No. 19-1186

In the Supreme Court of the United States

JOSH BAKER, DIRECTOR, SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, IN HIS OFFICIAL CAPACITY,

Petitioner,

v.

PLANNED PARENTHOOD OF SOUTH ATLANTIC, ET AL.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF *AMICUS CURIAE* OF AMERICANS UNITED FOR LIFE IN SUPPORT OF PETITIONERS

CATHERINE GLENN FOSTER
STEVEN H. ADEN
Counsel of Record
KATIE GLENN
NATALIE M. HEJRAN
AMERICANS UNITED FOR LIFE
1150 Connecticut Ave NW, Ste. 500
Washington, D.C. 20036
Steven.Aden@aul.org
Tel: (202) 741-4917
Counsel for Amicus Curiae

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INTEREST OF *AMICUS CURIAE*[1]

Americans United for Life (AUL) is a pro-life legal advocacy organization. Founded in 1971, AUL has nearly fifty years of dedicated commitment to comprehensive legal protections for human life from conception to natural death. AUL attorneys are often consulted on various bills and amendments across the country. AUL has created comprehensive model legislation and works extensively with state legislators to enact constitutional pro-life laws, including legislation directed at allocating public funds away from the subsidization of elective abortion providers and toward comprehensive and preventive women's health care.

It is AUL's long-time policy position that funds appropriated or controlled by the State should not be allocated to providers of elective abortions. AUL has filed amicus briefs in this Court in support of a writ of certiorari on behalf of Kansas, *Planned Parenthood of Kan. & Mid-Mo. v. Anderson*, 139 S. Ct. 638 (2018) (cert. den.) and Louisiana, *Gee v. Planned Parenthood of the Gulf Coast*, 139 S. Ct. 408 (2018) (cert. den.), and in similar cases before the Ninth Circuit, *Planned Parenthood of Arizona, Inc. v. Betlach*, 727 F.3d 960 (9th Cir. 2013), and the Fifth Circuit, *Planned Parenthood of the Gulf Coast v. Smith*, 913 F.3d 551 (5th Cir. 2019), and represented parties before this

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[1] No party's counsel authored any part of this brief. No person other than *Amicus* contributed any money intended to fund the preparation or submission of this brief. Counsel for all parties received timely notice of the intent to file and have consented to the filing of this brief.

Court in other cases involving rights of States not to use public funds to subsidize elective abortions or abortion providers. See, e.g., *Harris v. McRae*, 448 U.S. 297 (1980) and *Williams v. Zbaraz*, 448 U.S. 358 (1980).

SUMMARY OF ARGUMENT

The Supreme Court's decision in *O'Bannon v. Town Court Nursing Center*, 447 U.S. 773 (1980), was first, a determination that the federal Medicaid statute cannot be construed to grant Medicaid patients a right to legal process in federal court to challenge federal or state provider qualifications, and second, that Medicaid's "choice of qualified provider" provision (42 U.S.C. § 1396a(a)(23)) is a State plan requirement mandating that patients be afforded a range of choices among providers federal or State Medicaid officials have deemed qualified, not a substantive right to challenge a State's disqualification decision in federal court. As such, several circuits have erred in holding that § (a)(23) confers a private right of action upon Medicaid patients to challenge individual provider qualification determinations in a federal venue. As it stands, different States are subject to different requirements under the same Act of Congress. The Fourth, Fifth, Sixth, Seventh, Ninth, and Tenth Circuits have given Medicaid beneficiaries an implied private right to enforce § (a)(23) of the Medicaid Act, while the Eighth Circuit has found no private right of action under

§ (a)(23).[2] The petition should be granted to correct this error of federal statutory interpretation.

ARGUMENT

I. THE SUPREME COURT CONSTRUED THE "CHOICE OF QUALIFIED PROVIDER" PROVISION *AGAINST* RESPONDENTS' POSITION IN *O'BANNON V. TOWN COURT NURSING CENTER*.

