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April 27, 2016

Michael E. Gans
Clerk of Court
U.S. Court of Appeals for the Eighth Circuit
111 South 10th Street
St. Louis, MO 63102

RE: *Planned Parenthood AR, etc., et al. v. John Selig* (No. 15-3271)

Dear Mr. Gans:

Pursuant to Federal Rule of Appellate Procedure 28(j), I write to alert the Court to new authority supporting affirmance. The Centers for Medicare and Medicaid Services ("CMS") last week sent the attached letter to state Medicaid directors making clear Appellant's termination of Planned Parenthood of the Heartland ("PPH")'s Medicaid contracts violates the Doe Plaintiffs' federal right to obtain medical services from any provider "qualified to perform the . . . services required . . . who undertakes to provide . . . such services." 42 U.S.C. § 1396a(a)(23).

The letter reiterates the position in the United States's amicus brief in a related action (*Planned Parenthood Gulf Coast, Inc., et al. v. Gee*, No. 15-30987), brought to this Court's attention in an earlier 28(j) citation, that the "free choice of provider" provision limits a state's authority to terminate a Medicaid provider unless the action is "related to the fitness of the provider to perform covered medical services—*i.e.*, its capability to perform the required services in a professionally competent, safe, legal, and ethical manner—or the ability of the provider to appropriately bill for those services." CMS Letter at 2; United States Amicus Brief at 4. The letter further explains that proper "reasons [for such actions] may *not* include a desire to target a provider or set of providers for reasons unrelated to their fitness to perform covered services or the adequacy of their billing practices. The failure of a state to apply otherwise reasonable standards in an evenhanded manner may suggest such targeting." CMS Letter at 2. Significantly, the letter provides that a "state's action against a provider affecting beneficiary access to the provider must be supported by evidence of fraud or criminal action, material non-compliance with relevant requirements, or material issues concerning the fitness of the provider to perform covered services or appropriately bill for them. Taking such action against a provider without such evidence would not be in compliance with the free choice of provider requirement." *Id.*

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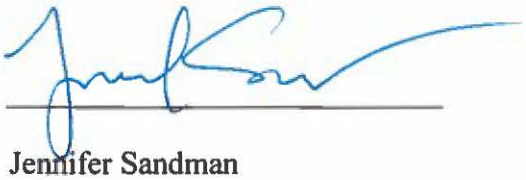
The CMS letter, therefore, supports Appellees' argument that termination of PPH's provider agreement violates federal law. *See* Appellees' Brief at 26-55.

Respectfully submitted,



Jennifer Sandman
Counsel for Plaintiffs-Appellees

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

SMD # 16-005

Re: Clarifying "Free Choice of Provider" Requirement in Conjunction with State Authority to Take Action against Medicaid Providers

April 19, 2016

Dear State Medicaid Director:

The Center for Medicaid and CHIP Services (CMCS) and Center for Program Integrity (CPI) are issuing this State Medicaid Director Letter to provide guidance to state Medicaid agencies on protecting the right of Medicaid beneficiaries to receive covered services from any qualified provider willing to furnish such services when the state exercises its authority to take action against providers that affects beneficiary access to those providers, including but not limited to the denial or termination of provider enrollment, or the exclusion of providers from program participation.

Background

Under section 1902(a)(23) of the Social Security Act, Medicaid beneficiaries generally have the right to obtain medical services "from any institution, agency, community pharmacy, or person, qualified to perform the service or services required . . . who undertakes to provide . . . such services." This provision is often referred to as the "any willing provider" or "free choice of provider" provision. Implementing regulations at 42 C.F.R. § 431.51(b)(1) require a state plan to allow a beneficiary to obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is (i) qualified to furnish services and (ii) willing to furnish them to that particular beneficiary. There is an exception for beneficiaries enrolled in certain managed care plans (to permit such plans to restrict beneficiaries to providers in the managed care plan network), except that such plans cannot restrict free choice of family planning providers. See section 1902(a)(23)(B); 42 C.F.R. § 431.51(b)(1); 42 C.F.R. Part 438.

