No. 17-50282

United States Court of Appeals
for the
Fifth Circuit

PLANNED PARENTHOOD OF GREATER TEXAS FAMILY PLANNING AND PREVENTATIVE HEALTH SERVICES, INC., ET AL.,

Plaintiffs-Appellees,

– v. –

DR. COURTNEY PHILLIPS, in her official capacity as Executive Commissioner of HHSC, ET AL.,

Defendants-Appellants.

On Appeal from the United States District Court
for the Western District of Texas, Austin Division,
No. 1:15-cv-01058

BRIEF *AMICI CURIAE* OF 77 MEMBERS OF CONGRESS IN SUPPORT OF APPELLANTS ON REHEARING EN BANC

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page(s)

Cases

Constitutional Provision

Statutes

Regulations

Other Authorities

STATEMENT OF INTEREST OF *AMICI CURIAE*[1]

Amici are 77 Members of Congress. A complete list of *Amici* Members is found in the Appendix to this brief.

Amici Members have a special interest in the correct interpretation, application, and enforcement of an Act passed by Congress. The Medicaid Act was enacted so that States could partner with the federal government to assist people with limited income and resources by helping with medical costs through unique State programs.

Several circuit courts, including the Fifth Circuit panel in *Planned Parenthood of Gulf Coast, Inc. v. Gee* (*Gee I*), 862 F.3d 445 (5th Cir. 2017), have erroneously found a private right of action under § 1396a(a)(23)(A) ("§ 23(A)") of the Medicaid Act (42 U.S.C. § 1395 *et seq*.) for Medicaid beneficiaries to challenge the merits of a State's disqualification of a Medicaid provider. Implying a private right of action greatly undermines the purpose of the Medicaid Act by hamstringing the flexibility of individual State Medicaid programs envisioned by the Medicaid Act and

[1] No party's counsel authored any part of this brief. No person other than *Amici*'s counsel contributed money intended to fund the preparation or submission of this brief.

eliminating States' ability to determine the best way to allocate their limited public funds to those in need.

Amici Members have an interest in protecting the sovereign authority of the States they represent and contract with. Congress enacted the Medicaid Act pursuant to its power under the Spending Clause, which requires that any surrender of State sovereign authority must be done voluntarily and knowingly and by a clear statement of Congress. Members of Congress never clearly authorized individual Medicaid beneficiaries to drag their State into court to challenge the State's disqualification of their preferred provider. Nor did States voluntarily and knowingly agree to this requirement as a condition on the acceptance of federal Medicaid funds. If this error is not corrected, Texas (as well as Louisiana and Mississippi) will be subject to a legislative contract Congress never created and forced to give up sovereign authority Congress never intended to take away.

Amici Members have an interest in seeing courts restrained from speaking where Congress has not spoken. The *Gee* panel decision, which constrained the *Smith* panel, contravened the constitutional authority of Congress to dictate the contours of the Medicaid Act. Giving Medicaid

beneficiaries an implied private right of action undermines the State administrative appeal process for disqualified providers required by Congress in the Medicaid Act. Unless *Gee* is overruled, Texas (as well as Louisiana and Mississippi) are vulnerable to federal court challenges by any Medicaid beneficiary to each of the hundreds of Medicaid disqualification decisions made by the States every year, and each disqualification challenge subjects States to expensive attorneys' fees.

Amici Members thus urge the *en banc* Fifth Circuit to overrule the *Gee* panel opinion's recognition of an implied private right of action under § 23(A) because it contravenes the will of Congress as expressed in the Medicaid Act and infringes upon the sovereign authority of States.

ARGUMENT

I. Congress enacted the Medicaid Act pursuant to its power under the Spending Clause, which requires that any surrender of State sovereign power must be done voluntarily and knowingly.

A. Except where Congress has spoken, all powers not otherwise directed by the Constitution are reserved to the States.

The United States Constitution created a system of "dual sovereignty" between the States and the federal government. *Murphy v. Nat'l Collegiate Athletic Ass'n*, 138 S. Ct. 1461, 1468 (2018). Notably,

"[t]he Constitution limited but did not abolish the sovereign powers of the States, which retained 'a residuary and inviolable sovereignty.'" *Id.* at 1475 (quoting The Federalist No. 39, p. 245 (C. Rossiter ed. 1961)). The balance of powers between the two sovereigns is embodied in the Tenth Amendment, which guarantees States all powers not prohibited to the States or delegated to Congress or the federal government in the Constitution. U.S. Const. amend. X.

