No. 17-50282

In the United States Court of Appeals
for the Fifth Circuit

Planned Parenthood of Greater Texas Family Planning and Preventative Health Services, Inc.; Planned Parenthood San Antonio; Planned Parenthood Cameron County; Planned Parenthood South Texas Surgical Center; Planned Parenthood Gulf Coast, Inc.; Jane Doe #1; Jane Doe #2; Jane Doe #4; Jane Doe #7; Jane Doe #9; Jane Doe #10; and Jane Doe #11,
Plaintiffs-Appellees

vs.

Charles Smith, in his official capacity as Executive Commissioner of HHSC; and Sylvia Kauffman, in her official capacity as Acting Inspector General of HHSC,
Defendants-Appellants

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

Amicus Curiae Brief of the States of Arkansas, Indiana, Kansas, the Commonwealth of Kentucky by and through Governor Matthew G. Bevin, Louisiana, Michigan, Missouri, Nebraska, Ohio, Oklahoma, South Carolina, Utah, West Virginia, Wisconsin, and Governor Phil Bryant of the State of Mississippi in Support of Defendants-Appellants and for Reversal

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Identity and Interests of the *Amici*

The 15 undersigned *Amici* States[1] have a strong interest in vindicating their authority—explicitly guaranteed by Congress—to (1) adopt and enforce qualification standards for medical providers in the Medicaid program and (2) remove from the Medicaid program medical providers who fail to adhere to these standards. If the district court's decision below stands, that guarantee of authority will become an empty promise. The district court has fundamentally misinterpreted the Medicaid Act, and sanctioned an end-run around the carefully balanced regime of cooperative federalism enacted by Congress. *Amici* States—both within and outside of the Fifth Circuit—believe remedying this significant legal error is important to the overall development of the law governing States' Medicaid decisions.

Argument

While this case involves a controversial organization, that ought not obscure the important, generally applicable legal issues in this case: whether 42 U.S.C. §1396a(a)(23) authorizes any private right of action at all and the proper scope of

[1] Arkansas, Indiana, Kansas, Kentucky by and through Governor Matthew G. Bevin, Louisiana, Michigan, Missouri, Nebraska, Ohio, Oklahoma, South Carolina, Utah, West Virginia, Wisconsin, and Governor Phil Bryant of the State of Mississippi. *Amici* States, through their Attorneys General, are authorized to file this amicus brief, and do so under Fed. R. App. P. 29 (a)(2).

any such right of action. The answers to these questions have monumental consequences for states and for enforcement of the rules of the Medicaid program—consequences that are completely divorced from funding or not funding Planned Parenthood.[2]

Even assuming *arguendo* that 42 U.S.C. §1396a(a)(23) could support some type of private right of action under 42 U.S.C. §1983,[3] it does not support the unwieldly type of §1983 claim asserted in this case. That is because the language of §1396a(a)(23) does not clearly and unambiguously manifest an intent to allow a patient[4] to collaterally challenge a state's decision to exclude a provider for transgressing accepted medical and ethical standards recognized by preexisting federal and state laws. It would be difficult enough to conclude that §1396a(a)(23) meets this high clarity burden if writing on a completely clean slate. But in light of the United States Supreme Court's decision in *O'Bannon v. Town Court Nursing Center*, 447 U.S. 773 (1980), such a conclusion should have been impossible.

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[2] *Amici* States agree with Appellants that, on the merits, they had extraordinarily strong justifications for disqualifying the relevant medical providers. Indeed, if their reasons for disqualification are not accepted as sufficient, it is difficult to see what reasons would ever be "good enough" to satisfy a reviewing court. In any event, *Amici* States' argument focuses on the threshold issue of standing/right of action presented in this case.

[3] *But see Armstrong v. Exceptional Child Center, Inc.*, 135 S. Ct. 1378 (2015).

[4] As Appellants note in their opening brief, any possible private right of action under §1396a(a)(23) could only accrue to patients, not providers. *See* Appellants' Brief at 17, 22 n.5.

