IN THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

PLANNED PARENTHOOD ARKANSAS & EASTERN OKLAHOMA, d/b/a Planned Parenthood of the Heartland, et al. **APPELLEES**

v. **No. 15-3271**

JOHN SELIG **APPELLANT**

ON INTERLOCUTORY APPEAL FROM
THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF ARKANSAS
WESTERN DIVISION

No. 4:15-CV-566 KGB

THE HONORABLE KRISTINE G. BAKER
UNITED STATES DISTRICT JUDGE

APPELLANT'S BRIEF

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SUMMARY OF THE CASE

This is an interlocutory appeal of a preliminary injunction entered against the Arkansas Department of Human Services ("DHS") in a Medicaid Act case. DHS determined that Planned Parenthood's practices related to obtaining and selling fetal body parts were unethical and violated professionally recognized standards of healthcare. The Medicaid Act allows a state to exclude a provider from the Medicaid program for these reasons, *see e.g.*, 42 U.S.C. §§ 1396a(p)(1), 1320a-7(b)(6)(B), and so DHS terminated Planned Parenthood's Medicaid provider agreements. Planned Parenthood chose not to administratively challenge DHS's decision. Instead, it recruited three patients to file suit to enforce 42 U.S.C. § 1396a(a)(23). But this sub-section of the Medicaid Act does not authorize a private suit to attack a state's decision to exclude a provider from the Medicaid program for misconduct. The preliminary injunction, which prohibits DHS from suspending Medicaid payments to Planned Parenthood for services rendered to the three patients, was predicated on a misreading of § 1396a(a)(23) and a misunderstanding of the Medicaid program. This Court should reverse the District Court's decision and vacate the preliminary injunction.

Thirty minutes for argument are necessary because the Medicaid statutes are complex, new Supreme Court precedent is applicable, and the legal issues have significant separation of powers and cooperative federalism implications.

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JURISDICTIONAL STATEMENT

Planned Parenthood and the three patient plaintiffs it recruited asserted three causes of action under 42 U.S.C. § 1983—two constitutional claims and one statutory claim. ECF 1, at p. 1, 13. Plaintiffs moved for a preliminary injunction solely on their statutory claim that DHS violated 42 U.S.C. § 1396a(a)(23), which requires that state Medicaid plans include a provision stating that eligible patients may obtain assistance from any person or entity qualified to provide the service. APX 10. The District Court had subject-matter jurisdiction over this case pursuant to 28 U.S.C. § 1331.[1]

The District Court denied Planned Parenthood's motion for a preliminary injunction—relief that would have required DHS to resume reimbursing Planned Parenthood for *all* covered claims under the state Medicaid program—under the theory that Planned Parenthood did not have standing. Add. 52-53. But the lower court granted a preliminary injunction to the three patient plaintiffs recruited by Planned Parenthood. Add. 53-54, 68. The injunction requires that DHS provide Medicaid reimbursement to Planned Parenthood for services provided to the three patient plaintiffs (but not to anyone else) until this litigation is resolved. Add. 68.

The District Court's Order granting a preliminary injunction was first filed on October 2, 2015, with an amended Order (simply correcting typographical

[1] DHS argued below and argues on appeal that the plaintiffs do not have a private right of action (and thus lack standing) to pursue this statutory claim.

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errors) filed on October 5, 2015. *See* APX 897; *see also* Add. 38 at n.1. DHS filed a notice of appeal on October 5, 2015. *See* APX 959. (The plaintiffs did not cross-appeal.) The Court of Appeals has jurisdiction over this appeal pursuant to 28 U.S.C. § 1292(a)(1).

STATEMENT OF ISSUES

1. **Did Congress, in 42 U.S.C. § 1396a(a)(23), clearly and unambiguously authorize a private right of action for Medicaid patients to collaterally challenge a state agency determination that a particular provider is not qualified to be part of the Medicaid program?**

   Armstrong v. Exceptional Child Center, Inc., 135 S.Ct. 1378 (2015); *Gonzaga University v. Doe*, 536 U.S. 273 (2002); *Blessing v. Freestone*, 520 U.S. 329 (1997); *O'Bannon v. Town Court Nursing Center*, 447 U.S. 773 (1980); 42 U.S.C. § 1396a(a); 42 U.S.C. § 1396a(b); 42 U.S.C. § 1396a(p)(1); 42 U.S.C. § 1396c; 42 U.S.C. § 1320a-7(b)(6)(B); 42 C.F.R. § 1002.213; 42 C.F.R. § 431.51(c); Ark. Admin. Code § 016.06.35-154.000; Ark. Admin. Code § 016.06.35-151.000(B); Ark. Admin. Code § 016.06.35-161.400; Ark. Code Ann. § 20-77-1718.

2. **Is a Medicaid patient's § 1396a(a)(23) challenge likely to succeed where the provider chose not to administratively appeal its disqualification from the Medicaid program?**

   See cases, statutes, and regulations cited for Issue 1.

3. **Do the harms identified by the patient plaintiffs—such as waiting 15 to 30 minutes longer for their appointments at other Medicaid providers—**

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satisfy the irreparable harm requirement for granting a preliminary injunction?

Winter v. Natural Def. Council, Inc., 555 U.S. 7, 20 (2008); *Roudachevski v. All-Am. Care Ctrs., Inc.*, 648 F.3d 701, 706 (8th Cir. 2011); *Dataphase Systems, Inc. v. C L Systems, Inc.*, 640 F.3d 109 (8th Cir. 1981).

4. In light of the foregoing, did the District Court commit reversible error in granting the preliminary injunction?

See cases and statutes cited above.

STATEMENT OF THE CASE

In the summer of 2015, a series of undercover videos exposed agents of Planned Parenthood engaging in conduct that—at the very least—violated norms of medical ethics, and may well have violated federal law. Among other things, the videos show agents of Planned Parenthood (1) conjuring up and haggling over arbitrary prices (in excess of costs) for aborted human fetal tissue and body parts and (2) discussing changes to normal abortion procedures to obtain intact fetal parts that fetch higher prices.[2]

In August 2015, DHS determined that Planned Parenthood's practices were unethical and did not conform to professionally recognized standards for

[2] A brief overview of the type of conduct shown in the videos is provided at APX 115-17. The videos themselves are attached to the back cover of Volume 1 of the DHS's Appendix, and transcripts of the videos are provided at APX 141, 167, and 286.

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healthcare and, therefore, Planned Parenthood was no longer qualified to be a Medicaid provider. Accordingly, DHS decided to terminate the Medicaid provider agreements it had with Planned Parenthood. *See* 42 U.S.C. § 1396a(p)(1) *and* 42 U.S.C. § 1320a-7(b)(6)(B) (grounds for exclusion from Medicaid program include failing "to meet professionally recognized standards of health care"); Ark. Admin. Code § 016.06.35-151.000(B) (same).