While Congress' legislative powers are sizable, they are not unlimited. *Murphy*, 138 S. Ct. at 1476. The Constitution does not confer on Congress plenary legislative power but only certain enumerated powers. *Id.* "[A]ll other legislative power is reserved for the States, as the Tenth Amendment confirms." *Id*. Thus, the authority to regulate in areas occupied jointly by Congress and State governments—including the police power to regulate the health and welfare of citizens—is reserved to the States. The sovereign authority of the States is not diminished just because a State acts in partnership with the federal government, such as under the Medicaid Act. *See Planned Parenthood of Greater Tex. Family Planning & Preventative Health Servs. v. Smith*, No. 17-50282, slip op. at 11 (5th Cir. Jan. 17, 2019) ("The Medicaid program exemplifies

cooperative federalism—a partnership between federal and state agencies to provide medical services to needy individuals.").

States, however, can surrender their sovereign authority to the federal government through Congress via Spending Clause legislation. But any purported surrender of a State's sovereign power must be interpreted strictly in favor of the State. *See, e.g.*, *Sossamon v. Texas*, 563 U.S. 277, 285 (2011) (explaining that 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 surrendering its authority); Kurt T. Lash, *Leaving the Chisholm Trail: The Eleventh Amendment and the Background Principle of Strict Construction*, 50 Wm. & 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."). Thus, the Medicaid Act, including the provision at issue here, must be construed strictly against the assertion of surrender of State power.

B. Except by a clear statement of Congress, States retain their sovereign power in all Spending Clause legislation.

"[I]f 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.'" *Will v. Mich. Dep't of State Police*, 491 U.S. 58, 65 (1989) (describing this principle as an "ordinary rule of statutory construction"). In the context of Spending Clause legislation specifically, if "Congress intends to impose a condition on the grant of federal moneys, 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 State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981) (describing what is known as the "*Pennhurst* clear statement rule").

Because Congress contracts with States at arm's length as co-equal sovereigns, States accepting funds from Congress via Spending Clause legislation 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.'" *Id.*; *see also Nat'l Fed'n of Indep.*

Bus. v. Sebelius, 567 U.S. 519, 577 (2012) ("The legitimacy of Congress's exercise of the spending power thus rests on whether the State voluntarily and knowingly accepts the terms of the contract." (internal quotation marks omitted)). "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." *Nat'l Fed'n of Indep. Bus.*, 567 U.S. at 577.

Thus, the legitimacy of the Medicaid Act under the Spending Clause depends upon the extent to which States voluntarily and knowingly accept Congress's terms when they choose to participate. Otherwise, enforcement of the legislative "contract" would upset the balance established by Congress and "undermine the status of the States as independent sovereigns in our federal system." *Id.*

II. Congress gave States broad authority under the Medicaid Act to determine who is qualified to participate in and who they can exclude from their State Medicaid programs.

A. Congress gave States broad authority and flexibility to create and run their own State Medicaid programs.

In the Medicaid Act Congress established a careful balance between the States and federal agencies, giving States "flexibility in designing plans that meet their 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). This flexibility and wide latitude is a reflection of two facts.

First, it reflects the fact that establishing qualifications for medical providers is a traditional State function and that Congress recognized that, under the Medicaid Act, States would be acting within their core or natural sphere of operation. *See, e.g.*, *Pa. Med. Soc'y v. Marconis*, 942 F.2d 842, 847 (3d Cir. 1991) ("The licensing and regulation of physicians is a state function. . . ."). As the Supreme Court explained, "[where] Congressional 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." *Gregory v. Ashcroft*, 501 U.S. 452, 460 (1991) (internal quotation marks omitted).

Second, it reflects the fact that, in addition to administering the federal share of funds, Congress requires States to expend a substantial outlay of their own funds to participate in the Medicaid program. *See, e.g.*, *Kelly Kare, Ltd. v. O'Rourke*, 930 F.2d 170, 172 (2d Cir. 1991) (In addition to the federal government, Medicaid funding "comes from the

individual states and, to a lesser degree, from municipalities and counties."). For instance, States must fund ten percent of Medicaid expenses for family planning services. 42 U.S.C. § 1396b(a)(5).

As part of a State's broad authority and flexibility to create its own Medicaid program, Congress intended the State to retain broad authority to establish provider qualifications that reflect State law and policy.[2]

B. Congress granted States authority co-extensive to the Secretary's authority to exclude providers in their State Medicaid programs.