I. Background on the Medicaid Act

The Medicaid program is an example of cooperative federalism, where Congress has directed that federal and state agencies work together to craft and fund a program that responsibly provides medical services to needy populations. The program is administered by a participating state (under federal oversight) and significantly subsidized by the federal government. As federal courts around the country have recognized, the Medicaid program "not only gives States the option of participating but also gives participating States significant flexibility in defining many facets of their systems." *Geston v. Anderson*, 729 F.3d 1077, 1079 (8th Cir. 2013) (citing *Wisc. Dep't of Health & Family Servs. v. Blumer*, 534 U.S. 473, 495 (2002)).

In the Medicaid Act, Congress explicitly gave states significant flexibility in determining which providers are qualified to participate in the program. Congress set forth numerous reasons that a state agency may exclude a provider as disqualified. *See* 42 U.S.C. §1396a(p)(1).[5] Wide latitude is afforded to states to set

[5] 42 U.S.C. §1396a(p)(1) provides that, "[i]n addition to any other authority, a State may exclude any individual or entity for purposes of participating under the State plan under this subchapter for any reason for which the Secretary [of the federal Department of Health and Human Services] 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." The cross-referenced statutes provide a complex and intricate web of over 50 reasons for the Secretary or a

their own qualification standards (in addition to federal standards) and exclude Medicaid providers based, for example, on criminal, unethical, or improper conduct. *See, e.g.*, 42 C.F.R. §431.51(c)(2) (permitting states to establish and enforce their own "reasonable standards relating to the qualifications of providers").[6]

Congress has delegated the authority to oversee this complex cooperative federalism program to the federal Department of Health and Human Services' Centers for Medicare and Medicaid Services ("CMS"). CMS, on behalf of the Secretary of Health and Human Services, oversees state agency administration of the program. To carry out oversight responsibility, Congress gave the Secretary the power of the purse. If the Secretary believes a State is improperly carrying out its duties under the Act—including determining whether a medical provider is

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state agency to exclude an entity from the qualified Medicaid provider pool. Most disqualifying reasons listed require a state agency to call on their expertise and experience in the Medicaid field to make technical and judgment-laden decisions regarding disqualification from the program. *See, e.g.*, 42 U.S.C. §1320a-7(b)(6)(B) (requiring a judgment-laden and technical decision to define and apply the phrase "substantially in excess of the needs of such patients" and to determine what conduct "fails to meet professionally recognized standards of health care").

[6] *See also Guzman v. Shewry*, 552 F.3d 941, 949 (9th Cir. 2009) (concluding that the applicable federal statutes and regulations "plainly contemplate[] that states have the authority to suspend or to exclude providers from state health care programs for reasons other than those upon which the Secretary of HHS has authority to act . . . ."); *First Med. Health Plan, Inc. v. Vega-Ramos*, 479 F.3d 46, 53 (1st Cir. 2007) (explaining that 42 U.S.C. §1396a(p)(1) "preserves the state's ability to exclude entities from participating in Medicaid under 'any other authority'" and that the "legislative history clarifies that this 'any other authority' language was intended to permit a state to exclude an entity from its Medicaid program for *any* reason established by state law") (emphasis in original).

qualified or unqualified to be in the Medicaid program—the Secretary, after consultation with the State, may withhold all or part of the federal Medicaid funds allotted to the State.[7] The carefully crafted enforcement mechanism ensures consultation, coordination, and cooperation between federal and state agencies. This scheme makes sense given that proper implementation of the program requires technical, experience-based, and judgment-laden decisions at both the state and federal levels.

II. 42 U.S.C. §1396a(a)(23) is an Anti-Steering Provision

42 U.S.C. §1396a(a)(23) is one of the 83 provisions that Congress required to be written into all state Medicaid plans. It requires that a state Medicaid plan include language that "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 . . . ." 42 U.S.C. §1396a(a)(23).

[7] In the federal Medicaid Act, Congress set forth a long and complex list of items—in 83 subsections—that must be written into a state Medicaid plan for the Secretary to approve the plan and start providing federal funds. *See* 42 U.S.C. §1396a(a); 42 U.S.C. §1396a(b) ("The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) of this section . . . ."). The Secretary is then charged with ensuring that states substantially comply with their plan. *See* 42 U.S.C. §1396c. 42 U.S.C. §1396c authorizes the Secretary to withhold all or part of a State's federal Medicaid funding if he finds that "the plan has been so changed that it no longer complies with the provisions of section 1396a" or that "in the administration of the plan there is a failure to comply substantially with any such provision." *Id*. (allowing the Secretary to discontinue payments "until [he] is satisfied that there will no longer be any such failure to comply"). However, before withholding any funds, the Secretary must provide the state agency "reasonable notice and opportunity for hearing." *Id*. And the Secretary may in his discretion waive any non-compliance. *See* 42 U.S.C. §1396n(b)(4).

