No. 17-1340

IN THE
Supreme Court of the United States

JEFF ANDERSEN, SECRETARY, KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT,
Petitioner,

v.

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

On Petition for Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit

BRIEF OF INDIANA, GEORGIA, IDAHO, LOUISIANA, MICHIGAN, NEBRASKA, OHIO, OKLAHOMA, SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, UTAH, WEST VIRGINIA, WISCONSIN, AND WYOMING AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

Office of the Indiana Attorney General
IGC South, Fifth Floor
302 W. Washington Street
Indianapolis, Indiana 46204
(317) 232-6255
Tom.Fisher@atg.in.gov

CURTIS T. HILL, JR.
Attorney General of Indiana
THOMAS M. FISHER*
Solicitor General
LARA LANGENECKERT
JULIA C. PAYNE
KIAN HUDSON
Deputy Attorneys General

Counsel for Amici *States*

**Counsel of Record*

Additional counsel with signature block

QUESTION PRESENTED

Whether the right-of-action doctrine announced in *Gonzaga University v. Doe*, 536 U.S. 273 (2002), precludes Medicaid providers and patients from suing to enforce the provider-choice Medicaid plan requirement of 42 U.S.C. § 1396a(a)(23).

TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

CASES [CONT'D]

CASES [CONT'D]

FEDERAL STATUTES

STATE STATUTES

REGULATIONS

RULES

OTHER AUTHORITIES

INTEREST OF THE *AMICI* STATES[1]

The States of Indiana, Georgia, Idaho, Louisiana, Michigan, Nebraska, Ohio, Oklahoma, South Carolina, South Dakota, Texas, Utah, West Virginia, Wisconsin and Wyoming respectfully submit this brief as *amici curiae* in support of the petitioner. The circuits have split 5–1 on the issue of whether the Medicaid provider-choice provision affords a private right of action under Section 1983 to healthcare providers and their patients whose Medicaid agreements have been terminated by the State. Until this split is resolved, patients in the Fifth, Sixth, Seventh, Ninth, and Tenth Circuits have the right to bring suit in federal court if their preferred provider's agreement is terminated, while patients in the Eighth Circuit do not.

The *amici* States have a strong interest in the proper functioning of the Medicaid system, both in terms of determining which providers are qualified to receive Medicaid funding and in terms of faithfully carrying out their contracts with the federal government. The Petition asserts that thousands of healthcare providers are disqualified by state administrators every year; under the decision below, a patient of any one could sue for reinstatement in federal court. Yet by the terms of the Medicaid Act federal-state contract, the States, not federal courts, are empowered to

---

[1] Pursuant to Supreme Court Rule 37.2(a), counsel of record for all parties have received notice of the Amici States' intention to file this brief at least 10 days prior to the due date of this brief.

determine the qualifications for eligible healthcare providers. Accordingly, the *amici* States urge the Court to address whether providers or patients have a private right of action under Section 1983 to enforce the Medicaid provider-choice provision.

SUMMARY OF THE ARGUMENT

While the Court in *Wilder v. Virginia Hospital Ass'n*, 496 U.S. 498 (1990), permitted private enforcement of a Medicaid plan requirement listed in Section 1396a(a), since then the Court has dramatically curtailed the circumstances in which private parties may enforce federal statutes. The Court has never expressly revisited *Wilder*, but its decisions in *Armstrong v. Exceptional Child Center, Inc.*, 135 S. Ct. 1378 (2015), and *Gonzaga University v. Doe*, 536 U.S. 273 (2002), have cast substantial doubt on its continued vitality and have left it unclear whether the Medicaid Act may be privately enforced. The circuits have split 5–1 on the private enforceability of the Medicaid provider-choice provision alone, and further disagreements exist with respect to other provisions of the Medicaid Act—and the continued significance of *Wilder* more generally.

With this deep division of authority in mind, the Court should grant certiorari and hold that, at the very least, the provider-choice provision of the Medicaid Act is not privately enforceable. Spending Clause legislation such as the Medicaid Act "is much in the nature of a contract: in return for federal funds, the

States agree to comply with federally imposed conditions." *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981). In particular, the Medicaid plan requirements—including the provider-choice provision—were intended by Congress as requirements for Medicaid plans to be eligible for federal reimbursement, not as individually enforceable rights. Section 1396a(a) is merely a list of conditions that a State Medicaid plan must meet to be approved by the Secretary of Health and Human Services. It is the role of the HHS Secretary, not individual healthcare providers, to determine in the first instance whether a State Medicaid program is meeting those conditions.

