed by the direct harm Plaintiffs
23 will suffer if the Arizona Act is enforced. Granting the injunction will simply require
24 Arizona to continue to allow PPAZ to receive Medicaid funds as it has since at least
25 1991. The balance of harms is therefore entirely in Plaintiffs' favor.

26 **D. Temporarily Enjoining Enforcement of the Arizona Act Is in the**
27 **Public Interest.**
28

1 The public interest is advanced by allocating Medicaid funds consistently with
2 congressional intent to ensure that Medicaid beneficiaries have the freedom to receive
3 family planning services from the qualified health care provider of their choice. PPAZ
4 uses Medicaid funding to provide family planning services to approximately 3,000
5 Medicaid patients each year. Beyond the Doe Plaintiffs in this case, these 3,000 patients
6 would lose the opportunity to receive health care services from the health care provider
7 they have chosen. Congress has made clear its specific intent to protect Medicaid
8 beneficiaries' freedom of choice in the family planning context, 42 U.S.C.
9 § 1396a(a)(23)(B), and it is in the family planning context that the Arizona Act would
10 limit the choice of PPAZ's Medicaid patients. Preserving the status quo with a
11 preliminary injunction ensures that those patients are able to continue to select the health
12 care provider of their choice until a trial on the merits can be held. In addition, PPAZ
13 provides health care services to many Medicaid patients in areas underserved by other
14 health care providers who may have difficulty securing alternative care. Ensuring that
15 more than 3,000 Medicaid patients have continuity of health care services during the
16 pendency of this case is in the public interest. For these reasons, enjoining Defendants
17 from enforcing the Arizona Act is in the public interest.

18 **III. BOND**

19 A preliminary injunction must be conditioned on the plaintiff posting security "in
20 an amount that the court considers proper to pay the costs and damages sustained by any
21 party found to have been wrongfully enjoined or restrained." Fed. R. Civ. P. 65(c). The
22 amount of the bond is within the Court's discretion. *See Save Our Sonoran, Inc. v.*
23 *Flowers*, 408 F.3d 1113, 1126 (9th Cir. 2005). A preliminary injunction in this case will
24 not cause the Defendants to suffer any monetary damages. In the absence of such injury,
25 only a nominal bond is required. A bond will therefore be required in the amount of
26 \$100.

27 **IV. DEFENDANTS' MOTION TO DISMISS COUNTS I AND II**

28

1 Defendants moved to dismiss Plaintiffs' Count I, that the Arizona Act violates
2 § 1396a(a)(23), and Count II, that the Arizona Act violates the Supremacy Clause of the
3 United States Constitution. When analyzing a complaint for failure to state a claim to
4 relief under Rule 12(b)(6), the well-pled factual allegations "are taken as true and
5 construed in the light most favorable to the nonmoving party." *Cousins v. Lockyer*, 568
6 F.3d 1063, 1067 (9th Cir. 2009) (internal quotation marks and citation omitted). To
7 avoid a Rule 12(b)(6) dismissal, the complaint must plead "enough facts to state a claim
8 to relief that is plausible on its face." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570
9 (2007). This plausibility standard "is not akin to a 'probability requirement,' but it asks
10 for more than a sheer possibility that a defendant has acted unlawfully." *Ashcroft v. Iqbal*,
11 556 U.S. 662 (2009) (quoting *Twombly*, 550 U.S. at 556). Dismissal is also appropriate
12 where the complaint lacks a cognizable legal theory or lacks sufficient facts alleged under
13 a cognizable legal theory. *Balistreri v. Pacifica Police Dept.*, 901 F.2d 696, 699 (9th Cir.
14 1990).

15 A motion to dismiss for lack of subject-matter jurisdiction under Rule 12(b)(1) can
16 be based on the face of the Complaint or extrinsic evidence demonstrating lack of
17 jurisdiction on the facts of the case. *White v. Lee*, 227 F.3d 1214, 1242 (9th Cir. 2000).
18 In evaluating a facial attack on jurisdiction, the court must accept the factual allegations
19 set forth in the Complaint as true. See *Miranda v. Reno*, 238 F.3d 1156, 1157 n.1 (9th
20 Cir. 2001). The burden rests with the party asserting jurisdiction. *Kokkonen v. Guardian*
21 *Life Ins. Co. of Am.*, 511 U.S. 375, 377 (1994).

22 On Count I, Defendants argue there is no right of action to enforce the Medicaid
23 Act under § 1983. Because Plaintiffs do have a private right of action for the reasons
24 stated above, Part II.A.1, Defendants' Motion to Dismiss Count I will be denied.