DHS notified Planned Parenthood of its decision to terminate the Medicaid provider contracts on August 14, 2015, and again on September 1, 2015.[3] DHS informed Planned Parenthood in both letters that the termination would be effective September 14, 2015, and that Planned Parenthood had a right to seek an administrative appeal. *See* Add. 1-3. DHS explained how Planned Parenthood could appeal the termination, and DHS specifically invited Planned Parenthood to "submit information or offer any comments on the nationally recognized videos

[3] The August 14, 2015 notice was issued pursuant to Section III.A of the Medicaid agreements, which provided that the agreements could be "voluntarily terminated by either party giving thirty (30) days written notice to the other party." APX 85, 115, and 123. Planned Parenthood has conceded that it understood the termination was being made because of Planned Parenthood conduct exposed in the aforementioned videos. *See* APX 30-31 and 67-68. The September 1, 2015 notice added a for-cause termination under Section III.C of the agreements, which allows termination to sanction a provider. This second notice explained that DHS was terminating the agreements "based in part upon the troubling circumstances and activities that have recently come to light regarding [Planned Parenthood . . . .]." Add. 2. DHS explained it was exercising this authority because "there is evidence that" Planned Parenthood was "acting in an unethical manner and engaging in what appears to be wrongful conduct." *Id.*

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that have raised questions on the conduct of Planned Parenthood." Add. 2. DHS even provided "specific questions" to which answers would "be helpful in the event Planned Parenthood determine[d] that an appeal [was] necessary to this determination." Add. 2.

Planned Parenthood chose not to seek an administrative appeal of the DHS determination that Planned Parenthood was no longer qualified to be part of the Medicaid program. Accordingly, DHS's findings and determination are final and binding. *See* Ark. Admin. Code § 016.06.35-154.000 ("[U]nless a timely and complete request for administrative reconsideration or appeal is received by the [DHS], the findings of [DHS] as set forth in the notice shall be considered a final and binding administrative determination.").

To side-step the state administrative appeals process, Planned Parenthood—by its own admission—recruited three patients to sue DHS in federal court. *See* APX. 439. On September 11, 2015, the plaintiffs moved for a temporary restraining order and preliminary injunction on a single claim—namely, that DHS's termination of Planned Parenthood as a Medicaid provider violated an obscure provision of the Medicaid Act, 42 U.S.C. § 1396a(a)(23).[4]

[4] In relevant part, 42 U.S.C. § 1396a(a)(23) requires a state Medicaid plan to "provide that . . . any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person *qualified* to perform the service or services required . . . who undertakes to

I. The Medicaid Program

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

A. States' Power to Set Qualifications and Exclude Unqualified Providers

The Medicaid Act gives states significant flexibility in determining which providers are qualified to participate in the program. Congress has set forth numerous reasons that a state agency either must or may exclude a provider as disqualified. 42 U.S.C. § 1396a(p)(1) provides that, "[i]n addition to any other authority, a State may exclude any individual or entity for purposes of participating under the State plan under this subchapter for any reason for which the Secretary [of the federal Department of Health and Human Services] could exclude the

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provide him [or her] such services." *See* 42 U.S.C. § 1396a(a)(23) (emphasis added).

individual or entity from participation in a program under subchapter XVIII of this chapter under section 1320a–7, 1320a–7a, or 1395cc(b)(2) of this title." The cross-referenced statutes provide a complex and intricate web of over 50 reasons for the Secretary or a state agency to exclude an entity from the qualified Medicaid provider pool.[5] While some of the listed reasons do not involve discretion (*e.g.*, mandatory exclusion for a felony conviction relating to controlled substances), many listed reasons require the Secretary or a state agency to call on their expertise and experience in the Medicaid field to make technical and judgment-laden decisions regarding disqualification from the program. *See, e.g.*, 42 U.S.C. § 1320a-7(b)(6)(B) (requiring a judgment-laden and technical decision to define and apply the phrase "substantially in excess of a patient's needs" and to determine what conduct "fails to meet professionally recognized standards or health care").

Aside from what is expressly listed in federal law, wide latitude is afforded to states to set their own additional qualification standards and exclude Medicaid providers based on criminal, unethical or improper conduct. *See, e.g.*, 42 C.F.R. § 431.51(c)(2) (permitting states to establish and enforce their own "reasonable

[5] This is a good faith, conservative estimate of the separate number of reasons identified in these incredibly detailed statutes for termination from the Medicaid Program.

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

Both federal and state law give providers an opportunity to challenge a state's termination decision. 42 C.F.R. § 1002.213, for example, requires a state to give terminated providers "the opportunity to submit documents and written argument" and "any additional appeals rights that would otherwise be available under procedures established by the state." Arkansas regulations give terminated providers an opportunity to administratively appeal within 30 calendar days of receipt of the termination decision. Ark. Admin. Code § 016.06.35-161.400. And,

[6] DHS has promulgated a manual that sets forth possible sanctions (including termination) and the reasons for imposing them. *See* Ark. Admin. Code § 016.06.35-151.000 *et seq*.

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with exceptions not applicable here, terminated providers can appeal an administrative decision to the state's courts. Ark. Code Ann. § 20-77-1718.

B. Federal Oversight and Enforcement of the Medicaid Act

Congress has delegated the authority to regulate this complex program to the federal Department of Health and Human Services' Center for Medicare and Medicaid Services ("CMS"). CMS, on behalf of the Secretary of Health and Human Services, oversees the state agency administration of the program. To carry out his oversight responsibility, Congress gave the Secretary the power of the purse.

In the federal Medicaid Act, Congress set forth a long and complex list of items—in 81 subsections[7]—that must be written into a state Medicaid plan for the Secretary to approve the plan and start providing federal funds. *See* 42 U.S.C. § 1396a(a); 42 U.S.C. § 1396a(b) ("The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) of this section . . . ."). If a State chooses to participate in the Medicaid program, and its plan meets the requirements of 42 U.S.C. § 1396a(a), the federal government provides the State a very large share of the funds required for the program. In exchange for these funds, the state submits to federal oversight of its program. And the Secretary is

[7] 42 U.S.C. § 1396a(a)(1) is one of the 81 subsections.

charged with ensuring that states substantially comply with their plan. 42 U.S.C. § 1396c.

Implementation of the program requires technical, experience-based, and judgment-laden agency decisions at both the state and federal levels. The mechanism Congress gave to the Secretary to oversee state implementation of a Medicaid plan relies on—indeed forces—consultation and coordination between federal and state agency experts. 42 U.S.C. § 1396c authorizes the Secretary to withhold all or part of a State's federal Medicaid funding if he finds that "the plan has been so changed that it no longer complies with the provisions of section 1396a" or that "in the administration of the plan there is a failure to comply substantially with any such provision." *Id*. (allowing the Secretary to discontinue payments "until [he] is satisfied that there will no longer be any such failure to comply"). However, before withholding any funds, the Secretary must provide the state agency "reasonable notice and opportunity for hearing." And the Secretary may in his discretion waive any non-compliance. *See* 42 U.S.C. § 1396n(b)(4). This enforcement mechanism delicately balances the need for ultimate federal authority with the desire for consultation, coordination, and cooperation between federal and state agencies.