This provision is an anti-steering rule. It reflects Congress' intent that state agencies not (1) directly or indirectly steer patients to one or more "favored" Medicaid providers within the overall pool of qualified providers, or (2) create a monopolistic arrangement that forces Medicaid patients to get a certain service from one particular Medicaid provider. The provision is about a patient's ability to choose between medical providers that are currently qualified to participate in the Medicaid program. That is, taking the pool of qualified providers as a given, a patient must be able to freely choose among that pool.

Numerous federal cases have persuasively interpreted 42 U.S.C. §1396a(a)(23) as an anti-steering provision. *See Chisholm v. Hood*, 110 F. Supp. 2d 499, 505-07 (E.D. La. 2000) (state may not require that children only receive Medicaid services from local school board) (collecting cases). *See also Harris v. Olszewski*, 442 F.3d 456 (6th Cir. 2006) (addressing where patient had a private right of action to challenge a single-supplier contract that required all state Medicaid patients to receive incontinence products from one specific supplier).

And this interpretation is the inescapable point of the United States Supreme Court's decision in *O'Bannon*, 447 U.S. at 785 (interpreting §1396a(a)(23) as requiring states to give patients the option to "choose among a range of *qualified* providers, without government interference") (emphasis in original). The detailed statutory interpretation of §1396a(a)(23) in *O'Bannon* makes painstakingly clear

that the provision is about patients' free choice between the current pool of qualified medical providers, not the antecedent question of who is in the pool of qualified providers.

III. 42 U.S.C. §1396a(a)(23) Cannot Be Used to Sanction a Patient's Collateral Attack on a State's Disqualification of a Medical Provider

Because §1396a(a)(23) is nothing more than an anti-steering provision—which assumes a pool of qualified providers and then ensures free choice between the providers in the pool—it cannot support a private right of action that collaterally challenges a state agency's decision to disqualify a provider for transgressing accepted medical and ethical standards recognized by preexisting federal and state laws. The provision at most supports a patient's private right of action to stop a state agency from steering providers to a particular qualified provider.[8]

Even assuming arguendo there was some ambiguity as to whether §1396a(a)(23) was (1) an anti-steering provision or (2) a guarantee by the state not to erroneously disqualify a particular medical provider, the provision would not support the private right of action Appellees seek. For conditional spending statutes like this one, only language that is clear and unmistakable would suffice.

[8] To the extent a sharply divided three-judge panel in *Planned Parenthood Gulf Coast, et al. v. Gee*, No. 15-30987, ---F.3d---, 2017 WL 2805637 (5th Cir. 2017) held otherwise, they got it wrong. On July 19, 2017, *Amici* States submitted an amicus brief supporting the request for rehearing en banc in *Gee*. The Court has not yet decided whether to rehear *Gee* en banc.

See Appellants' Brief at 18; *see also Gonzaga Univ. v. Doe*, 536 U.S. 273, 280 (2002) (private right of action only available to the extent that "Congress speaks with a clear voice and manifests an unambiguous intent to confer individual rights") (internal quotations omitted). This standard is certainly not met.

Congress could have quite clearly required states to allow a patient to sue in court to contest a disqualification of a certain provider. For example, Congress could have easily stated in the Medicaid Act that a state plan "must provide that any individual is entitled to challenge a state's determination that a provider is unqualified to be in the Medicaid program." Congress chose not to do so, and the courts should not (and may not under controlling precedent) try to divine such an intention in from the zeitgeist of §1396a(a)(23). Square pegs, round holes.[9]

Indeed, everything about the Medicaid program and common sense suggests that Congress would not have authorized a collateral attack by a patient on a State's disqualification decision. There are already significant checks on state action built into the Medicaid Act and required by the Act's implementing