What is more, the meaning of "qualified" provider is found not in the Medicaid Act itself, but in State regulations and State Medicaid plans, which set forth the reasons that a provider's Medicaid agreement may be terminated. For this reason, the proper method of challenging Kansas's determination that Planned Parenthood is not a qualified provider is through administrative review. Only then can the politically accountable bodies of state and federal government properly interpret and apply the entire body of relevant Medicaid statutes, regulations and plan requirements.

REASONS FOR GRANTING THE PETITION

I. The Court Should Resolve the Split over Whether the Provider-Choice Provision Is Enforceable via Section 1983

The Circuits are divided over whether Medicaid beneficiaries have a private right of action to challenge a State's disqualification of a provider under the Medicaid Act. Five circuits have decided that the Medicaid provider-choice provision may be privately enforced under Section 1983, while one has held that it may not. *Compare Planned Parenthood of Kan. & Mid-Mo. v. Andersen*, 882 F.3d 1205 (10th Cir. 2018), *Planned Parenthood of Gulf Coast, Inc. v. Gee* (*Gee II*), 862 F.3d 445 (5th Cir. 2017), *Planned Parenthood of Ariz. Inc. v. Betlach*, 727 F.3d 960 (9th Cir. 2013), *Planned Parenthood of Ind., Inc. v. Comm'r of Ind. State Dep't Health*, 699 F.3d 962 (7th Cir. 2012), *and Harris v. Olszewski*, 442 F.3d 456 (6th Cir. 2006), *with Does v. Gillespie*, 867 F.3d 1034 (8th Cir. 2017).

This split exists because the Court's right-of-action doctrine has changed substantially over the past 25 years. While the circuits permitting private enforcement of the provider-choice provision have relied on outdated precedents, the Eighth Circuit's rejection of such enforcement properly applied the Court's more recent pronouncements.

1. The Court's older (and now discarded) precedents demonstrated a highly permissive view of private enforcement of federal law. In *Wright v. City of Roanoke Redevelopment & Housing Authority*, the Court held that the Brooke Amendment to the Housing Act of 1937, which limited the amount that tenants of low-income housing projects could be charged for utilities, was privately enforceable under Section 1983. 479 U.S. 418, 419 (1987). In that era, it was sufficient to justify private enforcement that Congress had not "specifically foreclosed a remedy under § 1983." *Id.* at 424 (quoting *Smith v. Robinson*, 468 U.S. 992, 1004–05 & n.9 (1984)). Moreover, the remedial mechanisms provided in the Brooke Amendment were not "sufficiently comprehensive and effective to raise a clear inference that Congress intended to foreclose a § 1983 cause of action for the enforcement of tenants' rights secured by federal law." *Id.* at 425.

A few years later, in *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103 (1989), the Court applied a more systematic—yet still highly permissive—test when it held that the National Labor Relations Act was privately enforceable under Section 1983. In determining that the NLRA created a federal right, the Court considered (1) whether the statute "creates obligations binding on the governmental unit;" (2) whether it is "too vague and amorphous to be beyond the competence of the judiciary to enforce;" and (3) "whether the provision in question was intend[ed] to

benefit the putative plaintiff." *Id.* at 106 (internal citations omitted).

Once it concluded that a federal right was at issue, the Court also held (a la *Wright*) that Congress had not "specifically foreclosed a remedy under § 1983 . . . by providing a comprehensive enforcement mechanis[m] for protection of a federal right." *Id.* (internal citations omitted). The Court further explained that "[t]he availability of administrative mechanisms to protect the plaintiff's interests is not necessarily sufficient to demonstrate that Congress intended to foreclose a § 1983 remedy." *Id.* The question, rather, is whether the statutory framework is such that "[a]llowing a plaintiff to bring a § 1983 action would be inconsistent with Congress' carefully tailored scheme." *Id.* at 107 (internal quotations omitted).