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II. Relevant Procedural History

The plaintiffs filed their complaint and motion for a temporary restraining order and preliminary injunction on September 11, 2015. APX 10.[8] DHS filed an initial response to the motion on September 15, 2015. The Court conducted a hearing—consisting solely of legal argument—on September 17, 2015. *See* APX 459. On September 18, the Court issued a two-week temporary restraining order, pending resolution of the preliminary injunction motion. Add. 23. The temporary restraining order required DHS to continue reimbursing Planned Parenthood for Medicaid services. *Id*.

In its Order, the District Court made clear that, although the September 17 hearing was "an adversarial rather than *ex parte* hearing on the motion, it was not the sort of adversarial hearing that included presentation of evidence beyond the affidavits and exhibits filed with [the] motion and [DHS's] response so as to allow the basis of the relief requested to be strongly challenged." Add. 6. Specifically, the Order suggested the need for additional evidence at the preliminary injunction

[8] When they filed their initial complaint and motion on September 11, counsel for the plaintiffs were apparently unaware of the "for cause" termination letter sent to Planned Parenthood on September 1. Accordingly, the initial complaint only focused on the August 14 termination letter under the "at-will" provisions of the Medicaid contracts. The plaintiffs filed an amended complaint and supplemented their motion on September 15, addressing the "for cause" termination letter. *See* APX 51-52 and 66-67.

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phase on whether patient plaintiffs were at risk of irreparable harm from DHS's exclusion of Planned Parenthood from the Medicaid program. *See* Add. 12-13.

To obtain this additional evidence, DHS sought to examine (live or via telephone) the three patient plaintiffs at a preliminary injunction hearing. The District Court prohibited it. Add. 24-35. In lieu of live testimony, DHS sought to depose the three patient plaintiffs. The District Court prohibited that method of examining the plaintiffs, too. Add. 34-36. The only "discovery" allowed to DHS was submission of written questions to the plaintiffs' counsel—to which the three patient plaintiffs would provide written answers a few days later. Add 34.

The parties were afforded the opportunity to submit additional briefing before the Court ruled on the preliminary injunction motion. On September 25, 2015, the plaintiffs filed a reply in support of their preliminary injunction motion. On October 1, 2015, DHS filed a sur-reply. On October 5, 2015, the District Court granted a preliminary injunction to the three patient plaintiffs, but denied it for Planned Parenthood. Add. 52-54; 68. Because the three patient plaintiffs had sued only in their individual capacities, and not as representatives of a class, the District Court limited the scope of the preliminary injunction. Add. 53. The injunction

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requires DHS to reimburse Planned Parenthood for Medicaid services provided to those three patients. Add 53-54; 68.[9]

A. Standing/Private Right of Action

In its preliminary injunction Order, the District Court properly concluded that, before application of the *Dataphase* factors, it needed to determine "which plaintiffs, if any, have standing to bring this suit." Add. 47. The District Court also understood that standing in this litigation is dependent on whether Congress authorized a private right of action under § 1983 to enforce 42 U.S.C. § 1396a(a)(23) and the scope of any such authorization. *See* Add. 47-53.

The District Court held that Planned Parenthood lacked standing. Add. 52-53. The District Court first noted that the plaintiffs abandoned their initial argument that Planned Parenthood had a private right of action to enforce 42 U.S.C. § 1396a(a)(23). Add. 52.[10] The District Court then rejected the new

[9] In its preliminary injunction Order, the Court went out of its way to note that "the time for seeking [class] certification has not passed." Add. 53-54. After this appeal was filed, the plaintiffs moved in the District Court for class certification, a motion that is now *sub judice*. *See* Motion to Certify Class by All Plaintiffs, ECF 50 at p. 1. If the motion is granted, such procedural maneuvering will likely result in Planned Parenthood seeking indirectly the sort of class-wide injunctive relief that it cannot obtain directly under standing principles.

[10] It is not surprising that the plaintiffs abandoned this argument. Although, in its temporary restraining Order, the District Court "did not foreclose the possibility that [Planned Parenthood] might succeed in bringing its own private right of action," Add. 52, the Court subsequently indicated skepticism that § 1396a(a)(23) authorized a private right of action for medical providers. Transcript of Telephone

argument that Planned Parenthood had third-party standing to represent its patients. *See* Add. 52-53 (finding Planned Parenthood did not have third party standing to represent its patients because some of those patients were pursuing their own rights as named plaintiffs).

The District Court concluded, however, that Congress had authorized a private right of action under § 1983 for Medicaid patients to enforce 42 U.S.C. § 1396a(a)(23). Add. 49-52. The District Court defined the right envisioned by 42 U.S.C. § 1396a(a)(23) as "an absolute right to be free from government interference with the choice to [receive services from a provider] that continues to be qualified." Add. 49 (quoting *O'Bannon*, 447 U.S. at 785). Accordingly, the Court cast "[t]he central conflict in this case as whether Arkansas can terminate [Planned Parenthood] as a qualified Medicaid provider for the reasons it articulates in this litigation without violating" 42 U.S.C. § 1396a(a)(23). Add. 60-61.

The District Court found it likely that patient plaintiffs will be able to prove DHS's qualification decision was improper. Add. 59-67. But the District Court admitted to "struggl[ing]" to decide the "significance" of "the fact that [Planned Parenthood] has not availed itself of the administrative appeals process . . . ." Add. 56. Nonetheless, the District Court "decline[d] to find that [Planned Parenthood's]

Conference of Sept. 23, 2015, ECF 67 at p. 35 ("I do have concerns about Planned Parenthood's standing that still linger and, in particular, either direct standing or maybe even third-party standing under the statute.")

decision not to appeal [DHS's] determination foreclose[d]" the patient plaintiffs' claim "at this stage of the litigation." Add. 57.

B. Irreparable Harm and the Other *Dataphase* Factors

The District Court found the patient plaintiffs would likely suffer irreparable harm absent an injunction. Add. 55-59. The District Court cited three "harms" it believed rose to the level of irreparable harm: (1) the patient plaintiffs would be unable to use Planned Parenthood—the provider they want to use; (2) the patient plaintiffs might be subject to longer wait times at another provider; and (3) another provider might have a longer lead time for appointments than Planned Parenthood has. *Id*.

As for the balance-of-harms and public-interest factors, the Court essentially relied on its irreparable harm analysis, finding the harms identified in that analysis to outweigh any potential harm to Arkansas caused by requiring reimbursement to Planned Parenthood for Medicaid services provided to three patients. Add. 67.