Under the Medicaid Act, Congress gave States the power to exclude providers by: (a) refusing to enter into a participation agreement; (b) refusing to renew a participation agreement; or (c) terminating a participation agreement. 42 U.S.C. § 1396a(p)(3). Congress allows States to exclude Medicaid providers on their own initiative, irrespective of any action taken by the Office of Inspector General at the U.S. Department of

[2] The Department of Health and Human Services recently emphasized the broad authority Congress gave States to establish reasonable Medicaid provider qualification standards. *See* U.S. Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Letter SMD #18-003 to State Medicaid Director on Rescinding SMD #16-005 Clarifying "Free Choice of Provider" Requirement (Jan. 19, 2018), https://www.medicaid.gov/federal-policy-guidance/downloads/smd18003.pdf (re-scinding a 2016 letter, in part, because it purported to limit States' flexibility in making Medicaid provider qualification determinations).

Health & Human Services (HHS), 42 C.F.R. § 1002.1(b), and gave States discretion to determine the period of time for exclusion, *id.* § 1002.210.

Congress explicitly granted States the power to exclude any provider from participating in the State's program "for any reason for which the Secretary could exclude the [provider] from participation." 42 U.S.C. § 1396a(p)(1). There are three sections in the Medicaid Act that provide reasons why the Secretary, and likewise a State, may—and in some cases, must—exclude a provider from participation in a State Medicaid program. Many of these reasons have nothing to do with a Medicaid provider's ability or willingness to perform medical services.

Under the first section, a State may exclude providers in the case of:

- Conviction of program-related crimes;
- Conviction relating to patient abuse;
- Felony conviction relating to health care fraud;
- Felony conviction relating to controlled substance;
- Conviction relating to fraud;
- Conviction relating to obstruction of an investigation or audit;
- Misdemeanor conviction relating to controlled substance;

- License revocation or suspension;
- Exclusion or suspension under federal or State health care program, including for reasons bearing on a provider's professional competence, professional performance, or financial integrity;
- Claims for excessive charges or unnecessary services and failure of certain organizations to furnish medically necessary services;
- Fraud, kickbacks, and other prohibited activities;
- Entities controlled by a sanctioned individual;
- Failure to disclose required information;
- Failure to supply requested information on subcontractors and supplies;
- Failure to supply payment information;
- Failure to grant immediate access;
- Failure to take corrective action;
- Default on health education loan or scholarship obligations;
- Individuals controlling a sanctioned entity; or
- Making false statements or misrepresentation of material facts.

Id. § 1320a-7.

Under the second section, a State may exclude any provider for (a) improperly filed claims or (b) payments to induce reduction or limitation of services. *Id.* § 1320a-7a.

And under the third section, a State may exclude a provider that:

- Fails to comply substantially with the provisions of the agreement, the provisions of the Medicaid Act and regulations thereunder, or a required corrective action;
- Fails to substantially meet the applicable definition provisions;
- Has been excluded from participation in a program under the above two sections (42 U.S.C. §§ 1320a-7, 1320a-7a); or
- Has been convicted of a felony under federal or State law for an offense determined to be detrimental to the best interests of the program or program beneficiaries.

Id. § 1395cc(b)(2).

In addition to the reasons given in the three sections above, the corresponding federal regulations also provide numerous grounds on which a State can, for the same reasons as the Secretary, exclude a provider from its State Medicaid program.[3]

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[3] *See* 42 C.F.R. § 1001.101 (mandatory exclusion for convictions of certain criminal and felony offenses); *id.* § 1001.201 (permissible exclusion for conviction relating to program or health care fraud); *id.* § 1001.301 (permissible exclusion for conviction relating to obstruction of an investigation or audit); *id.* § 1001.401 (permissible exclusion for conviction relating to controlled substances); *id.* § 1001.501 (permissible exclusion for license revocation or suspension); *id.* § 1001.601 (permissible exclusion for exclusion or suspension under a Federal or State health care program); *id.* § 1001.701 (permissible exclusion for excessive claims or furnishing of unnecessary or substandard items and services); *id.* § 1001.801 (permissible exclusion for failure of HMOs and CMPs to furnish medically necessary items and services); *id.* § 1001.901 (permissible exclusion for false or improper claims); *id.* § 1001.951 (permissible exclusion for fraud, kickbacks, and other prohibited activities); *id.* § 1001.1001 (permissible exclusion of entities owned or controlled by a sanctioned person); *id.*

C. Congress explicitly acknowledged in the Medicaid Act that States retain their sovereign power to exclude providers for any reason authorized by State law.