Then, in *Wilder v. Virginia Hospital Ass'n*, the Court considered whether the now-repealed Boren Amendment to the Medicaid Act was enforceable through private action under Section 1983. 496 U.S. 498, 501–02 (1990). The Court applied the same three-part test from *Golden State Transit*: (1) "whether the provision in question was intend[ed] to benefit the putative plaintiff;" (2) whether it reflects "a binding obligation on the governmental unit;" and (3) whether it "is too vague or amorphous such that it is beyond the competence of the judiciary to enforce." *Id.* at 509 (internal citations omitted); *see also Bless-*

ing v. Freestone, 520 U.S. 329, 340–41 (1997) (restating the three-part test from *Wilder*). Applying this test, the Court held that a private-right-of-action did exist. *Wilder*, 496 U.S. at 509–10.

2. *Wilder*, however, represents the high water mark of the era where the Court freely found federal statutes to be privately enforceable via Section 1983.

First, in *Alexander v. Sandoval*, the Court held that Title VI of the Civil Rights Act did not "create a freestanding private right of action." 532 U.S. 275, 293 (2001). Rather than requiring defendants to show that Congress had specifically foreclosed private enforcement, as in *Wright* and *Golden State*, the Court required plaintiffs to show that Congress intended "to create not just a private right but also a private remedy." *Id.* at 286. While *Alexander* was not a Section 1983 case, the Court's more restrictive approach to private enforceability of federal statutes took hold.

In particular, the very next year, in *Gonzaga University v. Doe*, 536 U.S. 273, 283–84 (2002), the Court, relying on *Alexander*, cast aside the three-part test used in *Wilder* as it considered "whether a student may sue a private university for damages under [Section 1983] to enforce provisions of the Family Educational Rights and Privacy Act." *Id.* at 276. The Court "reject[ed] the notion that our cases permit anything short of an unambiguously conferred right to support a cause of action brought under § 1983." *Id.* at 283.

Alluding to *Golden State* and *Wilder*, it then explained that "we fail to see how relations between the branches are served by having courts apply a multifactor balancing test to pick and choose which federal requirements may be enforced by § 1983 and which may not." *Id.* at 286. Because FERPA did not unambiguously confer an individual right, the Court held that it could not be privately enforced under Section 1983. *Id.* at 290.

3. Yet even in the wake of *Gonzaga*, some circuits have continued to apply *Wilder* to permit private enforcement of various provisions of Medicaid using Section 1983.

In particular, after *Gonzaga* and before the Court's decision in *Armstrong v. Exceptional Child Center, Inc.*, 135 S. Ct. 1378 (2015), three circuits held that the Medicaid provider-choice provision affords a private right of action to Medicaid recipients under Section 1983. *See Planned Parenthood of Ariz. Inc. v. Betlach*, 727 F.3d 960, 966–68 (9th Cir. 2013); *Planned Parenthood of Ind., Inc. v. Comm'r of Ind. State Dep't of Health*, 699 F.3d 962, 972–74 (7th Cir. 2012); *Harris v. Olszewski*, 442 F.3d 456, 461–62 (6th Cir. 2006). Critically, the Sixth and Seventh Circuits relied substantially on *Wilder* because it addressed enforcement of Medicaid and was not directly overruled by *Gonzaga. See Planned Parenthood of Ind.*, 699 F.3d at 975–76; *Harris*, 442 F.3d at 461, 463.

Once those decisions came down, the State of Arizona conceded the issue in *Betlach*. 727 F.3d at 966.

4. But in 2015, the Court decided *Armstrong*, where it held that healthcare providers do not have a private right of action under the Supremacy Clause to challenge a State's failure to amend its Medicaid reimbursement rates. 135 S. Ct. at 1387–88. It explained that "the sole remedy Congress provided for a State's failure to comply with Medicaid's requirements . . . is the withholding of Medicaid funds by the Secretary of Health and Human Services." *Id.* at 1385. The Court expressly recognized that the provision at issue in *Armstrong* was "parallel" to that interpreted by *Wilder*, yet the Court declined to follow *Wilder*'s lead. *Id.* at 1386–87. Instead, the Court applied the more stringent standard of *Gonzaga* to hold that no individual rights were "unambiguously conferred." *Id.* at 1387–88. And while *Armstrong* dealt with a Supremacy Clause claim rather than a Section 1983 claim, the Court made the critical observation that, in all likelihood, the plaintiffs had not asserted a § 1983 action precisely because "our later opinions plainly repudiate the ready implication of a § 1983 action that *Wilder* exemplified." *Id.* at 1386. That passage obviously undercuts the holdings of the Sixth and Seventh Circuits in *Harris* and *Planned Parenthood of Ind.*, which, again, relied on *Wilder* rather than *Gonzaga*.

