No. 17-1340

In the Supreme Court of the United States

JEFF ANDERSEN, SECRETARY,
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT,
IN HIS OFFICIAL CAPACITY,
Petitioner,

v.

PLANNED PARENTHOOD OF KANSAS
AND MID-MISSOURI, ET AL.,
Respondents.

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

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

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INTEREST OF *AMICUS CURIAE*[1]

Americans United for Life (AUL) is the oldest and most active pro-life non-profit advocacy organization. Founded in 1971, before this court's decision in *Roe v. Wade*, AUL has over 45 years of dedicated commitment to comprehensive legal protections for human life from conception to natural death. AUL attorneys are highly-regarded experts on the constitution and pro-life legal language, 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. *See, e.g.*, Ams. United for Life, Defending Life 460–61 (2018 ed.) (AUL state policy guide provides model bills that reallocate public funds to comprehensive and preventive health care providers). 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 filed an amicus brief in a similar case before the Ninth Circuit, *Planned Parenthood of Arizona, Inc. v. Betlach*, 727 F.3d 960 (9th Cir. 2013)—one of the cases in the circuit split identified by the petition for certiorari—as well as other cases involving rights of

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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.

States not to use public funds to subsidize elective abortions or abortion providers. *See, e.g.*, *Harris v. McRae*, 448 U.S. 297 (1980).

SUMMARY OF ARGUMENT

The Tenth Amendment guarantees that States retain their sovereign power, absent an explicit surrender through an act of Congress. Under the Medicaid Act, as an enactment under the Spending Clause, any surrender of State sovereign power must be done voluntarily and knowing through a clear statement. The Act explicitly gives States power to exclude Medicaid providers and beneficiaries and expressly acknowledges that States retain their Sovereign power of exclusion under other authorities, such as State law. As the Eighth Circuit correctly held, § 23(A) does not clearly and unambiguously grant a private right of action. In contrast, the Tenth Circuit, along with the Fifth, Seventh, and Ninth Circuits, all erroneously found that States do not retain their sovereign power of exclusion to determine who is qualified under and who is excluded from their State Medicaid plans. As such, this Court should grant certiorari to correct the unconstitutional expansion of federal authority in direct violation of clearly established Supreme Court guidance.

ARGUMENT

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

A. Under the Tenth Amendment, all power is reserved to the States where the Constitution or Congress have not spoken.

The Tenth Amendment guarantees States all powers that the Constitution does not delegate to the federal government or prohibit to the States. U.S. Const. amend. X. Likewise, the authority to regulate in areas occupied jointly by the federal and State governments—including the police power to regulate the health and welfare of its citizens—is reserved to the States. This sovereign power of the States is not diminished just because a State acts in partnership with the federal government, such as under the Medicaid Act.

States, however, can surrender their sovereign power to the federal government through Congress via a Spending Clause enactment. 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) (explain 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 said to be 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 statute, including the provision at issue here, must be construed strictly against the assertion of surrender of State power.

B. Under *Pennhurst*, States do not give up their sovereign power in Spending Clause legislation absent a clear statement by Congress.

"[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, when "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). This is known as the "*Pennhurst* clear statement rule."

Because States contract at arms' length as co-equal sovereigns with the federal government to implement federal programs, States accepting funds from the federal government via a Spending Clause statute 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, *Pennhurst* establishes that the federal Medicaid statute's legitimacy under the Spending Clause depends upon the extent to which States voluntarily and knowingly accept Medicaid's terms in choosing to participate. Otherwise, enforcement of the legislative "contract" would "undermine the status of the States as independent sovereigns in our federal system." *Id.*

II. Under the Medicaid Act, States have broad authority to determine who is qualified to participate in and who it can exclude from its Medicaid program.

A. The Medicaid Act gives States broad authority to create and run their own State Medicaid programs.

The Medicaid Act guarantees 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 is a reflection of two facts.

First, it reflects the fact that the State is acting within its core or natural sphere of operation, since establishing qualifications for medical providers is a traditional State function. *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 explained in *Gregory v. Ashcroft*, "[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." 501 U.S. 452, 460 (1991) (internal quotation marks omitted) (quoting *Atascadero State Hosp. v. Scanlon*, 473 U.S. 234, 243 (1985)).

Second, it reflects the fact that the State expends its own funds to administer Medicaid. In addition to administering the federal share, participation in the Medicaid program requires States to expend a substantial outlay of their own funds, including ten percent for family planning services. 42 U.S.C. 1396b(a)(5).

As part of a State's authority to create its own Medicaid program, a State retains broad authority under the Medicaid Act to establish provider qualifications that reflect State law and policy.