O'Bannon v. Town Court Nursing Center was an attempt by Medicaid recipients to secure a federal due process right to a qualification determination for their chosen Medicaid provider, decided before the Supreme Court radically expanded the jurisprudence of implied rights of action to encompass Spending Clause provisions in *Wright v. Roanoke Redevelopment & Housing Auth.*, 479 U.S. 418 (1987) and *Wilder v. Va. Hosp. Ass'n.*, 496 U.S. 498 (1990). *O'Bannon* provided a substantive interpretation of

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[2] If the circuit conflict is characterized as a difference in the appellate courts' interpretation of *O'Bannon*, the split is 6-2, insofar as the Second Circuit interpreted *O'Bannon* in *Kelly Kare, Ltd. v. O'Rourke*, 930 F.2d 170 (2d Cir. 1991) in the same manner as the Eighth Circuit did in *Does v. Gillespie*, 867 F.3d 1034 (8th Cir. 2017). Additionally, as Petitioner notes, the Fifth Circuit is "poised to decide whether to overturn its prior decision," Petition for Writ of Certiorari at 25, *Baker v. Planned Parenthood S. Atl.,* No. 19-1186 (Filed March 2020); *Planned Parenthood of Greater Tex. Family Planning & Preventative Health Servs., Inc v. Smith*, 913 F.3d 551, 554 (5th Cir. 2019), reh'g *en banc*, *Planned Parenthood of Greater Tex. Family Planning & Preventative Health Servs., Inc v. Smith*, No. 17-50282. If that occurs, the broader split over the meaning of *O'Bannon* will be 5-3.

the "choice of qualified provider" provision, 42 U.S.C. § 1396a(a)(23), that renders Respondents' position untenable. Thus, Judge Shepherd correctly concluded in his concurrence in *Gillespie* that "*O'Bannon* controls the outcome of this case." 867 F.3d at 1047. Accord *Planned Parenthood of the Gulf Coast v. Gee*, 862 F.3d 445, 475 (5th Cir. 2017) (Owen, J., dissenting) ("The decision in *O'Bannon* controls here."); and *Planned Parenthood of the Gulf Coast v. Gee*, 876 F.3d 699, 700 (5th Cir. 2017) (Elrod, J., dissenting from the denial of rehearing *en banc*) (calling *O'Bannon* "binding precedent").

In *O'Bannon*, the federal Secretary of Health, Education and Welfare (HEW, now Health and Human Services or HHS) disqualified Town Court Nursing Center, a Pennsylvania skilled nursing facility, based on a survey conducted by the Pennsylvania Department of Public Welfare (DPW), which found that the facility failed numerous federal statutory requirements. 447 U.S. at 776 n.3, citing 42 U.S.C. § 1395x(j) and 42 C.F.R. §§ 405.1121–24, 1127, 1132, 1134. Pennsylvania likewise disqualified Town Court, citing federal rules that mandated that a State agency follow suit when the federal secretary has disqualified a provider. 447 U.S. at 776 n.4, citing 45 C.F.R. § 249.33(a)(9).

The home and several of its Medicaid patients brought an action in federal court asserting the right to an evidentiary hearing on the disqualification decision before Medicaid could be discontinued. Much like the plaintiffs' complaint herein, the Medicaid recipients alleged that terminating Medicaid payments would force Town Court's closure and cause

the individual plaintiffs to suffer "immediate and irreparable psychological and physical harm" as a result of their having to move to a different Medicaid provider. *Id*. at 777.

Although the district court declined to find a right to a hearing existed, the Third Circuit reversed on the ground that the Medicaid statute and regulations, specifically the "choice of qualified provider" provision (42 U.S.C. § 1396a(a)(23)) and regulations prohibiting certified facilities from transferring patients except for certain specified reasons (42 C.F.R. § 405.1121(k)(4)) and reducing or terminating a recipient's financial assistance without a hearing (42 C.F.R. § 205.10(a)(5)) created a constitutionally protected property interest in continued residency at the home. *Town Court Nursing Ctr., Inc. v. Beal*, 586 F.2d 280 (3rd Cir. 1978). The circuit majority relied on the "general due process maxim that, whenever a governmental benefit may be withdrawn only for cause, the recipient is entitled to a hearing as to the existence of such cause." *O'Bannon*, 447 U.S. at 780. Applying this reasoning in *Town Court*, six judges (over a dissent authored by Chief Judge Seitz) held that the patients were entitled to a pretermination hearing on the issue of whether Town Court's Medicare and Medicaid provider agreements should be renewed. *Town Court*, 586 F.2d. at 282–83.