Since *Armstrong*, three more circuits have divided—indeed have demonstrated outright confusion—over whether Section 1983 affords a private-right-of-action to Medicaid recipients to enforce the Medicaid provider-choice provision. To begin, the Fifth Circuit in *Planned Parenthood of Gulf Coast, Inc. v. Gee* (*Gee I*), 837 F.3d 477 (5th Cir. 2016), held that such a right-of-action exists, only to withdraw its opinion nine months later when one judge changed her position, *Planned Parenthood of Gulf Coast, Inc. v. Gee* (*Gee II*), 862 F.3d 445 (5th Cir. 2017). Then, after the Eighth Circuit concluded that no private-right-of-action under the provider-choice provision exists for Medicaid recipients in *Does v. Gillespie*, 867 F.3d 1034 (8th Cir. 2017), the Fifth Circuit denied rehearing en banc for *Gee* in a sharply divided 7–7 vote. *Planned Parenthood of Gulf Coast, Inc. v. Gee* (*Gee III*), 876 F.3d 699 (5th Cir. 2017). A Petition for Writ of Certiorari is likely to be filed in *Gee*, as well.

When the Eighth Circuit in *Does* ruled that the Medicaid provider-choice provision is not privately enforceable, it justified its split from other circuits on the grounds of "evolution in the law," namely with reference to "the now-repudiated *Wilder* decision." 867 F.3d at 1043. In *Gonzaga* and *Armstrong*, the Eighth Circuit said, "the Court '*sub silentio* overrule[d] cases such as . . . *Wilder*,' because the Boren Amendment did not 'clear[ly] and unambiguous[ly] intend *enforceability under § 1983*.'" *Id.* at 1040 (quoting *Gonzaga*, 536 U.S. at 300 n.8 (Stevens, J., dissenting)). The

court concluded that "for purposes of our obligation to apply Supreme Court precedent . . . the Court's 'repudiation' of Wilder is the functional equivalent of 'overruling.'" *Id.* at 1040 (internal citation omitted).

Even so, in this case the Tenth Circuit—expressly recognizing its split from the Eighth—aligned with the Fifth, Sixth, Seventh, and Ninth Circuits, ruling that the provider-choice provision is privately enforceable. *Planned Parenthood of Kan. & Mid-Mo. v. Andersen*, 882 F.3d 1205 (10th Cir. 2018). Like those other circuits, the Tenth relied heavily on *Wilder*, concluding that it was still binding because *Armstrong* was a plurality decision. *Id.* at 1229.

5. Underscoring the need for Supreme Court review, the Circuits are also divided over private enforcement of the Medicaid Act more generally.

As with the provider-choice provision, most circuits, even after *Armstrong*, continue to rely on *Wilder* to justify private enforcement of various Medicaid provisions by way of Section 1983. Especially illustrative is *BT Bourbonnais Care, LLC v. Norwood*, 866 F.3d 815, 820–21 (7th Cir. 2017), which held that Section 1396a(a)(13)(A) is privately enforceable via Section 1983. While recognizing that *Wilder* "addressed a version of the statute that is now history," the Seventh Circuit also commented that "the Supreme Court has never overruled its decision in *Wilder*." *Id.*

Other examples include: *Bryson v. Shumway*, 308 F.3d 79, 88–89 (1st Cir. 2002) (citing *Wilder* to establish private enforceability of Section 1396a(a)(8) under Section 1983); *Rabin v. Wilson-Coker*, 362 F.3d 190, 202 (2d Cir. 2004) (finding private right of action under Section 1396r-6); *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 192 (3d Cir. 2004) (holding that Medicaid Act sections 1396a(a)(8), 1396a(a)(10) and 1396d(a)(15) are privately enforceable because "the Court has refrained from overruling *Wright* and *Wilder*, which upheld the exercise of individual rights under statutes that contain similar (or, in the case of *Wilder,* identical) provisions to 42 U.S.C. § 1396."); *Doe v. Kidd*, 501 F.3d 348, 356 (4th Cir. 2007) (citing *Wilder* to permit private enforcement of Section 1396a(a)(8) because the "Medicaid Act does not explicitly forbid recourse to § 1983."); *Legacy Cmty. Health Servs., Inc. v. Smith*, 881 F.3d 358, 372 (5th Cir. 2018) (deciding the *Armstrong* plurality did not overrule *Wilder,* making Section 1396a(bb) privately enforceable).[2]