SUMMARY OF THE ARGUMENT

Congress has not—in 42 U.S.C. § 1396a(a)(23) or any other provision—clearly and unambiguously authorized a private right of action for Medicaid patients to collaterally challenge a state agency's decision to exclude a provider from the Medicaid program. Because the patient plaintiffs do not have a private

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right of action to pursue their § 1983 claim, and thus lack standing, the preliminary injunction should not have been granted.

In light of the Supreme Court's recent decision in *Armstrong v. Exceptional Child Center, Inc.*, 575 U.S. ___, 135 S.Ct. 1378 (2015), it should be evident that enforcement of 42 U.S.C. § 1396a(a)(23) is the purview of the Secretary of HHS and not subject to a private right of action. 42 U.S.C. § 1396a(a)(23) is a very small part of a larger Congressional scheme that places oversight of a state's Medicaid program—both creation and implementation of the program—in the hands of the Secretary of HHS. Congress specifically entrusted to the Secretary—not private citizens—the responsibility for ensuring the plan language is appropriately written, *see* 42 U.S.C. § 1396a(b), and then appropriately carried out by a state once federal funding begins. *See* 42 U.S.C. § 1396c (authorizing the Secretary to withhold all or some federal funding if a State fails to properly administer the plan that was approved).

Even assuming *arguendo* that § 1396a(a)(23) authorizes a private right of action under § 1983, the scope of such a private right of action would be strictly limited to the actual "right" identified in the statute. 42 U.S.C. § 1396a(a)(23) does not address the federal or state governments' determination of whether a provider is qualified to be part of the Medicaid program. Rather, the statute narrowly focuses on the Medicaid patient's right to freely choose from the pool of

providers that the federal and state governments consider qualified. 42 U.S.C. § 1396a(a)(23) pre-supposes a pool of qualified Medicaid providers, and it asks a state to agree to be neutral between such providers. The provision does not provide a right for Medicaid patients to use an unqualified provider, such as a provider that a state has excluded from the Medicaid program for reasons provided in 42 U.S.C. § 1396a(p)(1). And the provision does not provide a right for patients to collaterally challenge a state or federal agency's decision to exclude the provider for such reasons.

Beyond standing issues, the District Court's grant of a preliminary injunction should be reversed for at least two other reasons. *First*, the patient plaintiffs are unlikely to succeed on the merits of their claim. Planned Parenthood had the opportunity to administratively challenge DHS's decision that its practices were unethical and failed to meet professionally recognized healthcare standards. *See supra at* 9. Planned Parenthood could have even challenged the administrative decision in state court. *Id.* Planned Parenthood intentionally declined to do so. Federal and state Medicaid regulations specifically contemplate that challenges to a state agency's termination decision will be made by the terminated provider—through the state administrative appeals process or in state court. *See*, *e.g.*, 42 C.F.R. § 1002.213 (requiring a state to give terminated providers "the opportunity to submit documents and written argument" and "any additional appeals rights that

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would otherwise be available under procedures established by the state"); Ark. Admin. Code § 016.06.35-161.400 (affording terminated providers an opportunity to administratively appeal within 30 calendar days of receipt of the termination decision); Ark. Code Ann. § 20-77-1718 (allowing terminated providers to appeal an administrative decision to the state's courts).

Accordingly, DHS's qualification decision (and the termination of Planned Parenthood from the Medicaid program in Arkansas) is final and binding. *See* Ark. Admin. Code § 016.06.35-154.000. Moreover, while the Secretary of HHS (through CMS) is aware of DHS's decision and termination of Planned Parenthood, he has not taken any of the steps that 42 U.S.C. § 1396c call for if the Secretary believes Arkansas is not substantially complying with its responsibilities. Especially under these circumstances, the patient plaintiffs are not likely to prevail on a claim that is essentially a collateral attack on a state agency's decision to terminate a provider from its Medicaid program.

Second, the harms identified by the three patient plaintiffs—such as potential longer wait times and potential scheduling issues—are speculative and do not rise to the level of harm identified by this Court as necessary to justify the extraordinary remedy of a preliminary injunction.

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ARGUMENT

I. Standard of Review

A preliminary injunction is an "extraordinary and drastic remedy . . . that should not be granted unless the movant, by a clear showing, carries the burden of persuasion. *Mazerek v. Armstrong*, 520 U.S. 968, 972 (1997) (citation and quotation omitted); *Sanborn Mfg. Co., Inc. v. Campbell/Hausfield Scott Fetzer Co.*, 997 F.2d 484, 485-96 (8th Cir. 1983) (noting the "heavy" burden on movant) (citation omitted). This Court's opinion in *Dataphase Systems, Inc. v. C L Systems, Inc.*, 640 F.3d 109 (8th Cir. 1981), set forth the four factors a Court must evaluate to determine if a movant has carried his high burden to prove a preliminary injunction is warranted: (1) the likelihood of success on the merits, (2) the risk of irreparable harm in the absence of a preliminary injunction, (3) the balance between any irreparable harm and the harm caused by granting an injunction, and (4) the public interest.

This Court "review[s] a district court's ultimate ruling on a preliminary injunction for abuse of discretion," but "review[s] its underlying legal conclusions de novo." *See Barrett v. Claycomb*, 705 F.3d 315, 320 (8th Cir. 2013). A district court abuses its discretion if it "rests its conclusion on . . . erroneous legal conclusions." *Id.* at 320. Moreover, the question of standing in this case—which is antecedent to any evaluation of the *Dataphase* factors—is also subject to de

novo review. *See, e.g., St. Paul Area Chamber of Commerce v. Gaertner*, 439 F.3d 481, 484 (8th Cir. 2006).

II. The Patient Plaintiffs Lack Standing Because 42 U.S.C. § 1396a(a)(23) Does Not Authorize a Private Right of Action Under § 1983 to Collaterally Attack a State Agency's Decision to Exclude a Provider from the Medicaid Program.

The patient plaintiffs seek to use 42 U.S.C. § 1983 to enforce 42 U.S.C. § 1396a(a)(23). The Supreme Court has made clear that, in order to seek redress through § 1983, "a plaintiff must assert a violation of a federal *right*, not merely a violation of federal *law*. *Blessing v. Freestone* 520 U.S. 329, 340 (1997) (citation omitted) (emphasis added). In Spending Clause cases like this one, that standard is very high. The Supreme Court has insisted that "unless Congress speaks with a clear voice, and manifests an unambiguous intent to confer individual rights, federal funding provisions provide no basis for private enforcement." *Gonzaga University v. Doe*, 536 U.S. 273, 280 (2002).