The Supreme Court reversed, over a single dissenting vote (Justice Brennan, *O'Bannon*, 447 U.S. at 805 et seq.), "essentially for the reasons stated by Chief Judge Seitz in his dissent." *Id.* at 783. The Court found "unpersuasive" the plaintiffs' argument that the "choice of qualified provider" provision and other

Medicaid provisions relied upon by the court of appeals conferred on them a property right to remain in the home of their choice absent good cause for transfer and therefore entitled them to a federal hearing on whether good cause existed:

> *Whether viewed singly or in combination*, the Medicaid provisions relied upon by the Court of Appeals do not confer a right to continued residence in the home of one's choice. [42 U.S.C. § 1396a(a)(23)] gives recipients *the right to choose among a range of qualified providers*, without government interference. By implication, it also confers an absolute right to be free from government interference with the choice to remain in a home that continues to be qualified. But it clearly does not confer a right on a recipient to enter an unqualified home and demand a hearing to certify it, nor does it confer a right on a recipient to continue to receive benefits for care in a home that has been decertified.

Id. at 785. (emphases added). The Supreme Court held that "enforcement by HEW and DPW of their valid regulations did not directly affect the patients' legal rights or deprive them of any constitutionally protected interest in life, liberty, or property." *Id*. at 790.

In crediting Chief Judge Seitz's analysis, the Court quoted at length with approval his response to the Third Circuit majority's position:

> The majority finds that continued residency in the nursing home of one's choice absent specific cause for transfer is an underlying substantive interest created by three Medicaid provisions. Under the first, 42 U.S.C. § 1396a(a)(23), a Medicaid recipient may obtain medical care "from any institution . . . qualified to perform the service or services required." *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 by the Secretary to be "qualified."*

Id. at 782 n.13 (emphasis added). And the Supreme Court disagreed with Justice Blackmun's concurring view, which likewise interpreted § 1396(a)(23) to vest "each patient with a broad right to resist governmental removal, which can be disrupted only when the Government establishes the home's noncompliance with program participation requirements." *Id.* at 791 (Blackmun, J., concurring in the judgment).

The Court also adopted Chief Judge Seitz's view that "since decertification does not reduce or terminate a patient's financial assistance, but merely requires him to use it for care at a different facility, regulations granting recipients the right to a hearing prior to a reduction in financial benefits are irrelevant." *Id.* at 785–86. On this basis, the *O'Bannon* Court set aside the plaintiffs' impact evidence. "[S]ome may have difficulty locating other homes they consider suitable or may suffer both emotional and physical harm as a result of the

disruption associated with their move. Yet none of these patients would lose the ability to finance his or her continued care in a properly licensed or certified institution." *Id*. at 787.[3]

Justice Brennan in his *O'Bannon* dissent and Judge Adams of the Third Circuit both urged that it "begs the question" to hold that § 1396a(a)(23) expressly gives the patients only a right to stay in "qualified" facilities, *Id*. at 782, citing *Town Court*, 586 F.2d at 287 (Adams, J., concurring), implying that the only way to avoid a circular argument over the definition of "qualified" is to find that federal courts have authority to decide whether a provider is "qualified to provide the services required." But if the question is "begged", only a strained reading of § (a)(23) could yield the answer to which the *O'Bannon* dissent came. All that *O'Bannon* said on the subject of what "qualified" means is that § (a)(23)

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[3] If possible, the impact evidence presented by Respondents herein was even more subjective than that offered by the *O'Bannon* plaintiffs. They pleaded, for example, that "Many individuals specifically go to Planned Parenthood for their reproductive health care because they are concerned about their privacy and fear being judged by other providers." Pls.' Mot. for TRO & Prelim. Inj. 4, *Planned Parenthood S. Atl. v. Baker*, No. 18-2078 (Dist. S.C. July 30, 2018) ECF No. 5-1. (citing Decl. of Jenny Black in Supp. of Pls.' Mot. for TRO & Prelim. Inj. [hereinafter "Black Decl."] ¶ 9; Decl. of Julie Edwards in Supp. of Pls.' Mot. for TRO & Prelim. Inj. ¶ 11–12). Likewise, "[E]ven if PPSAT is reinstated as a Medicaid provider many of its patients will remain confused as to whether it is a provider in good standing, and for that reason will not return as patients; every day that PPSAT is forced to turn away patients this harm increases." Pls.' Mot. for TRO and Prelim. Inj. 9 (citing Black Decl. ¶ 27).

does not grant federal courts the authority to make that decision. "[W]hile a patient has a right to continued benefits to pay for care in the qualified institution of his choice, he has no enforceable expectation of continued benefits to pay for care in an institution that [federal or State authorities] ha[ve] determined to be unqualified." *Id*. at 786.