Under the Medicaid Act, Congress allows States to retain their sovereign power of exclusion. Not only does Congress fail to prohibit States from excluding providers from State health care programs for reasons other than those mentioned above, the Medicaid Act and governing regulations specifically acknowledge that States have and retain such authority.[4]

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§ 1001.1101 (permissible exclusion for failure to disclose certain information); *id.* § 1001.1201 (permissible exclusion for failure to provide payment information); *id.* § 1001.1301 (permissible exclusion for failure to grant immediate access); *id.* § 1001.1401 (permissible exclusion for violations of Prospective Payment System corrective action); *id.* § 1001.1501 (permissible exclusion for default on health education loan or scholarship obligations); *id.* § 1001.1551 (permissible exclusion of individuals with ownership or control interest in sanctioned entities); *id.* § 1001.1552 (permissible exclusion for making false statements or misrepresentations of material facts); *id.* § 1001.1601 (permissible exclusion of physicians for violation of the limitations on physician charges); *id.* § 1001.1701 (permissible exclusion of physicians for billing for services of assistant at surgery during cataract operations); *id.* § 1003.200 (permissible exclusions for false or fraudulent claims and other similar misconduct); *id.* § 1003.300 (permissible exclusion for anti-kickback and physician self-referral violations); *id.* § 1003.500 (permissible exclusion for EMTALA violations); *id.* § 1003.1000 (permissible exclusion for beneficiary inducement violations).

[4] Texas has exercised this authority by providing numerous state grounds for subjecting a provider to administrative actions or sanctions, including exclusion. *See, e.g.*, 1 Tex. Admin. Code § 371.1651 (provider eligibility); *id.* § 371.1653 (claims and billing); *id.* § 371.1655 (program compliance); *id.* § 371.1657 (unallowable fiscal gain); *id.* § 371.1659 (compliance with health care standards); *id.* § 371.1661 (convictions and prohibited acts); *id.* § 371.1663 (managed care); *id.* § 371.1665 (cost reporting violations); *id.* § 371.1667 (records and documentation); *id.* § 371.1669 (self-dealing).

For instance, § 1396a(p)(1) of the Medicaid Act acknowledges that the extensive statutory grounds for exclusion set forth above are merely "[i]n addition to any other authority" States have. 42 U.S.C. § 1396a(p)(1). Likewise, while giving States authority to exclude a provider for any number of stated reasons, Part 1002.3 of the governing regulations acknowledges that this authority is "[i]n addition to any other authority [the State] may have." 42 C.F.R. § 1002.3(a). Individually, and even more so when read together, these provisions clearly contemplate that States have the authority to suspend or exclude providers from State Medicaid programs for reasons other than those upon which the Secretary has authority to act. Any other reading would render these provisions redundant.

When § 1396a(p)(1) was added to the Medicaid Act in 1987, Congress purposely did not make that provision subject to the already-existing "choice of provider" provision (§ 23(A)). The legislative history behind this provision makes explicitly clear that States retain the power to exclude providers for *any bases* under State law: "This provision is not intended to preclude a State from establishing, under State law, any other bases for excluding individuals or entities from its Medicaid

program." S. Rep. No. 100-109, at 20 (1987), *as reprinted in* 1987 U.S.C.C.A.N. 682, 700. As the First Circuit explained, the language of Medicaid's exclusion provision—that a State may exclude providers by "any other authority"—"was intended to permit a state to exclude an entity from its Medicaid program for *any* reason established by state law." *First Med. Health Plan, Inc. v. Vega-Ramos*, 479 F.3d 46, 53 (1st Cir. 2007).

In addition, Part 1002.3 of the governing regulations states explicitly that the Medicaid Act is not to be read narrowly to limit States' power of exclusion: "*Nothing* contained in [these 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*." 42 C.F.R. § 1002.3(b) (emphases added).

Section 1396a(p)(1) and Part 1002.3 are dual statements that the States' power to exclude is co-extensive with the Secretary's authority over mandatory and discretionary exclusion under certain enumerated grounds. These provisions are an explicit acknowledgement and reservation of already existing inherent State authority to exclude providers for reasons germane to State law and policy.

As discussed above (*supra* Sections I.B and II.A), States' ability to set reasonable provider qualifications inheres in their sovereignty, not in any authorization to do so by a federal statute. Thus, States retain this sovereign authority absent a clear statement by Congress. Moreover, Congress' express acknowledgment of States' retained inherent authority applies without any distinction between initial qualifications and disqualifications or exclusions. *See* 42 U.S.C. § 1396a(p)(3) ("[T]he term 'exclude' includes the refusal to enter into or renew a participation agreement or the termination of such an agreement."). Thus, States exercise their own sovereign authority—authority Congress did not require to be relinquished in exchange to receive federal funds under Medicaid—by enacting State laws which govern the contours, including provider qualifications, of their own Medicaid programs.