To show the existence of individual federal rights, a plaintiff must show that (1) "Congress . . . intended that the provision in question benefit the plaintiff;" (2) "the right assertedly protected by the statute is not so "vague and amorphous" that its enforcement would strain judicial competence;" and (3) "the statute . . . unambiguously impose[s] a binding obligation on the States." *Blessing*, 520 U.S. at 340. Moreover, the Court has concluded that, even where this test is met, a § 1983 claim does not lie if Congress has—expressly or impliedly—foreclosed a

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private remedy. *Blessing* 520 U.S. at 340 (noting that Congress could impliedly foreclose a private remedy "by creating a comprehensive scheme of enforcement that is incompatible with individual enforcement under § 1983").

A. 42 U.S.C. § 1396a(a)(23) Does Not Support a Private Right of Action Under the Logic of *Armstrong v. Exceptional Child Center, Inc.*

The Supreme Court's most recent jurisprudence has acknowledged its evolution toward "reject[ing] attempts to infer enforceable rights from Spending Clause statutes." *Gonzaga Univ.*, 536 U.S. at 280. The latest and clearest advance in this evolution is the 2015 *Armstrong* decision. *See Armstrong v. Exceptional Child Center, Inc.*, 575 U.S. ___, 135 S.Ct. 1378 (2015).[11] *Armstrong* held that "the Medicaid Act implicitly precludes private enforcement of [§ 1396a(a)(30)(A)[12]], and respondents cannot, by invoking our equitable powers, circumvent Congress's exclusion of private enforcement." *Id*. at 1385. The Court

[11] The first three parts of the *Armstrong* decision represent a majority opinion. The fourth part is a *plurality* opinion. Unless specifically stated otherwise, citations to *Armstrong* are limited to the majority opinion.

[12] 42 U.S.C. § 1396a(a)(30)(A) requires state Medicaid plans to "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title) 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[.]"

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explained that "the 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 . . . ." *Id.* at 1385 ("As we have elsewhere explained, the 'express provision of one method of enforcing a substantive rule suggests that Congress intended to preclude others.") (quoting *Alexander v. Sandoval*, 532 U.S. 275, 290 (2001)).

The basis and logic of the Supreme Court's conclusion concerning § 1396a(a)(30)(A) applies with equal force to § 1306a(a)(23). As detailed above (*see supra* at 8-11), Congress quite intentionally created a comprehensive agency-run system to (1) instruct states on what is required to be in their Medicaid plans, (2) condition approval of a state plan on the Secretary's judgment that the plan complies with federal law and regulations, and (3) allow the Secretary to in his discretion enforce compliance by a state through the power of the purse. The enforcement system Congress created delicately balances federal agency authority with the desire for consultation, coordination, and cooperation between federal and state agencies to administer a highly technical program requiring administrative expertise and judgment. Creation of this system indicates preclusion of a private right of action.

The *Armstrong* Court also held that certain characteristics of the language of § 1396a(a)(30)(A) supported its conclusion that Congress intended to foreclose a

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private right of action. The Court found the language in the subsection "broad[]," not "specific," and creating a "judgment-laden standard." *Id.* The Court concluded that "[e]xplicitly conferring enforcement of this judgment-laden standard upon the Secretary alone establishes, we think, that Congress 'wanted to make the agency remedy that it provided exclusive,' thereby achieving 'the expertise, uniformity, widespread consultation, and resulting administrative guidance that can accompany agency decisionmaking' and 'avoiding the comparative risk of inconsistent interpretations and misincentives that can arise out of an occasional application of the statute in a private action." *Id.* (quoting *Gonzaga Univ.*, 536 U.S. at 292 (Breyer, J., concurring)).

The language of 42 U.S.C. § 1396a(a)(23) warrants a similar conclusion. The provision speaks of providers who are "qualified to perform the service or services required," but it does not define that term. Whether a provider is qualified to perform the service or services required is precisely the type of judgment-laden standard that would—under *Armstrong*—further support a conclusion that Congress wanted to make the agency remedy that it provided exclusive and preclude a private right of action.

A provider may be unqualified for purposes of 42 U.S.C. § 1396a(a)(23) for any number of reasons, including having been excluded from the Medicaid program. As detailed above (*see supra* at 6-7), there is a complex web of federal

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and state statutes and regulations that provide valid reasons for excluding a Medicaid provider from the pool of qualified providers. This includes whether a provider has "failed to meet professionally recognized standards for health care," itself an inherently vague and judgment-laden standard. *See, e.g,* 42 U.S.C. § 1396a(p)(1); 42 U.S.C. § 1320a-7(b)(6)(B); Ark. Admin. Code § 016.06.35-151.000(B). These vague and judgment-laden terms are best enforced by the Secretary (through CMS). The agency-based enforcement system Congress created allows for—indeed requires—the federal agency and state agency to use their technical and experience-based expertise to collaborate on the meaning and application of these vague phrases under the Medicaid Act's cooperative federalism framework. *See supra* at 9-11. And it provides the Secretary discretion concerning collaboration versus enforcement. *Id.*

The District Court dismissed *Armstrong* as irrelevant for three reasons, none of which hold water. Add. 43. The District Court noted that a provider was the only named plaintiff in *Armstrong* while there are patient plaintiffs in this case. But the identity of the plaintiff is completely irrelevant to *Armstrong*'s analysis of whether Congress precluded private enforcement. *Armstrong* was not decided based on the identity of the plaintiff, but rather based on the Court's analysis of the overall Medicaid enforcement scheme created by Congress and the judgment-laden

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standard in the statute at issue. These same factors are present in the instant case and statutory provision.

The District Court also noted that *Armstrong* is not a § 1983 case. That is true, but it misses the point. *Armstrong*'s discussion, logic, and holding against private enforcement of § 1396a(a)(30)(A) *must* significantly inform the § 1983 analysis. That is because both the § 1983 inquiry in the instant case and the private enforcement inquiry conducted in *Armstrong* turn on the application of the same factors. In *Gonzaga University*, the Supreme Court has made clear that the § 1983 inquiry into "whether a statute confers any right at all . . . is no different from the . . . inquiry in an implied right of action case." *Gonzaga Univ.*, 536 U.S. at 284-85 ("A court's role in discerning whether personal rights exist in the § 1983 context, should . . . not differ from its role in discerning whether personal rights exist in the implied right of action context.") (citation omitted).

Moreover, *Armstrong* specifically analyzed whether Congress impliedly precluded private enforcement of 42 U.S.C. § 1396a(a)(30)(A). The instant case requires the same analysis of a different sub-subsection of the exact same funding statute. As discussed above, *see supra* at 22-24, the bases for *Armstrong*'s decision that Congress precluded private enforcement applies with equal force to 42 U.S.C. § 1396a(a)(23).