B. The Medicaid Act grants States authority to exclude providers for any reason that the Secretary can.

Under the Medicaid Act, the States' exclusion power includes: (a) refusal to enter into a participation agreement; (b) refusal to renew a participation agreement; or (c) termination of a participation agreement. 42 U.S.C. § 1396a(p)(3). States can exclude individuals and entities on their own initiative, irrespective of any action taken by the Office of Inspector General at the U.S. Department of Health & Human Services (HHS), 42 C.F.R. § 1002.1(b), and have discretion to determine the period of the exclusion, *id.* § 1002.210.

The Medicaid Act specifically grants States the power to exclude any individual or entity from participating in the State's plan "for any reason for which the Secretary could exclude the individual or entity from participation." 42 U.S.C. § 1396a(p)(1).

There are three sections that give reasons why the Secretary, and likewise a State, may—and in some cases, must—exclude an individual or entity from participation. Many of these reasons have nothing to do with a Medicaid provider's ability to perform medical services.

Under the first, the State may exclude individuals and entities 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 professional competence, professional performance, or financial integrity;
- Claims for excessive charges or unnecessary services and failure of certain organizations go 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 person for (a) improperly filed claims or (b) payments to induce reduction or limitation of services. *Id.* § 1320a-7a.

Under the third section, the State may exclude a provider that:

- Fails to comply substantially with the provisions of the agreement, the provisions of the title 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, the corresponding federal regulations also provide numerous grounds on which States can exclude an individual or entity from its State Medicaid plan for the same reasons as the Secretary.[2]

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[2] *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 and kickbacks and other prohibited activities); *id.* § 1001.1001 (permissible exclusion of entities owned or controlled by a sanctioned person); *id.* § 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 PPS 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.* § 1001.1610 (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

C. The Medicaid Act acknowledges and reserves States' power to exclude providers for any reason authorized by State law.

Not only does the Medicaid Act fail to prohibit States from excluding providers from State health care programs for reasons other than those mentioned above, the Act and governing regulations specifically acknowledge that States have and retain such authority.

For instance, § 1396a(p)(1) 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 an individual or entity for any number of stated reasons, the governing regulations acknowledge that this authority is "[i]n addition to any other authority [the State] may have." 42 C.F.R. § 1002.3(a). These provisions clearly contemplate that States have the authority to suspend or exclude providers from State health care programs for reasons other than those upon which the HHS Secretary has authority to act. Any other reading would render these phrases redundant.

(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).

When § 1396a(p)(1) was added to the Medicaid Act in 1987, Congress did not make this exclusion provision subject to the already-existing "choice of qualified provider" provision. The legislative history behind the exclusion provision of the Medicaid law is clear that States have 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 the First Circuit explained, the language of Medicaid's exclusion provision—that a Sate 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).

Not only that, the governing regulations state 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).

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

As discussed above (*supra* Sections I.B, II.A), the States' ability to set reasonable provider qualifications thus inheres in their sovereignty, and not in any authorization to do so by a federal statute.

This express acknowledgment of retained inherent State authority applies without any distinction between initial qualifications and disqualifications or exclusions. *See* 42 U.S.C. § 1396a(p)(3) ("As used in this subsection, the 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 by enacting State laws which govern the specifics of their own Medicaid programs.

III. The Medicaid Act does not clearly or unambiguously confer a private right of action on Medicaid providers or beneficiaries.

A. A Section 1983 claim requires a deprivation of a federal right clearly established by Congress, such that it is not "vague" or "amorphous."

Section 1983 provides a cause of action for the deprivation of any rights secured by federal law. 42 U.S.C. § 1983. Importantly, a § 1983 action supplies a remedy for a violation of federal *rights*, and not merely 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*. As this Court recently noted in *Armstrong*, *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." *Armstrong v. Exceptional Child Ctr.*, 135 S. Ct. 1379, 1386 n.* (2015) (explaining that the "ready implication of a § 1983 action" exemplified in *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498 (1990), has been "plainly repudiate[d]" by the Court's later opinions).

In order to determine whether a statutory provision gives rise to a federal right and thus a private right of action under § 1983: (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). The second prong requires that plaintiffs bear the burden of demonstrating that the right they claim is not so "vague" that it would "strain judicial competence" to enforce it. *Id*. at 340.

B. The choice of provider provision does not clearly establish a private right of action.

The basis for the alleged right of action in this Section 1983 claim comes from § 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).

1. Section 23(A) is framed as a directive to a federal agency and focused on conditions State plans must meet to receive federal funds.

Section 23(A) appears in a section concerning state plans for medical assistance, which directs the Secretary of HHS to approve any plan 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 the eighty-three conditions is § 23. *See id.* § 1396a(a).

Like the provision in *Armstrong*, the provision here 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). The Medicaid Act is not "phrased in terms of the persons benefited," a necessary prerequisite to find a private right. *Gonzaga*, 536 U.S. at 284. *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).