III. Congress did not clearly or unambiguously confer a private right of action on Medicaid beneficiaries under § 23(A) of the Medicaid Act.

A. Congress must clearly establish a federal right that is not vague or amorphous for a successful § 1983 claim.

This case was brought under § 1983, which provides a cause of action for the deprivation of any rights secured by federal law. 42 U.S.C. § 1983. As the Supreme Court stated in *Gonzaga*, the specific remedy

under § 1983 is for a violation of federal *rights*, and not merely a violation of federal law or "the broader or vaguer 'benefits' or 'interests.'" *Gonzaga Univ. v. Doe*, 536 U.S. 273, 283 (2002). Thus, to support a § 1983 action, a plaintiff must establish that Congress clearly intended to create an enforceable federal right under federal law. *See id*. Later in *Armstrong*, the Court explained that *Gonzaga* expressly rejects the notion that the Court "permit[s] anything short of an unambiguously conferred right to support a cause of action brought under § 1983," noting that the "ready implication of a § 1983 action" exemplified in *Wilder v. Virginia Hospital Association*, 496 U.S. 498 (1990), has been "plainly repudiate[d]" by the Court's later opinions. *Armstrong v. Exceptional Child Ctr.*, 135 S. Ct. 1379, 1386 n.* (2015).

To determine whether a statutory provision gives rise to a federal right, and thus a private right of action under § 1983, three factors must be met: (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) (internal quotation marks omitted). The second *Blessing* factor—the main factor at issue in this case—requires plaintiffs to bear the burden of demonstrating that the right they claim is not so "vague and amorphous" that it would "strain judicial competence" to enforce it. *Id*. at 340.

The basis for the alleged right of action for the § 1983 claim in this case is found in § 23(A) in the Medicaid Act, which states:

> A State plan for medical assistance must . . . provide that [ ] any individual eligible for medical assistance . . . may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required . . . who undertakes to provide him such services.

42 U.S.C. § 1396a(a)(23)(A). This provision does not meet the *Blessing* factors because Congress did not intend to create a private right since Congress framed the Medicaid Act as a directive to a federal agency and provided explicit rights and remedies within the Act that are incompatible with an implied private right of action; and, at best, the provision is vague and amorphous, which requires a reading in favor of State sovereignty.

B. Congress did not clearly establish a private right of action under § 23(A).

1. Congress framed § 23(A) as a directive to a federal agency, focusing on the conditions State plans must meet to receive federal funds.

Under the first *Blessing* fact, Congress must have "intended that the provision in question benefit the plaintiff." *Blessing*, 520 U.S. at 340. "Statutes that focus on the person regulated rather than the individuals protected create no implication of an intent to confer rights on a particular class of persons." *Alexander v. Sandoval*, 532 U.S. 275, 289 (2001) (internal quotation marks omitted). Looking to the Act as a whole, the focus of § 23(A) is on the States—the agency being regulated. *See Does v. Gillespie*, 867 F.3d 1034, 1041 (8th Cir. 2017) (explaining that § 23(A) focuses on the agency doing the regulating, not the individuals protected or the funding recipients being regulated). In context, the provision at issue appears in a section that directs the Secretary of HHS to approve any State plan for medical assistance that fulfills eighty-three conditions. *See* 42 U.S.C. § 1396a(b) ("The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) . . . ."). One of those eighty-three conditions is § 23(A). *See id.* § 1396a(a).

As the Supreme Court explained in *Gonzaga*, when a statute speaks to the government official regulating the recipient of federal funding, the focus is "two steps removed" from individual recipients and "clearly does not confer the sort of '*individual* entitlement' that is enforceable under § 1983." *Gonzaga*, 536 U.S. at 287 (quoting *Blessing*, 520 U.S. at 343). Similar to the provision at issue in *Armstrong*, the language of § 23(A) is not focused on the rights of Medicaid beneficiaries. It is "phrased as a directive to the federal agency charged with approving state Medicaid plans, not as a conferral of the right to sue upon the beneficiaries of the State's decision to participate in Medicaid." *Armstrong*, 135 S. Ct. at 1387 (plurality opinion). Compare the provision at issue in *Gonzaga*, 20 U.S.C. § 1232g(b)(1) ("No funds shall be made available . . . to any educational agency or institution which has a policy or practice of . . . ."), and the provision at issue here, 42 U.S.C. § 1396a(a)(23) ("A State plan for medical assistance must . . . provide . . . ."), with Title VI, 42 U.S.C. § 2000d ("No *person* in the United States shall . . . be subjected to discrimination . . . .") (emphasis added), and Title IX, 20 U.S.C. § 1681(a) ("No *person* in the United States shall . . . be subjected to discrimination . . . .") (emphasis added). Since § 23(A) is not "phrased in terms of the