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If there were any doubt about the applicability of *Armstrong's* analysis to the §1983 context, *Armstrong* itself removes such doubt. The Supreme Court made clear that its conclusion—that Congress precluded private enforcement of 42 U.S.C. § 1396a(a)(30)(A)—also meant that a § 1983 action would not lie. *See Armstrong*, 135 S.Ct. 1386 n. 2 (noting that plaintiffs did not and could not have brought a § 1983 claim to enforce 42 U.S.C. § 1396a(a)(30)(A)).[13]

The District Court's last reason for ignoring *Armstrong* was that the statute at issue in *Armstrong* "includes meaningfully different language from the statutory language at issue here." Add. 49. But *Armstrong* did not create a floor for measuring whether statutory language was vague and judgment-laden enough to indicate preclusion of private enforcement. Rather, it set forth a principle that where Congress has created an agency-enforcement scheme for Spending Clause statutes like Medicaid, provisions that include judgment-laden language are best evaluated by agencies with experience and expertise in the area, and thus private

[13] Although not specifically at issue in this case, the Court should recognize that the *Pediatric Specialty Care, Inc. v. Arkansas Department of Human Services* cases—where this Court found viable a § 1983 suit to enforce 42 U.S.C. § 1396a(a)(30)(A)—is irreconcilable with *Armstrong*. *Pediatric Specialty Care, Inc. v. Arkansas Dep't of Human Servs.*, 443 F.3d 1005, 1008 (8th Cir. 2006); *Pediatric Specialty Care, Inc. v. Arkansas Dep't of Human Servs.*, 293 F.3d 472, 479 (8th Cir. 2002).

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enforcement is not appropriate.[14] The provision at issue in our case is a clear example of this principle, and accordingly no § 1983 private right of action is available.

B. If a Private Right of Action is available under 42 U.S.C. § 1396a(a)(23), it is Not the Private Right of Action the Patient Plaintiffs are Pursuing.

If there is a federal right to be enforced by §1983, it must be strictly limited to the right Congress intended. That proposition follows logically from the fact that a Court will not find a private right of action in a Spending Clause statute unless Congress clearly and unmistakably provided for it. *Gonzaga Univ.*, 536 U.S. at 280. Moreover, the *Blessing* factors focus on what benefit Congress was trying to provide and to whom it was trying to provide that benefit. *See*, *e.g.*, *id.* at 285-86. This confirms that any private enforcement must be strictly limited to the actual right (benefit) Congress created.

42 U.S.C. § 1396a(a)(23) requires a state plan to "provide that . . . any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person qualified to perform the service or services required . . . who undertakes to provide him [or

[14] The District Court made one additional error that highlights its misunderstanding of *Armstrong*. While it analyzed the three initial factors identified in *Blessing*, Add. 50-52, it failed to analyze the remaining issue identified in *Blessing* and highlighted in *Gonzaga University*.: whether Congress expressly or impliedly precluded private enforcement. *See Gonzaga Univ.*, 536 U.S. at 297-98.

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her] such services." *See* 42 U.S.C. § 1396a(a)(23). To properly interpret the provision, it must be read in context of the remainder of 42 U.S.C. § 1396a. *See Brown v. Gardner*, 513 U.S. 115, 118 (1994) ("[T]he meaning of statutory language, plain or not, depends on context.") (citation omitted); *see also Gonzaga Univ.*, ("[W]here the text and structure of a statute provide no indication that Congress intends to create new individual rights, there is no basis for a private suit, whether under § 1983 or under an implied right of action.")

To the extent Congress has provided Medicaid patients with a specific, enforceable benefit in 42 U.S.C. § 1396a(a)(23), that benefit is the ability to choose any provider the patient wants within the pool of qualified Medicaid providers. It is not a right to choose which providers are in the pool of qualified Medicaid providers. 42 U.S.C. § 1396a(a)(23) reflects Congress's intent that state agencies not (1) directly or indirectly steer patients to one or more "favored" Medicaid providers within the overall pool of qualified providers, or (2) create a monopolistic arrangement that forces Medicaid patients to get a certain service from a particular Medicaid provider. *See e.g., Chisholm v. Hood*, 110 F. Supp. 2d 499, 505-07 (E.D. La. 2000) (state may not require that children only receive Medicaid services from local school board) (collecting cases). Congress wanted states to allow Medicaid patients to freely choose from the pool of providers that the federal and state governments consider qualified to be in the Medicaid

program. Thus, the Secretary was given the authority (in 42 U.S.C. § 1396c) to ensure that a state would provide Medicaid benefits to any eligible citizen that used any qualified provider in the Medicaid program. As the Supreme Court explained in *O'Bannon v. Town Court Nursing Center*, 447 U.S. 773 (1980), the provision asks States to give patients the option "to choose among a range of *qualified* providers, without government interference." *Id.* at 785 (emphasis in original).

The provision does not, however, address federal or state decisions regarding which entities are in the qualified provider pool. Those questions are addressed by other intricately crafted parts of 42 U.S.C. § 1396a and the Medicaid program. *See, e.g.*, § 1396a(p)(1) (providing a non-exhaustive list of reasons for exclusion of a provider from the Medicaid program); 42 C.F.R. § 431.51(c)(2) (permitting states to establish and enforce their own "reasonable standards relating to the qualifications of providers"). Indeed, there appears to be a judicial consensus that 42 U.S.C. § 1396a(a)(23) does not require states to allow Medicaid patients to use providers who have been excluded from the Medicaid program under other sub-sections of the Medicaid Act or federal or state regulations permitted by the Medicaid Act. *See O'Bannon*, 447 U.S. at 785 (noting that 42 U.S.C. §1396a(a)(23) does not "confer a right on a recipient to continue to receive benefits for care [from a provider] that has been decertified"). Even the cases most cited by the plaintiffs and relied on by the District Court in its opinion below are clear that

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the choice of providers in § 1396a(a)(23) does not include providers who have been excluded from the Medicaid program by the federal government or a state.[15]

The Supreme Court's *O'Bannon* decision directly addresses the type and scope of benefit (if any) conferred on Medicaid patients by 42 U.S.C. § 1396a(a)(23). The plaintiffs in that case were Medicaid residents of a nursing home that was initially part of the Medicaid program. *See id.* at 776-77. The state de-certified the nursing home, removing it from the Medicaid program, which required the residents on Medicaid to move to a different facility (that was Medicaid certified). *See id.* at 776, 781. The plaintiffs asserted that 42 U.S.C. § 1396a(a)(23) gave them the right to challenge the de-certification decision. *See id.* at 784. The Supreme Court rejected this argument, explaining that 42 U.S.C. § 1396a(a)(23) only allows Medicaid recipients to choose from a pool of qualified healthcare providers, and does not give Medicaid recipients the right to participate in decisions regarding which providers are qualified. *See id.* at 785. Nor did the fact that the Medicaid recipients were already receiving care from that provider

[15] *See, e.g., Planned Parenthood Arizona, Inc. v. Betlach*, 727 F.3d 960 (9th Cir. 2013) (referring to §1396a(p)(1) as an "exception[]" to §1396a(a)(23)); *Planned Parenthood Ariz. v. Betlach*, 922 F. Supp. 2d 858, 864 (D. Ariz. 2013) (referring to §1396a(p)(1) as an "exception to the freedom of choice guarantee"); *Planned Parenthood Ariz. v. Betlach*, 899 F. Supp. 2d 868, 881 (D. Ariz. 2012) (explaining that § 1396a(p)(1) is an "exception[]" to the "general mandate" of §1396a(a)(23) "that Medicaid patients have free choice of qualified providers").