A. *O'Bannon*'s Due Process Analysis Presupposed the *Absence* of Any Implied Federal Right for Respondents.

The Fourth and other Circuits have incorrectly dismissed *O'Bannon* as a due process case[4] because, as Judge Owen stated in dissent in *Gee*, "there is no right to due process unless there is a substantive right

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[4] See, e.g., *Planned Parenthood S. Atl. v. Baker*, 941 F.3d 687, 704 (4th Cir. 2019) ("the patients [in *O'Bannon*] did not bring a substantive claim seeking to vindicate their rights under the free-choice-of-provider provision, but rather sued for violation of their procedural due process rights"); *Planned Parenthood of Ind., Inc. v. Comm'r of Ind. State Dep't of Health*, 699 F.3d 962, 977 (7th Cir. 2012) (distinguishing *O'Bannon* on the basis that "the free-choice-of-provider statute was raised in the context of a due-process claim" and that "[t]his is not a due-process case"); *Planned Parenthood of the Gulf Coast v. Gee*, 862 F.3d 445, 460 (5th Cir. 2017) (*O'Bannon* "is inapposite. There, the patient-plaintiffs' injuries were alleged to stem from a deprivation of due process rights, specifically, the right to a hearing to contest the state's decertification of a health care provider, not just its Medicaid qualification."); *Planned Parenthood of Kan. & Mid-Mo. v. Andersen*, 882 F.3d 1205, 1231 (10th Cir. 2018) ("[W]e note that the nursing home residents in *O'Bannon* asserted procedural due-process rights, not substantive rights, as the patients do here.").

that may be vindicated if adequate process is accorded." *Gee*, 862 F.3d at 475. She explains:

> The Due Process Clause does not confer a "right to a hearing" in the abstract; rather, it does so only as a prerequisite to a deprivation of "life, liberty, or property." Before a plaintiff can prevail on a due process claim, she must show that a liberty or property interest exists and that the State has interfered with that interest.

Id., quoting U.S. Const. amend. XIV, § 1. Accord *Gillespie*, 867 F.3d at 1048 (Shepherd, J., concurring) ("The plaintiffs' argument also exhibits a fundamental misunderstanding of due process rights. Any right to due process, whether asserted as a procedural or substantive claim, exists only when there is an underlying substantive right at issue.").

Thus, "[t]hough the Medicaid recipients in *O'Bannon* claimed that they were 'entitled to an evidentiary hearing on the merits of the decertification decision,' they were first required to show that the State had deprived them of a 'liberty or property interest' by terminating reimbursement agreements with their preferred Medicaid provider." *Gee,* 862 F.3d at 475–76 (Owen, J., dissenting), quoting *O'Bannon*, 447 U.S. at 777, 784. "The Court concluded that recipients do not have such a right." *Id*. at 476. Because *O'Bannon* held they had no right in substance, no right of action can be implied. In short, as Judge Owen said, "§ 1396a(a)(23) does not give a patient the right to contest a State's determination that a provider is not 'qualified' to provide Medicaid services or a determination that the

provider has not otherwise met state or federal statutory requirements. The Supreme Court's decision in *O'Bannon* makes this clear." *Gee*, *id*. at 474. Respondents' position is therefore foreclosed by *O'Bannon*.

B. *O'Bannon* Substantively Construed the "Choice of Qualified Provider" Provision to Mandate Only that State Medicaid Plans Offer Patients a Broad Range of Choices Among Qualified Providers, Not a Right to a Federal Court Hearing on Whether a Particular Provider Is Qualified.