persons benefited," it fails to meet the necessary prerequisite to find a private right of action for a § 1983 claim. *Gonzaga*, 536 U.S. at 284.

2. Congress provided explicit rights of action and remedies in the Medicaid Act for excluded providers that are incompatible with finding a private right of action.

In the Medicaid Act, Congress established a comprehensive Medicaid enforcement scheme. The scheme protects against the improper exclusion of Medicaid providers through several procedural safeguards, explicit rights of action, and available remedies.[5] These procedures are described in more detail below.

Administrative procedures. When a State exercises its power of exclusion for any reason that the Secretary could exclude a Medicaid provider under the regulations, "[t]he State agency *must* have administrative procedures in place." 42 C.F.R. § 1002.210 (emphasis added). These procedures include notice, administrative appeal, judicial review, and a method for reinstatement.

Notice. When a State agency initiates a Medicaid provider exclusion, it must notify the provider subject to the exclusion, as well as

[5] While mandating certain procedures, Congress still gives States much leeway within the Medicaid Act to create their own unique procedures and processes, and power over reinstatement decisions.

other State agencies, the State medical licensing board (when applicable), the public, and beneficiaries, among others. *Id.* § 1002.212. Texas requires that providers receive notice of the action or potential action being taken against them, which generally includes the basis, effect, and duration of the action, as well as the provider's due process rights, such as "the right to submit additional evidence or information for consideration." 1 Tex. Admin. Code §§ 371.1609, 371.1703(e). In addition, the State agency must notify the Inspector General of any intended exclusion of a provider to participate in its program. 42 C.F.R. § 1002.4(b).

Appeal. Before the State agency can exclude a Medicaid provider, the provider *must* be given the opportunity to submit documents and written argument against the exclusion, in addition to any other appeal rights that would otherwise be available under other procedures established by State law. 42 C.F.R. § 1002.213. For instance, Texas gives providers an opportunity to request in writing an informal resolution meeting within 30 days of receiving the notice of exclusion and allows providers an opportunity to submit documentary evidence or written argument. 1 Tex. Admin. Code § 371.1613(a)–(b), (d); *id.* § 371.1703(f)(1).

This written request may also be combined with a request for an administrative hearing. *Id.* § 371.1613(e). Once a provider receives a final notice of a sanction, the provider may appeal by requesting in writing an administrative hearing within 15 days of receiving the final notice or an expedited administrative hearing within 10 days of receiving the final notice. *Id.* §§ 371.1615, 371.1703(f)(2). The exclusion will become final: 30 days after service of the final notice, if no appeal request is received; as a result of a settlement agreement; or on a final order after the administrative hearing. *Id.* § 371.1617(a).

Possibility of reinstatement. Congress gave States power to determine whether they will allow an excluded provider to apply for reinstatement. *See* 42 C.F.R. § 1002.214. Reinstatement will only be granted after a determination of a number of factors, including "any factors set forth in State law"—again, demonstrating that under the Medicaid Act Congress intended States to retain their power to determine provider qualifications. *Id.* § 1002.215(a). Specifically, Texas allows providers to request reinstatement for good cause. 1 Tex. Admin. Code §§ 371.1717, 371.1703(h). Any denial of reinstatement may be appealed according to State procedures, but it does not need to be subject to State

administrative or judicial review, unless required by State law. 42 C.F.R. § 1002.215(b).