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change the fact that they had no right to challenge its termination from the Medicaid program. *See id.*

> Title 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 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.
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> ***
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> In holding that these provisions create a substantive right to remain in the home of one's choice absent specific cause for transfer, the Court of Appeals failed to give proper weight to the contours of the right conferred by the statutes and regulation. As indicated above, while 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 has been determined to be unqualified.

Id. (emphasis in original).

The District Court discovered in 42 U.S.C. § 1396a(a)(23) a broad right of Medicaid patients to challenge a state or federal agency determination that a particular provider is not qualified. This discovery not only runs afoul of *O'Bannon*, but contravenes the Supreme Court's common sense admonition that Congress "does not . . . hide elephants in mouse holes." *Whitman v. American*

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Trucking Assoc., 531 U.S. 457, 468 (2001). If Congress had intended to provide authority for Medicaid patients to collaterally challenge qualification determinations made by state or federal agencies, it would have done so in a more conspicuous and straight-forward manner. It would not have buried the provision in a long list of instructions on how to prepare a state Medicaid plan—especially given that Congress devised a specific federal agency-enforcement regime to apply and enforce the instructions in that list.

Certainly, the provision, viewed in the context and structure of the Medicaid Act, does not include an "unambiguously conferred right" to collaterally challenge a state or federal agency's determination that a specific provider should be excluded from the Medicaid program as unqualified based on misconduct. *See Gonzaga Univ.*, 536 U.S. at 283 (rejecting "the notion that our cases permit anything short of an unambiguously conferred right to support a cause of action under § 1983"); *id.* at 280 (noting that "the key" to the very few prior decisions allowing a § 1983 action to enforce Spending Clause legislation was that "Congress spoke in terms that 'could not be clearer'") (quotation and citation omitted).

It is unsurprising that Congress did not craft a provision giving *patients* a right to challenge a state agency's determination that a particular provider was unqualified and excluded from the Medicaid program. There is no need for

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patients to have this ability. The providers themselves have the incentive, ability, knowledge and opportunity to challenge those determinations through the state administrative process. Both federal and state law give providers an opportunity to challenge a state's termination decision. 42 C.F.R. § 1002.213 requires a state to give terminated providers "the opportunity to submit documents and written argument" and "any additional appeals rights that would otherwise be available under procedures established by the state." Arkansas regulations give terminated providers an opportunity to administratively appeal within 30 calendar days of receipt of the termination decision. Ark. Admin. Code § 016.06.35-161.400. And, with exceptions not applicable here, terminated providers can appeal an administrative decision to the state's courts. Ark. Code Ann. § 20-77-1718.[16]

C. The Out-of-Circuit Cases Cited by the District Court are Inapposite.

To support its conclusion that the patient plaintiffs had a private right of action, the District Court primarily pointed to three **pre-*Armstrong*** out-of-circuit cases. Add. 49. But the three cases are inapposite to the instant case.

In *Planned Parenthood of Arizona v. Betlach*, 727 F.3d 960 (9th Cir. 2013), the Ninth Circuit found 42 U.S.C. § 1396a(a)(23) to provide patients a private right

[16] In addition to the providers being able to contest disqualification decisions, the Secretary of HHS has the authority to use his funding power to ensure that states are making appropriate determinations, consistent with the law, regarding which entities are qualified Medicaid providers. *See* 42 U.S.C. § 1396c.

of action under § 1983 to challenge state legislation that "bar[red] patients eligible for the state's Medicaid program from obtaining covered family planning services through health care providers who perform abortions in cases other than medical necessity, rape, or incest." *Id.* at 962. But the Ninth Circuit was clear that § 1396a(a)(23) only applied because this case did not involve a state agency's exercise of its power under § 1396a(p)(1) to exclude a specific individual provider for unethical or improper conduct. *See id.* at 973. The Court acknowledged that a state's power to exclude a provider under § 1396a(p)(1) was an exception to the free-choice-of-provider rule in § 1396a(a)(23). *See id.* But the Court found that exception inapplicable because the state legislation "does not set out grounds for excluding *individual* providers" on the basis of "criminal, fraudulent, abusive, or otherwise improper behavior." *See id.* "Rather, the legislation preemptively bars *a class* of providers on the ground that their scope of practice includes certain perfectly legal medical procedures." *Id.* (emphasis in original). *Betlach* is simply inapplicable to a situation like the case at bar where an individual provider was excluded because DHS found unethical[17] and wrongful conduct, where that provider did not challenge DHS's determination, and where a patient is now trying to argue that determination was factually incorrect.

[17] *Betlach* specifically notes that the term "qualified to perform" in § 1396a(a)(23) encompasses a provider acting in an ethical manner. *See Betlach*, 727 F.3d at 969.

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In *Planned Parenthood of Indiana, Inc. v. Commissioner of Indiana State Department of Health*, 699 F.3d 962 (7th Cir. 2012), the Seventh Circuit addressed the same type of statute as was addressed in *Betlach*, and it came to the same conclusions for the same reasons. As in *Betlach*, the *Commissioner of Indiana* case was not one where the state Department of Health excluded a single provider from the Medicaid system for specific unethical or otherwise improper conduct that DHS believed violated 42 U.S.C. § 1320a-7(b)(6)(B) and thus authorized exclusion under 42 U.S.C. § 1396a(p)(1). Rather, "Indiana's defunding laws exclude[d] a class of providers from Medicaid for reasons unrelated to provider qualifications." *Id.* at 980. *Commissioner of Indiana* is discussing a different type of private right of action than the one at issue in our case.

In *Harris v. Olszewski*, 442 F.3d 456 (6th Cir. 2006), the Sixth Circuit addressed a far more traditional § 1396a(a)(23) issue—a single-supplier contract that required all Medicaid patients to receive incontinence products from one specific supplier. *Harris* has absolutely nothing to do with whether a patient has a private right of action to collaterally challenge a state agency exclusion of one provider based on its determination that the provider has engaged in unethical conduct or conduct that fails to meet the professional standards of healthcare. That would be a radically different right that Congress did not intend or provide.

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III. The Plaintiffs Are Not Likely to Succeed on the Merits of their 42 U.S.C. § 1396a(a)(23) Claim.

The Medicaid Act gives a state agency like DHS the power to exclude providers from the Medicaid program for a large number of reasons related to unethical and improper behavior or practices. And because 42 U.S.C. § 1396a(a)(23)'s so-called free-choice-of-provider provision is expressly limited to choosing among *qualified* providers, the statute does not give Medicaid patients the right to choose providers who have been duly removed from the Medicaid program. Accordingly, the patient plaintiffs are not likely to succeed on the merits of their § 1396a(a)(23) claim where, as here, DHS terminated Planned Parenthood from the Medicaid program for unethical and improper practices and Planned Parenthood has not appealed that agency decision and termination.