Presuming for argument's sake that a private right of action could be implied in § (a)(23), the Court nonetheless "must examine the precise contours of that right." *Gillespie*, 867 F.3d at 1046 (Shepherd, J., concurring), citing *Gonzaga Univ. v. Doe*, 536 U.S. 273, 280 (2002) (requiring "conferred benefits be sufficiently specific and definite to qualify as enforceable rights"). The *O'Bannon* Court "clearly stated that it was defining the contours of the 'substantive right . . . conferred by the statutes and regulations.'" 867 F.3d at 1048 (Shepherd, J., concurring). In the words of Judge Shepherd, "the Court carefully delineated the limits of the right conferred by [§ (a)(23)]; there is no enforceable right of continued care from a provider determined by the state to be unqualified." *Id*. at 1047. There is a complete dearth of guidance in the provision; § (a)(23) says nothing about which qualifications are permissible, nor about which governmental agency—federal or state—has the statutory authority to make

the qualification decision in a particular instance or a disqualification decision afterward. Thus, no substantive individual right can be derived from the provision.

Similarly, circuits and judges have misread *O'Bannon* to be limited to circumstances involving a provider that is disqualified for health and safety reasons, based upon their supposition that § (a)(23) provides a definition of "qualified" that is strictly limited to an ability to deliver medical services.

> [As] the Fifth Circuit recently explained, "the [*O'Bannon*] plaintiffs had no right to reside in an unqualified facility *when the disqualification decision was connected to the state's enforcement of its health and safety regulations*." *Gee*, 862 F.3d at 461. The language of the freedom-of-choice provision supports this understanding because the word "qualified" is modified by the phrase "to perform the service or services required." 42 U.S.C. § 1396a(a)(23)(A).

Gillespie, 867 F.3d at 1053 (Melloy, J., dissenting): See also *Planned Parenthood of Ariz. v. Betlach*, 727 F.3d 960 (9th Cir. 2013); *Planned Parenthood of Kan. & Mid-Mo. v. Andersen*, 882 F.3d 1205, 1231 (10th Cir. 2018) ("*O'Bannon* addressed a different situation—one where *no one contested that the nursing home was unqualified to perform the services*. . . .[U]nlike in *O'Bannon,* the Providers in the case before us remained qualified to perform the medical services.").

This view reads into the provision a common-usage definition of "qualified," imported from outside the Medicaid statute. As Judge Melloy argues, "The provision thus indexes the relevant 'qualifications' not to any Medicaid-specific criteria (whether imposed by the federal government or the states), but to factors external to the Medicaid program; the provider's competency and professional standing as a medical provider generally." *Gillespie*, 867 F.3d at 1053 (Melloy, J., dissenting), quoting *Betlach*, 727 F.3d at 969.

In rejecting this extra-statutory definition, the Eighth Circuit explicated the important distinction between "qualified" to be a Medicaid provider and "qualified" to provide medical services:

> The dissent's attempt to distinguish *O'Bannon* fails because it assumes that Planned Parenthood was somehow *wrongfully* disqualified as a Medicaid provider. The dissent claims to find proof of this wrongful termination in the fact that Planned Parenthood remains licensed to serve other patients. So according to the dissent, a Medicaid recipient has the right to challenge the merits of a provider's decertification when the State permits that provider to continue providing care to other patients. But this interpretation is plainly wrong. "Under federal statutory and regulatory provisions, a State may terminate a provider's Medicaid agreement on many grounds, and it is not a prerequisite for such terminations that the

> State preclude a provider from providing services to any and all patients." *Gee*, 862 F.3d 445, 477, (Owen, J., dissenting).

Gillespie, 867 F.3d at 1048–49 (emphasis in original).

This "common usage" reading of § (a)(23) amounts to a "drive by" definition for a key operative concept in the Medicaid statute, in spite of the fact that federal and state qualification authority is the subject of numerous other more explicit provisions, *e.g.*, Sec. 1396a(p)(1); and authority cited and discussed *infra* at 19–21. As Judge Elrod observed, the view that a fully-orbed definition of "qualified" can be found in § (a)(23) "is not only at odds with *O'Bannon* but also with the entirety of the statutory framework in 42 U.S.C. § 1396a":

> Under the exclusionary provision in § 1396a(p)(1), a Medicaid provider can be disqualified for reasons unrelated to health and safety that would require the provider to cease dispensing care to the general public. . . 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.

Gee, 876 F.3d at 701.