Yet, as with the Eighth Circuit in *Does v. Gillespie*, 867 F.3d 1034, 1040 (8th Cir. 2017), the Eleventh Circuit has treated *Wilder* as supplanted by *Gonzaga*. In *Martes v. Chief Executive Officer of South Broward Hospital District*, 683 F.3d 1323 (11th Cir. 2012), the

---

[2] Relatedly, in *Briggs v. Bremby*, 792 F.3d 239, 244 (2d Cir. 2015), the court permitted private enforcement of the Food Stamp Act under Section 1983 by analogizing it to the Medicaid Act and concluding that *Gonzaga* did not undercut *Wilder*.

court did not cite *Wilder* but instead employed *Gonzaga*'s "unambiguously conferred right" test and held that Section 1396a(a)(25)(C) does not confer such rights because it "is formulated as a requirement of a Medicaid State plan as it relates to third party liability for payment of Medicaid patients' medical expenses." *Id.* at 1326, 1328–30.

That happens to be the correct (because literal) reading of Section 1396a(a), and yet also the reading expressly rejected by so many other circuits. *See Planned Parenthood of Kan. v. Andersen*, 882 F.3d 1205, 1228–29 (10th Cir. 2018); *Planned Parenthood of Gulf Coast, Inc. v. Gee* (*Gee II*), 862 F.3d 445, 461–62 (5th Cir. 2017); *Planned Parenthood of Arizona, Inc. v. Betlach*, 727 F.3d 960, 966–67 (9th Cir. 2013); *Planned Parenthood of Ind., Inc. v. Comm'r of Ind. State Dept. of Health*, 699 F.3d 962, 974–75 (7th Cir. 2012); *Harris v. Olszewski*, 442 F.3d 456, 462–63 (6th Cir. 2006).

Furthermore, the D.C. Court of Appeals also has rejected the vitality of *Wilder*. In *Jones v. District of Columbia*, 996 A.2d 834, 845 (D.C. 2010), the court found no enforceable rights among several sections of the Medicaid Act and rejected plaintiffs' reliance on *Wilder* because "the Court's *Gonzaga* decision in 2002 was a game-changer for § 1983 suits."

To add to the confusion, even when they accept the general proposition that at least some Medicaid plan

requirements might be enforceable, lower courts routinely disagree as to which ones are. Cases listed in an Appendix to this brief demonstrate both the frequency with which such private Medicaid Act claims arise and the need for guidance in addressing them.

***

As the multiple divergent circuit decisions demonstrate, the Court's intervention with respect to private Medicaid Act enforcement is necessary. It should take this case to confirm its repudiation of *Wilder* by holding that the Medicaid Act—or at the very least its plan requirements provision—is not privately enforceable under Section 1983.

II. Medicaid Act Plan Requirements Govern State-HHS Agreements Without Conferring Individually Enforceable Rights

Selective private enforcement of Medicaid plan requirements through Section 1983 is particularly troublesome because, without the *Wilder* decision as an overlay, no portion of 42 U.S.C. section 1396a(a) can reasonably be read to confer individual rights. The Medicaid Act is not a civil rights statute imposing duties and restraints on States with respect to healthcare financing. Rather, it creates a program that States may elect to use to finance their own healthcare benefits for the poor and disabled. Under the Medicaid model, States may establish healthcare

benefits programs and, if their programs are satisfactory to the Secretary of Health and Human Services, seek federal matching grants.

In particular, Section 1396a(a) establishes conditions under which States may qualify to receive federal funding and begins as follows: "A State plan for medical assistance must . . . ." 42 U.S.C § 1396a(a). Each subsection then delineates requirements and prohibitions (with varying degrees of specificity) for State plans to qualify for federal matching grants. In context, these provisions say nothing about individual rights, even if some may incidentally yield individually recognizable benefits.