[9] It would be passing strange if Congress secretly intended §1396a(a)(23) to govern qualifications decisions. Congress specifically spoke to the state's authority to disqualify medical providers and thus exclude them from the Medicaid program in a separate provision of the Medicaid Act. *See* 42 U.S.C. §1396a(p). And it did so without mentioning §1396a(a)(23) in any way. Reading both provisions in context of the entire Act, as courts must, the far better interpretation of §1396a(a)(23) is that its anti-steering provisions are divorced from the antecedent question of who is qualified to be part of the pool of providers in which free choice is guaranteed.

regulations. For example, a provider who believes it has been wrongly excluded from the program is entitled to an administrative appeal and can in most circumstances even go to state court to attempt to overturn the exclusion. The opportunity for an appeal by the provider is a required feature of the program.[10] Moreover, if the federal government believes a state improperly removed a provider from the Medicaid program, it can withhold all or part of a state's Medicaid funding until the improper removal is reversed.[11] It is through this carefully constructed state-federal cooperative administrative scheme that the program has operated for decades. Nothing in the underlying facts of this case compels judicial re-writing of the statute to manufacture standing for a patient to collaterally undo a State's decision to terminate a medical provider from the Medicaid program.

Of course, it makes eminent sense that the Medicaid program requires states to afford the provider an administrative appeal and even further judicial review by a state court—for example, to argue that the agency decision was arbitrary and capricious. This provides due process to the medical provider charged with the

[10] *See, e.g.,* 42 C.F.R. §1002.213. If a medical provider took the administrative appeal and then a direct appeal to the state courts, it is beyond dispute that the state court would adopt an arbitrary and capricious standard of review. Appellants' Brief at 30-32. By foregoing an administrative appeal and instead recruiting a patient to sue under §1396a(a)(23), the medical provider is attempting to side-step state court and avoid the deferential standard of review normally applicable to state agency decisions. This Court should not reward or incentivize such conduct.

[11] *See* 42 U.S.C. §1396c.

misconduct, which is the entity that has the best incentive to challenge the disqualification. The medical provider is also obviously in a very good position to have an important perspective on whether it violated program rules, both in terms of the knowledge of its own conduct and the necessary medical expertise to argue about the rules.

Similarly, it makes eminent sense that the federal government—specifically CMS—is afforded by the Medicaid Act a strong lever to prevent state action with which it disagrees. CMS has the medical and policy expertise to know whether a state has improperly found a provider engaged in disqualifying misconduct. Indeed, this potential sanction of withholding funds heavily incentivizes policy experts from the federal and state level—the two entities with enforcement interest and expertise—to work collaboratively to resolve disputes.

What *doesn't* make sense is for Congress to allow a patient (potentially *millions* of individual patients) to collaterally challenge a provider's disqualification from the Medicaid program. The patient—who in a very human way just wants to be able to keep using his or her provider—has no direct, relevant knowledge of the misconduct of the provider and no expertise with which to justifiably second-guess a state's conclusions as to the misconduct or the proper consequences. Allowing a collateral attack by a patient opens the floodgates of litigation against states in federal courts, does almost no good (if it does any), and

could do a lot of harm. One could easily imagine a patient challenging a provider's disqualification even after the federal government, state government, and the provider itself all affirmatively agreed to the penalty. There is simply no reason to believe Congress would have given a patient (potentially *millions* of individual patients) the ability to interfere in the highly complex administrative process between the federal government, the state government, and the provider regarding enforcement of the technical rules of the Medicaid program.

Conclusion

For the foregoing reasons, the 15 *Amici* States respectfully request that this Court reverse the district court's decision and vacate the preliminary injunction.

Respectfully submitted,

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By: /s/ *Michael A. Cantrell*

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Certificate of Service

I, Michael A. Cantrell, hereby certify that a copy of the above and foregoing *Amicus Curiae* Brief In Support of Defendants-Appellants and for Reversal has this day been filed with the Clerk for the Fifth Circuit Court of Appeals utilizing the CM/ECF System in accordance with Fed. R. App. P. 25 and Fifth Circuit Rule 25 which will send a notice of electronic filing to counsel for Plaintiffs-Appellees, Defendants-Appellants, and *amicus curiae*.

Little Rock, Arkansas, this 14th day of August, 2017.

/s/ Michael A. Cantrell
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Little Rock, Arkansas, this 14th day of August, 2017.

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