In sum, as Judge Elrod explained, "The panel majority opinion here makes the very same error that the Court saw fit to correct in *O'Bannon*: 'In holding

that [§ 1396a(a)(23)] create[s] a substantive right' it 'fails to give proper weight to the contours of the right conferred by the statutes and regulations.'" *Id.* The majority circuits have improperly conflated a "right" and a private right of action. The fact that the provision intended to benefit Medicaid patients by ensuring that State plans secure for them a right to choose among qualified providers does not a fortiori mean that Congress intended to bestow on them a private right of action to enforce that provision in federal court, as this Court has made clear in numerous cases. See, e.g., *Alexander v. Sandoval*, 532 U.S. 275 (2001), *Suter v. Artist M*, 503 U.S. 347 (1992), *Armstrong v. Exceptional Child Ctr., Inc.*, 575 U.S. 320 (2015).

II. THE EIGHTH CIRCUIT AND SECOND CIRCUIT'S READING OF *O'BANNON* ACCORDS WITH THE MEDICAID ACT'S STATUS AS A SPENDING CLAUSE "CONTRACT" WITH THE STATES AND THIS COURT'S ANALYSIS IN *ARMSTRONG V. EXCEPTIONAL CHILD CENTER*.

A. Congress Has Made No "Clear Statement" that States Are Subject to Suit in Federal Court to Enforce § 1396a(a)(23).

The 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 (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. (citing THE FEDERALIST No. 39, p. 245 (C. Rossiter ed. 1961)). Consequently, the Constitution does not confer on Congress plenary legislative power, but only certain enumerated powers. *Id*. 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. While States can surrender their sovereign authority to the federal government through Congress via Spending Clause legislation, 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). Thus, the Medicaid Act, including the provision at issue here, must be construed strictly against the assertion of surrender of State power.

In light of this system of dual sovereignty, "if Congress intends to alter the 'usual constitutional balance between the States and the Federal Government,' it must make its intention to do so 'unmistakably clear in the language of the statute.'" *Will v. Mich. Dep't of State Police*, 491 U.S. 58, 65 (1989) (quoting *Atascadero State Hosp. v. Scanlon*, 473 U.S. 234, 242 (1985)) (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 of the *Pennhurst* clear statement rule, 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.

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) (citing *Dandridge v. Williams*, 397 U.S. 471, 487 (1970)). This flexibility and wide latitude reflects the fact that establishing qualifications for medical providers is a traditional State function, and that under the Medicaid Act, States are 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. . . .Thus,

the state regulation is presumed valid. To rebut this presumption, appellants must show that Congress intended to displace the state's police power function."). As this Court has 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) (quoting *Atascadero*, 473 U.S. at 243). For this reason, the Medicaid statute expressly prohibits federal interference with the practice of medicine or the manner in which medical services are provided, or the exercise of any supervision or control over the operation of any institution providing health services. 42 U.S.C. § 1395.

Given the *Pennhurst* clear statement rule, one would expect to encounter explicit constraints on the States' authority to determine provider qualifications in Medicaid if that were truly Congress' intent. But the opposite is true; State authority is recognized and affirmed through the warp and woof of the Medicaid Act.

Congress explicitly reserved to 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). The Medicaid Act provides dozens of reasons why the Secretary, and likewise the States, may—and in some cases, must—

exclude a provider from participation in a State Medicaid program, and many of these have nothing to do with a Medicaid provider's ability or willingness to perform medical services.

For example, § 1320a-7 provides that a State may exclude providers in the case of conviction of program-related crimes or crimes relating patient abuse; convictions related to fraud, including health care fraud, or controlled substances; overcharging, charging for unnecessary services, or failing to furnish necessary services; default on health education loans or scholarship obligations; and false statements or misrepresentation of material facts. Under § 1395cc-(b)(2), a State may exclude a provider that fails to comply substantially with the provisions of the Medicaid provider agreement, the provisions of the title and regulations thereunder, or a required corrective action, or has been convicted of a felony under federal or State law for an offense the State determines to be detrimental to the best interests of the program or program beneficiaries.[5]

States may also exclude providers from the program on their own initiative, irrespective of any action taken by the federal government, 42 C.F.R. § 1002.1(b), and they have discretion to determine the period of time for exclusion, *id.* § 1002.210. In fact, Congress explicitly affirmed that States retain their

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[5] It is also worth noting that Congress gave the Secretary power to waive the State plan requirements listed in § 1396a, including § (a)(23), 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).

power to exclude providers for *any reason* authorized by State law. 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" the States have. 42 U.S.C. § 1396a(p)(1). When § 1396a(p)(1) was added to the Medicaid Act in 1987, Congress purposefully did not make this provision subject to the already-existing "choice of provider" provision. The legislative history of § 1396a(p)(1) 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) (emphasis supplied). Likewise, 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) (emphasis added). As the First Circuit explained, the broad language of Medicaid's exclusion provision "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). This authority has been 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).