The Medicaid Act provides discretion for States in designing and administering their programs within broad federal guidelines. A few baseline requirements exist, such as providing coverage to "categorically needy" groups for certain basic services. *See* Barbara S. Klees, Christian J. Wolfe & Catherine A. Curtis, Ctrs. for Medicare & Medicaid Servs., *Brief Summaries of Medicare & Medicaid: Title XVIII & Title XIX of The Social Securities Act* 23–27 (Nov. 20, 2017), *available at* https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/MedicareMedicaidSummaries2017.pdf. In virtually all other matters, however, States can choose the most suitable options. They can, for example, establish eligibility standards, opt to provide coverage for other medical

services, define the amount, duration, and scope of services, and determine the payment methodology and payment rate for services. *Id.* at 23–30. The Secretary determines whether the State has met the requirements of the Act and, if not, whether to dock some or all of a non-conforming State's funding. *See* 42 U.S.C. § 1396c; 42 C.F.R. § 430.12(c).

Thus, by its terms, the Medicaid Act imposes legal obligations only on the Secretary, who must ensure that States substantially comply with plan requirements before approving federal matching grants. *See* 42 U.S.C. § 1396c. If the Secretary finds that a state plan "has been so changed that it no longer complies" with the requirements of Section 1396a or that "in the administration of the plan there is a failure to comply substantially with any such provision[,]" then the Secretary "shall notify [the] State [] that further payments will not be made to the State." *Id.* Payments will be discontinued "until the Secretary is satisfied that there will no longer be any such failure to comply." *Id.* Or, rather than cutting off payments completely, the Secretary may, in her discretion, "limit payments to categories under or parts of the State plan not affected by [the] failure [to comply]." *Id.*

Critically, States are in no way obligated to implement a Medicaid program in accordance with the conditions required for federal funding. *See, e.g.*, *Harris v. McRae*, 448 U.S. 297, 301 (1980) ("participation in the Medicaid program is entirely optional"). States

participating in Medicaid remain free to amend their programs, even if that means the Secretary will deny federal funding as a consequence. *See* 42 U.S.C. § 1396c; 42 C.F.R. § 430.12(c). Even after a state accepts federal funds, Section 1396c recognizes that state's continuing prerogative to alter its Medicaid program. Any State that administers a non-compliant program runs the risk that the Secretary will turn off the funding spigot, but this remains a *lawful* option for the State under the statute. "[T]he *sole remedy* Congress provided for a State's failure to comply with Medicaid's requirements—for the State's 'breach' of the Spending Clause contract—is the withholding of Medicaid funds by the Secretary of Health and Human Services." *Armstrong*, 135 S. Ct. at 1385 (emphasis added).

Moreover, allowing a private cause of action to enforce the Medicaid provider-choice provision would disregard the administrative process that Congress envisioned as Medicaid's primary enforcement mechanism. As the Eighth Circuit recognized in *Does*, federal lawsuits under Section 1983 "would result in a curious system for review of a State's determination that a Medicaid provider is not 'qualified.'" 867 F.3d at 1041. The Medicaid Act "requires that when a state terminates a Medicaid provider, the state must afford the provider an opportunity for administrative appeal and judicial review in the state courts." *Id.* If "individual patients separately could litigate or relitigate the

qualifications of the provider in federal court," the inevitable result will be "parallel litigation and inconsistent results." *Id.* at 1041–42.

Allowing a private right of action under the provider-choice provision for Medicaid recipients would frustrate both the federal-state contract that the Medicaid Act creates and the Congressionally-intended enforcement mechanism of state administrative review processes.

III. The Meaning of "Qualified Provider" Is a Function of the State Medicaid Plan Approved by HHS, Not Simply the Medicaid Act

The decision below illustrates one of the significant structural risks—namely, erosion of political accountability for enforcing the terms of federal-state grant programs—that can arise when private parties bring actions in federal court to enforce their view of the meaning of federal law without an accompanying federal right at stake.