Withholding of funds. Congress expressly provided a mechanism for enforcing a State's compliance with the various provisions of the Medicaid Act. If a State plan violates the Act or the administration of the plan fails to comply substantially with any provision—including an improper exclusion of a Medicaid provider—the Secretary shall withhold payments from the State until the failure to comply is rectified. 42 U.S.C. § 1396c. As the Supreme Court explained in *Armstrong*, the withholding of Medicaid funds by the Secretary of HHS is "the sole remedy Congress provided for a State's failure to comply with Medicaid's requirements." *Armstrong*, 135 S. Ct. at 1385. The Act's explicit provision for relief, along with the "judicially unadministrable nature" of the text, were the two reasons why the Court found that the Medicaid Act implicitly precluded private enforcement under the provision at issue in *Armstrong*. *See id.*

When faced with the same issue, the Eighth Circuit correctly recognized that, under the Medicaid Act, the mandatory opportunity for administrative appeal and judicial review in state courts is "inconsistent" with the finding that Congress intended to convey a private right of

action. *See Gillespie*, 867 F.3d at 1041–42. "The potential for parallel litigation and inconsistent results gives us further reason to doubt that Congress in § 23(A) unambiguously created an enforceable federal right for patients." *Id.* at 1042. If Medicaid beneficiaries have an implied private right of action, excluded Medicaid providers will be able—as they already have—to bypass the statutorily required administrative review process, opting instead to litigate in federal court by proxy. *See Gee v. Planned Parenthood of Gulf Coast, Inc.* (*Gee III*), 139 S. Ct. 408, 409 (2018) (Thomas, J., dissenting from the denial of certiorari) ("[T]he suits give Medicaid providers 'an end run around the administrative exhaustion requirements in [the] state's statutory scheme.'" (second alteration in original) (quoting *Planned Parenthood of Gulf Coast, Inc. v. Gee* (*Gee II*), 876 F.3d 699, 702 (5th Cir. 2017) (Elrod, J., dissenting from the denial of rehearing *en banc*))). This means that States face a constant "threat of a federal lawsuit—and its attendant costs and fees—whenever it changes providers of medical products or services for its Medicaid recipients," which will, in result, "dissuade state officials from making decisions that they believe to be in the public interest." *Gee III*, 139 S. Ct. at 409 (Thomas, J., dissenting).

In sum, since the Medicaid Act is framed as a directive to a federal agency, focuses on the conditions State plans must meet, and provides explicit rights of action and remedies, § 23(A) does not clearly and unambiguously confer a private right of action such that States can be considered to have voluntarily and knowingly relinquished their sovereign power of exclusion as required by Spending Clause legislation.

C. At best, § 23(A) is vague and amorphous, requiring a reading in favor of State sovereignty.

Under the second *Blessing* factor, § 23(A) must not be so "vague and amorphous that its enforcement would strain judicial competence." *Blessing*, 520 U.S. at 340–41 (internal quotation marks omitted). In § 23(A), Congress requires State Medicaid plans to provide that Medicaid beneficiaries may obtain required services from any qualified provider. Notably, this "choice of providers" provision merely guarantees choice among "*qualified* providers." Thus, this issue turns, in part, on the definition of "qualified."

As the Supreme Court explained in *O'Bannon*, freedom of choice entails "the right to choose among a range of *qualified* providers," who "*continue[] to be qualified*" because a patient "has no enforceable expectation of continued benefits to pay for care in an institution that has

been determined to be unqualified." *O'Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773, 785, 786 (1980) (second emphasis added). The *O'Bannon* Court reversed the lower court for essentially the same reasons given by the dissenting judge below, who stated, "Clearly, what the majority characterizes as a recipient's right to obtain medical care from a 'freely selected provider' is limited to a choice among institutions which have been determined . . . to be 'qualified.'" *Id.* at 781–83 & n.13. "*Gee* is inconsistent with the Supreme Court's decision in *O'Bannon* and in tension with numerous other provisions of the Medicaid statute." *Smith*, slip op. at 33 (Jones, J., concurring); *see also Gee II*, 876 F.3d at 700–01 (Elrod, J., dissenting) (*Gee* "is directly at odds with the Supreme Court's holding in *O'Bannon*" and at odds with "the entirety of the statutory framework in 42 U.S.C. Section 1396a.").

Under the Medicaid Act, whether a provider is qualified is determined in the first instance by the State and then by the Secretary. In addition, under the statutory scheme created by Congress, States retain the authority to determine qualifications for providers *outside* of their ability to perform the required medical service.