B. The Minority Circuit's Construction of § 1396a(a)(23) Accords With the Supreme Court's Modern Refusal to "Readily Imply" Private Causes of Action in Medicaid Provisions.

In *Armstrong v. Exceptional Child Ctr.,* claimants sued state officials in federal court, asserting the State violated a similar provision to § 1396a(a)(23), 42 U.S.C. § 30(A),[6] by reimbursing providers of habilitation services at inadequate rates. 575 U.S. at 324. The Ninth Circuit affirmed judgment for the claimants, holding that the providers possessed an implied right of action under the Supremacy Clause to challenge State actions inconsistent with its obligations under § 30(A). The Supreme Court

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[6] 42 U.S.C. § 1396a(a)(30)(A), in the same statutory section of the Medicaid Act as the "choice of qualified provider" provision, mandates that in order to be approved by the federal secretary, State plans must

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

reversed, holding that § 30(A) cannot be construed to grant a right of action either under the Supremacy Clause or § 1983. With respect to the § 1983 claim, 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* has been "plainly repudiate[d]" by the Court's later opinions. *Armstrong*, 575 U.S. at 331 n.*. And the Court saw the claimants' attempt to employ the Supremacy Clause as an attempted end-run around their lack of a private right of action to enforce § (30)(A). "In our view, the Medicaid Act implicitly precludes private enforcement of §30(A), and respondents cannot, by invoking our equitable powers, circumvent Congress's exclusion of private enforcement." *Id*. at 328.

Armstrong concluded that two aspects of §30(A) established Congress's intent to foreclose equitable relief. First was the fact that "the *sole remedy* Congress provided for a State's failure to comply with Medicaid's requirements . . . is the withholding of Medicaid funds." *Id.* at 328. (emphasis added). The Court's use of the phrase "sole remedy" precludes a finding that there was any other remedy Congress intended for breach of a Medicaid provision, *i.e.*, that there was no intention to create a private right of action anywhere in § 1396a. Second was the fact that "Section 30(A) lacks the sort of rights-creating language needed to imply a private right of action." *Id*. at 331.

> 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. *The Act says that the "Secretary shall approve any plan which fulfills the conditions specified in subsection (a)," the subsection that includes § 30(A). 42 U.S.C. § 1396a(b). We have held that such language "reveals no congressional intent to create a private right of action*."

Id. at 331 (emphasis added).

To imply a private right of action in a federal statute, claimants must demonstrate that Congress intended that the provision benefit the plaintiff, and that it be stated in "mandatory rather than precatory terms." *Blessing v. Freestone*, 520 U.S. 329, 341 (1997). "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." *Sandoval*, 532 U.S. at 289 (2001) (internal quotation marks omitted). As with § 30(A), the focus of § (a)(23) is on the States—the agency being regulated. See *Gillespie*, 867 F.3d at 1041 (explaining that § (a)(23) 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 includes § (a)(23). See *id.* § 1396a(a).

Consequently, 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). Like the provision at issue in *Armstrong*, the language of § (a)(23) 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*, 575 U.S. at 331 (plurality opinion). *Compare* the provision at issue in *Armstrong*, 20 U.S.C. § 1232g(b)(1) (“No funds shall be made available . . . .”), *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* . . . .”) (emphasis added), *and* Title IX, 20 U.S.C. § 1681(a) (“No *person* in the United States *shall* . . . .”) (emphasis added). Since § (a)(23) 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.

CONCLUSION

The petition should be granted, and the decision below reversed.

Respectfully submitted,

CATHERINE GLENN FOSTER
STEVEN H. ADEN
COUNSEL OF RECORD
KATIE GLENN
NATALIE M. HEJRAN
AMERICANS UNITED FOR LIFE
1150 CONNECTICUT AVE. NW,
SUITE 500
WASHINGTON, D.C 20036
STEVEN.ADEN@AUL.ORG
(202) 741-4917

Counsel for Amicus Curiae

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