Looking to the statute as a whole, the focus of § 23(A) is on one of a number of conditions State plans must meet to be approved for funding by the Secretary; the focus is not on the rights of Medicaid providers or beneficiaries. *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). As this 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). "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).

2. The Medicaid Act's explicit rights of action and remedies for excluded Medicaid providers and beneficiaries are incompatible with finding a private right of action.

The Medicaid Act protects individuals and entities from improper exclusion through several procedural safeguards, explicit rights of action, and available remedies.[3] Under these procedures, any provider or beneficiary who thinks that they have been wrongly excluded are given the right to appeal that decision. 42 C.F.R. § 1002.213. Congress expressly prescribed a mechanism ensuring that a State complies with the provisions of the Medicaid Act—the withholding of Medicaid funds by the Secretary. *See* 42 U.S.C. § 1396c.

Administrative procedures. When a State exercises its power of exclusion for any reason for which the Secretary could exclude an individual or entity under the regulations, the State agency *must* have administrative procedures in place. 42 C.F.R. § 1002.210.

Notice. When a State agency initiates an exclusion, it must notify the individual or entity subject to the exclusion, as well as other State agencies, the State medical licensing board (when applicable), the public, and beneficiaries, among others. *Id.* § 1002.212. In addition, the State agency

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

must notify the Inspector General of any intended exclusion of an individual or entity to participate in its program. *Id.* § 1002.4(b).

Appeal. Before the State agency can impose an exclusion, the individual or entity *must* be given the opportunity to submit documents and written argument against the exclusion, in addition to any other appeals rights that would otherwise be available under procedures established by State law. *Id.* § 1002.213.

Possibility of reinstatement. States are given power to decide whether they will allow an excluded individual or entity to apply for reinstatement. *Id.* § 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 States retain the power to determine provider qualifications. *Id.* § 1002.215(a). Any denial of reinstatement may be appealed according to State procedures, but it need not be subject to administrative or judicial review, unless required by state law. *Id.* § 1002.215(b).

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

The Eighth Circuit is correct that, under the Medicaid Act, the mandatory opportunity for administrative appeal and judicial review in the 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.

In sum, § 23(A) does not clearly and unambiguously confer a private right of action as required by Spending Clause litigation for States to give up their sovereign power.

C. At best, "qualified" is vague and amorphous, requiring a reading in favor of State sovereignty.

Under the second *Blessing* prong, § 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). Section 23(A) requires State plans to provide that any Medicaid beneficiary may obtain required services from a qualified provider. Notably, the choice of providers provision merely guarantees choice among "*qualified* providers." Thus, this case turns, in part, on the definition of "qualified."

The Tenth Circuit found that the definition of "qualified" could not be "legitimately debated" and must mean any provider that is "(1) qualified to perform the medical services, and (2) undertak[es] to do so." *Planned Parenthood of Kan. & Mid-Mo. v. Andersen*, 882 F. 3d 1205, 1227 (10th Cir. 2018). As such, a provider who is excluded by the State, but is still able and willing to perform medical services would remain qualified within the meaning of the choice of provider provision.

But as this Court explained in *O'Bannon*, freedom of choice entails "the right to choose among a range of *qualified* providers," who "*continue[] to be qualified*." *O'Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773, 785 (1980) (second emphasis added); *see id.* at 786 (A patient "has no enforceable expectation of continued benefits to pay for care in an institution that has been determined to be unqualified.").[4] Under the Medicaid Act, whether a provider is qualified is determined by

[4] In *O'Bannon*, this Court reversed the Third Circuit for essentially the same reasons given by the judge dissenting 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 by the Secretary to be 'qualified.'" 447 U.S. at 782–83 & n.13.

in the first instance by the State. And the authority to determine qualifications for providers outside of their ability to perform a medical service is also retained by States under the statutory scheme of the Act.

First, looking to the plain reading of the text, the choice of providers provision does not explicitly preclude States from imposing qualifications based on scope of practice. Second, § 1396a(p)(1) acknowledges that States have plenary—though not arbitrary or unreasonable—authority to set qualification standards. Further, the Act has an extensive list of reasons why the Secretary or States are statutorily authorized to exclude individuals and entities from the Medicaid program, many reasons 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)(11) (failure to supply payment information); *id.* § 1320a-7(b)(12) (failure to grant immediate access); *id.* § 1320a-7(b)(14) (default on health education loan or scholarship obligations). 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).

While "qualified" could conceivably mean, as the Tenth Circuit 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 State approved Medicaid provider. At best, the definition of "qualified" is unclear and not unambiguous, which makes it "so 'vague and amorphous' that its enforcement . . . strain[s] judicial competence," *Blessing*, 520 U.S. at 340–41. An unclear conveyance of an enforceable right requires a reading in favor of State sovereignty and against finding an implied private right of action under the Medicaid Act.

CONCLUSION

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

Respectfully submitted,

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