The Fifth Circuit *Gee* panel adopted the Seventh and Ninth Circuits' pre-*Armstrong* definition of a "qualified" provider: "[An] individual Medicaid recipient is free to choose any provider so long as two criteria are met: (1) the provider is 'qualified to perform the service or services required,' and (2) the provider 'undertakes to provide [the recipient] such services.'" *Gee I*, 862 F.3d at 458 (second alteration in original) (quoting *Planned Parenthood of Ariz., Inc. v. Betlach*, 727 F.3d 960, 967 (9th Cir. 2013)). Thus, according to the *Gee* panel, a provider who is excluded by the State but is still able and willing to perform required medical services would remain qualified within the meaning of § 23(A). *But see Gee II*, 876 F.3d at 701 (Elrod, J., dissenting) ("Nowhere does the statute require that the disqualification of a Medicaid provider can occur only if the provider is deemed unfit to provide care for the general public, as the panel majority opinion holds."). The *Smith* panel was "constrained" to follow the controlling *Gee* panel opinion holding "that the plaintiffs possess a private right of action." *Smith*, slip op. at 2, 13, 16. The *en banc* Fifth Circuit is not so constrained.

In contrast, the Medicaid Act as a whole contemplates that the States, along with the Secretary, may determine whether a provider is

"qualified" to participate in State Medicaid programs. First, looking to the plain reading of the text, the "choice of provider" provision does not explicitly preclude States from imposing qualification standards based on scope of practice. Second, Congress gave the Secretary power to waive the requirements in § 1396a, including § 23(A), demonstrating that Congress did not intend State Medicaid programs to necessarily include all providers who are able and willing to provide services. 42 U.S.C. § 1396n(b). Third, § 1396a(p)(1) acknowledges that States have plenary (though not arbitrary or unreasonable) authority to make qualification determinations. Fourth, Congress gave an extensive list of reasons why the Secretary and States are statutorily authorized to exclude individuals and entities from the Medicaid program, many of which are unrelated to a provider's ability to perform a medical service. *See, e.g.*, 42 U.S.C. § 1320a-7(b)(2) (conviction relating to obstruction of an investigation or audit); *id.* § 1320a-7(b)(9) (failure to disclose required information); *id.* § 1320a-7(b)(12) (failure to grant immediate access); *id.*

§ 1320a-7(b)(14) (default on health education loan or scholarship obligations).[6]

To further expose the incongruity of finding an implied private right of action under § 23(A), providers—including Plaintiffs in this case—can deliberately forfeit their right to state administrative and judicial review to avoid a mootness challenge in federal court. *See Smith*, slip op. at 6 ("Instead of responding to the Notice and pursuing administrative and state judicial avenues of relief, the Provider Plaintiffs sued in federal court to block the termination."); *see also Gee I*, 862 F.3d at 455 (Provider Plaintiff affirmatively chose not to "avail itself of administrative appeal" and instead filed suit in federal court.). In her *Smith* concurrence, Judge Jones explained that "it makes no practical sense to hold that a Medicare provider charged with misfeasance by state regulating authorities may simply bypass state procedures, which are required by the Medicaid state, and use patients as stalking horses for federal court review of its status." *Smith*, slip op. at 30 (Jones, J.,

[6] This authority has been, and likely will continue to be, exercised broadly for many reasons that advance State law and policy. *See, e.g.*, *Guzman v. Shewry*, 552 F.3d 941, 950 (9th Cir. 2009) (fraud); *First Med. Health Plan*, 479 F.3d at 49 (conflicts of interest); *Plaza Health Labs., Inc. v. Perales*, 878 F.2d 577, 578–79 (2d Cir. 1989) (engaging in industrial pollution); *Triant v. Perales*, 491 N.Y.S.2d 486, 488 (N.Y. App. Div. 1985) (inadequate recordkeeping).

concurring). And as Judge Elrod pointed out in her dissent from this Court's denial of rehearing *en banc* in *Gee*, "to the extent § 1396a(a)(23) can be interpreted to secure any private right of action, such a right is surely limited to 'qualified' providers and does not include providers who voluntarily choose not to contest their disqualification." *Gee II*, 876 F.3d at 701 (Elrod, J., dissenting).

While "qualified" could *conceivably* mean (as the *Gee* panel found) the ability and willingness to perform the required medical services, the better reading, looking to the Act as a whole, is that "qualified" means a Medicaid provider approved by the State and the Secretary. At best, the definition of "qualified" is unclear and ambiguous, which makes it "so 'vague and amorphous' that its enforcement would strain judicial competence." *Blessing*, 520 U.S. at 340–41. And an unclear conveyance of an enforceable right requires a reading in favor of State sovereignty and against finding an implied private right of action.

CONCLUSION

This Court should overrule the *Gee* panel opinion and find that § 23(A) of the Medicaid Act does not create a private right of action for

Medicaid beneficiaries to challenge the termination of their providers' contracts by the State.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that on March 14, 2019, I electronically filed the foregoing brief with the Clerk of the Court through the CM/ECF system, which shall send notification of such filing to any CM/ECF participants.

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