25 On Count II, Defendants argue that Plaintiffs cannot state a preemption claim
26 because there is no state law that conflicts with the Medicaid Act. A state law that
27 violates the Medicaid Act does not conflict with federal law, according to Defendants,
28 because the state's participation in Medicaid is voluntary. Even if the Arizona Act does

1 not comport with § 1396a(a)(23), the only remedy would be for the Secretary to refuse to
2 fund the state's Medicaid plan. Defendants further argue that Plaintiffs have no private
3 right of action to challenge their disqualification from Medicaid through a federal
4 preemption claim. Defendants contend that Plaintiffs may not raise a direct Supremacy
5 Clause challenge under the Medicaid Act statute because the Medicaid Act was enacted
6 under the Spending Clause.

7 Defendants first argument is not persuasive; once again, though a state's
8 "participation in the Medicaid program is entirely optional, after a State elects to
9 participate, it must comply with the requirements of [the Medicaid Act]." *Harris v.*
10 *McRae*, 448 U.S. 297, 301 (1980). "There is of course no question that the Federal
11 Government, unless barred by some controlling constitutional prohibition, may impose
12 the terms and conditions upon which its money allotments to the States shall be
13 disbursed, and that any state law or regulation inconsistent with such federal terms and
14 conditions is to that extent invalid." *King v. Smith*, 392 U.S. 309, 333 n.34 (1968). More
15 recently, the Supreme Court in *PhRMA v. Walsh*, 538 U.S. 664 (2003), implicitly rejected
16 the contention that a plaintiff could not bring a preemption claim under federal Spending
17 Clause legislation. The Ninth Circuit adopted the implicit rejection in *PhRMA*, and held
18 that "[u]nder the well-established law of the Supreme Court, this court, and the other
19 circuits, a private party may bring suit under the Supremacy Clause to enjoin
20 implementation of state legislation allegedly preempted by [the Medicaid Act]." *Indep.*
21 *Living Ctr. of S. Cal., Inc. v. Shewry*, 543 F.3d 1050, 1065 (9th Cir. 2008). Under
22 *Shewry*, Plaintiffs have stated a claim under the Supremacy Clause.

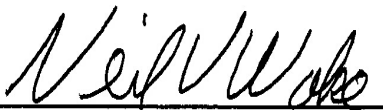
23 The Court notes – as have other district courts recently considering the availability
24 of a freestanding claim under the Supremacy Clause – that the Supreme Court granted
25 certiorari in its October 2011 term "to decide whether Medicaid providers and recipients
26 may maintain a cause of action under the Supremacy Clause to enforce a federal
27 Medicaid law – a federal law that, in their view, conflicts with (and pre-empts) state
28 Medicaid statutes that reduce payments to providers." *Douglas v. Indep. Living Ctr. of S.*

1 *Cal., Inc.*, __ U.S. __, 132 S.Ct. 1204, 1207 (2012). However, the Supreme Court
2 remanded that case to the Ninth Circuit in light of changed factual circumstances without
3 answering the underlying legal question. See *Planned Parenthood of Cent. N. C. v.*
4 *Cansler*, No. CV11-0531, 2012 WL 2513510 (M.D.N.C. June 28, 2012). Two other
5 district courts have conducted a similar Supremacy Clause analysis while awaiting the
6 Supreme Court's decision in *Douglas*. Both courts concluded that the present weight of
7 authority allows such a preemption claim under the Spending Clause. *Planned*
8 *Parenthood of Cent. N. C. v. Cansler*, 804 F. Supp. 2d 482, 488-89 (M.D.N.C. 2011);
9 *Planned Parenthood of Ind.*, 794 F. Supp. 2d at 911. The Court finds that reasoning
10 persuasive. Further, in the absence of contrary instruction from the Supreme Court, the
11 Ninth Circuit's holding in *Shewry* remains binding precedent. 543 F.3d at 1065-66.
12 Thus, Plaintiffs may bring a preemption claim under the Supremacy Clause, and the
13 claim is within the Court's federal question jurisdiction under 28 U.S.C. § 1331. Having
14 met their burden to establish jurisdiction, Plaintiffs have alleged sufficient facts to state a
15 claim for relief under the Supremacy Clause that is plausible on its face. For these
16 reasons, Defendants' Motion to Dismiss Count II will be denied.

17 IT IS THEREFORE ORDERED that Plaintiffs' Motion for Preliminary Injunction
18 (Doc. 6) is GRANTED, conditioned upon Plaintiffs posting a bond in the amount of \$100
19 pursuant to Fed. R. Civ. P. 65(c).

20 IT IS FURTHER ORDERED that Defendants' Motion to Dismiss Counts I and II
21 (Doc. 37) is DENIED.

22 Dated this 19th day of October, 2012.

23
24 
25 _____
26 Neil V. Wake
27 United States District Judge
28