To determine the meaning of "qualified provider" under the Medicaid Act, it is necessary to look not only at the Act itself, but also at the contract that it sets up between states and the federal government. The Medicaid Act provides that "any individual eligible for medical assistance . . . may obtain such assistance from any institution . . . *qualified* to perform the

service or services required." 42 U.S.C. § 1396a(a)(23) (emphasis added). The Act does not define "qualified." However, federal regulations provide that "a State may exclude any individual or entity from participation in the Medicaid program for any reason for which the Secretary could exclude the individual or entity from participation" or "for any reason . . . authorized by state law." 42 C.F.R. § 1002.3 (implementing 42 U.S.C. § 1396a(p)(1)). Thus, the definition of a "qualified" healthcare provider must be governed in reference to the State Medicaid plan, which in turn is governed by State and federal statutes and regulations.

The Kansas Administrative Regulations provide a list of reasons for terminating a provider's Medicaid agreement, including, but not limited to, voluntary withdrawal, non-compliance with state law or its Medicaid provider agreement, and unethical or unprofessional conduct. Kan. Admin. Regs. § 30-5-60(a). Similarly, federal law authorizes exclusion "for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity," 42 U.S.C. § 1320a-7(b)(5)(B), and for "fail[ing] to grant immediate access . . . [to] the State agency, to perform the reviews and surveys required under State plans." 42 U.S.C. § 1320a-7(b)(12). Kansas's Medicaid plan, which has been approved by the Secretary of Health and Human Services, sets forth these reasons for terminating a provider's Medicaid agreement. *See* Kan. Admin. Regs. § 30-5-60(a).

Indeed, when it terminated Planned Parenthood's provider agreement, Kansas invoked four paragraphs from its regulations: "(2) noncompliance with applicable state laws, administrative regulations, or program issuances concerning medical providers; (3) noncompliance with the terms of a provider agreement; (9) unethical or unprofessional conduct; and (17) other good cause." Kan. Admin. Regs. § 30-5-60(a).

In terms of contesting application of the Kansas plan to its situation, Planned Parenthood should have pursued state administrative and judicial review remedies. Kan. Stat. §§ 77-601–31; Kan. Admin. Regs. §§ 30-7-67–68. But in terms of whether Kansas's Medicaid plan itself violates the terms of the Medicaid Act, it is the responsibility of the federal government to make that determination in the first instance, since, after all, it is federal money that is at stake. *See* 42 U.S.C. § 1396a(b).

The Tenth Circuit purported to accept the Kansas regulations as valid determiners of a healthcare provider's qualification to receive Medicaid funding, yet disregarded Kansas's application of those standards. *See Andersen*, 882 F.3d at 1230–31. That decision interferes with the comprehensive planning and review system embodied by federal and State Medicaid statutes, regulations, and plan documents. Ultimately, it vitiates the political accountability that safeguards proper administration of Medicaid. Such structural

risks are a consequence of permitting private plaintiffs to enforce federal statutes that do not confer federal rights.

The Court should grant certiorari and reverse.

CONCLUSION

The Petition for Writ of Certiorari should be granted.

Respectfully submitted,

Office of the Indiana
Attorney General
IGC South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
(317) 232-6255
Tom.Fisher@atg.in.gov

Counsel for Amici *States*

CURTIS T. HILL, JR.
Attorney General
THOMAS M. FISHER*
Solicitor General
LARA LANGENECKERT
JULIA C. PAYNE
KIAN HUDSON
Deputy Attorneys
General

**Counsel of Record*

Dated: April 23, 2018

ADDITIONAL COUNSEL

CHRISTOPHER M. CARR
Attorney General
State of Georgia

ALAN WILSON
Attorney General
State of South Carolina

LAWRENCE G. WASDEN
Attorney General
State of Idaho

MARTY J. Jackley
Attorney General
State of South Dakota

JEFF LANDRY
Attorney General
State of Louisiana

KEN PAXTON
Attorney General
State of Texas

BILL SCHUETTE
Attorney General
State of Michigan

SEAN D. REYES
Attorney General
State of Utah

DOUG PETERSON
Attorney General
State of Nebraska

PATRICK MORRISEY
Attorney General
State of West Virginia

MICHAEL DEWINE
Attorney General
State of Ohio

BRAD SCHIMEL
Attorney General
State of Wisconsin

MIKE HUNTER
Attorney General
State of Oklahoma

PETER K. MICHAEL
Attorney General
State of Wyoming

Counsel for Amici *States*