State Authority to Establish Provider Qualifications

The "free choice of provider" provision does not infringe on states' traditional role of setting "reasonable standards relating to the qualifications of providers." 42 C.F.R. § 431.51(c)(2). States must propose any standards relating to the qualifications of providers during the

Medicaid state plan approval process, as specified in section 1902(a)(22) of the Act. Because the "free choice of provider" provision guarantees Medicaid beneficiaries the right to see any willing and "qualified" provider of their choice, this provision limits a state's authority to establish qualification standards, or take certain actions against a provider, unless those standards or actions are related to the fitness of the provider to perform covered medical services—*i.e.*, its capability to perform the required services in a professionally competent, safe, legal, and ethical manner—or the ability of the provider to appropriately bill for those services. Such reasons may *not* include a desire to target a provider or set of providers for reasons unrelated to their fitness to perform covered services or the adequacy of their billing practices. The failure of a state to apply otherwise reasonable standards in an evenhanded manner may suggest such targeting. For instance, if a state were to take certain actions against one provider or set of providers, but not other similarly situated providers, it would raise questions as to whether the state is impermissibly targeting disfavored providers.

Moreover, when invoking standards that are validly related to a provider's "qualifications," the "free choice of provider" provision ensures that a state may not deny Medicaid beneficiaries the right to see the provider of their choice unless there is a sufficient basis. A state's action against a provider affecting beneficiary access to the provider must be supported by evidence of fraud or criminal action, material non-compliance with relevant requirements, or material issues concerning the fitness of the provider to perform covered services or appropriately bill for them. Taking such action against a provider without such evidence would not be in compliance with the free choice of provider requirement. If a state does not have evidence supporting its finding that a provider failed to meet a state standard, that provider remains "qualified to furnish" Medicaid services. 42 C.F.R. § 431.51(b)(1)(i).

The "free choice of provider" provision is specific with respect to the free choice of family planning providers. Consistent with the reasonable standards guidance above, states may not deny qualification to family planning providers, or take other action against qualified family planning providers, that affects beneficiary access to those providers—whether individual providers, physician groups, outpatient clinics or hospitals—solely because they separately provide family planning services or the full range of legally permissible gynecological and obstetric care, including abortion services[1] (not funded by federal Medicaid dollars, consistent with the federal prohibition), as part of their scope of practice.

Conclusion

[1] Federal Medicaid funding of abortion services is not permitted under federal law except in certain extraordinary circumstances (in cases of rape, incest, or when the life of the woman would be in danger).

Pursuant to § 431.51(b)(1)(i), states may establish provider standards or take action against Medicaid providers that affects beneficiary access to those providers only (1) based on reasons relating to the fitness of the provider to perform covered medical services or to appropriately bill for those services, and (2) with supporting evidence of the provider's failure to meet the state's reasonable provider standards. This is consistent with longstanding CMS policy that Medicaid beneficiaries are provided with competent care by qualified providers and have the same ability to choose among available providers as those with private coverage.

Providing the full range of women's health services neither disqualifies a provider from participating in the Medicaid program, nor is the provision of such services inconsistent with the best interests of the beneficiary, and shall not be grounds for a state's action against a provider in the Medicaid program.

CMS is available to work closely with each state to ensure compliance with Medicaid's "free choice of provider" provision while at the same time preserving states' authority to take appropriate actions against providers in their Medicaid programs. If you have any questions regarding this information, please contact Kirsten Jensen, CMCS Director Division of Benefits and Coverage, 410-786-8146.

Sincerely,

/s/

Vikki Wachino
Director

cc:

National Association of Medicaid Directors

National Academy for State Health Policy

National Governors Association

American Public Human Services Association

Association of State Territorial Health Officials

Council of State Governments

National Conference of State Legislatures