Unlike in *Betlach* and *Commissioner of Indiana*, DHS has not categorically excluded an entire class of providers for reasons unrelated to legal or ethical propriety. Instead, DHS has terminated its Medicaid contracts with one entity—Planned Parenthood—precisely because it found that Planned Parenthood operated in an unethical manner and potentially in violation of federal law. As made clear in DHS's September 1, 2015 letter to Planned Parenthood, DHS's decision to terminate Planned Parenthood from the Medicaid program was based upon "the troubling circumstances and activities that have recently come to light regarding" the Planned Parenthood organization. DHS noted that the "national videos . . .

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have raised questions on the conduct of Planned Parenthood" and that "there is evidence that [Planned Parenthood is] acting in an unethical manner and engaging in what appears to be wrongful conduct." *See supra* at 5; n. 3.

A state agency may terminate a provider from the Medicaid program when, *inter alia*, the provider has "furnished items or services to patients . . . of a quality which fails to meet professionally recognized standards of health care." 42 U.S.C. § 1320a-7(b)(6)(B). *Accord* Ark. Admin. Code § 016.06.35-151.000(B) (referring to acts or omissions that "fail[] to meet professionally recognized standards for health care" as a grounds for termination or other sanction). The "professionally recognized standards of health care," of course, include more than just technical proficiency at performing a clinical procedure; they also include *ethical* considerations. *See, e.g., Commissioner of Indiana*, 699 F.3d at 978 ("Read in context, the term 'qualified' as used in § 1396a(a)(23) unambiguously relates to a provider's . . . capa[bility] of performing the needed medical services in a professionally competent, safe, legal, and ethical manner."). Because of its experience, expertise, and technical knowledge, as well as the cooperative federalism framework undergirding the Medicaid program, a state agency is given wide latitude in determining what practices violate this standard.

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A. DHS's Determination and Termination are Binding and Final Because Planned Parenthood Did Not Appeal DHS's Decision.

Both federal and state law give providers like Planned Parenthood an opportunity to challenge a state's termination decision. 42 C.F.R. § 1002.213 requires a state to give terminated providers "the opportunity to submit documents and written argument" and "any additional appeals rights that would otherwise be available under procedures established by the state." Arkansas regulations give terminated providers an opportunity to administratively appeal within 30 calendar days of receipt of the termination decision. Ark. Admin. Code § 016.06.35-161.400. And, with exceptions not applicable here, terminated providers can appeal an administrative decision to the state's courts. Ark. Code Ann. § 20-77-1718.

Planned Parenthood chose not to appeal DHS's decision and termination. Planned Parenthood made that choice even though DHS fully informed Planned Parenthood of the opportunity to appeal, how to appeal, and the Arkansas regulations governing any appeal. *See* Add. 1-3. Because Planned Parenthood chose not to appeal, DHS's findings and determination (and the termination) are final and binding. *See* Ark. Admin. Code § 016.06.35-154.000 ("Unless a timely and complete request for administrative reconsideration or appeal is received by the [DHS], the findings of [DHS] as set forth in the notice shall be considered a final and binding administrative determination."). And because DHS's findings

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and determinations (and the termination) are final and binding, Planned Parenthood is no longer in the pool of qualified providers for purposes of 42 U.S.C. § 1396a(a)(23). So patients cannot show a violation of the statute predicated on their inability to use Planned Parenthood as a Medicaid provider.

The District Court admitted to "struggl[ing]" to decide the "significance" of "the fact that [Planned Parenthood] has not availed itself of the administrative appeals process . . . ." Add. 56. But the District Court "decline[d] to find that [Planned Parenthood's] decision not to appeal [DHS's] determination foreclose[d]" the patient plaintiffs' claim "at this stage of the litigation." Add. 57. The District Court arrived at this conclusion because it was concerned that the "right" given to Medicaid patients should not have "to be enforced by the provider through the administrative appeals process." Add. 56-57. But this argument misunderstands the right, if any, that Congress was providing to patients in 42 U.S.C. § 1396a(a)(23). It is not a free-floating right to second-guess and challenge agency determinations of which provider is or is not qualified and should or should not be in the qualified provider pool. Rather, it is a more specific right to be able to choose among those providers who are part of the Medicaid program.

The right to challenge the initial DHS decision and termination is the provider's right, under a different set of statutes and regulations. *See supra* at 9. That makes perfect sense, as the provider is the one with the knowledge, incentive,

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and ability to determine whether to challenge the agency decision or to let it stand. A patient, on the other hand, would have no idea whether its providers' conduct did or did not fail to meet professionally recognized standards of health care, was otherwise unethical, or violated federal law. Where a provider intentionally foregoes an appeal, then that provider is no longer qualified for purposes of § 1396a(a)(23) and not part of the pool that a patient has a right to use. *See O'Bannon*, 447 U.S. at 785 (noting that 42 U.S.C. §1396a(a)(23) does not "confer a right on a recipient to continue to receive benefits for care [from a provider] that has been decertified"). A patient cannot then succeed on a claim under 42 U.S.C. § 1396a(a)(23) that he or she should be free to use the now terminated provider.

B. The Videos Show that DHS Properly Terminated Planned Parenthood's Medicaid Agreement.

Especially in light of Planned Parenthood's decision not to appeal DHS's determination, the videos justified DHS's decision to terminate Planned Parenthood from the Medicaid program.

42 U.S.C. § 274(e) bans the sale of human fetal body parts. While allowing recovery of costs, the law prohibits any person from knowingly acquiring, receiving, or otherwise transferring "any human organ for valuable consideration . . . ." The American Medical Association Safeguards state that "fetal tissue is not provided in exchange for financial remuneration above that which is necessary to cover reasonable expenses[.]" APX 140. The standard is intended to reduce the

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prospect that financial considerations could "influence" the "decision to donate fetal tissue" and, ultimately, a patient's "decision to have an abortion." *Id.*

Planned Parenthood does not deny that at least some of its affiliates have received compensation for human fetal body parts, and the information in the videos show it is likely that the compensation has exceeded the costs necessary to cover reasonable expenses. For one example, a video shows Dr. Gatter, president of Planned Parenthood Federation of America's Medical Directors' Council, haggling over the price of fetal tissue, stating: "[L]et me just figure out what others are getting; if this is in the ballpark, it's fine, if it's low then we can bump it up. I want a Lamborghini." APX at 164. Dr. Gatter strongly implies that the price of fetal tissue is set by the market and negotiations, not by the reasonable costs incurred. Dr. Gatter also told two actors posing as potential buyers that she did not want to "throw[] out the figure first" because she did not want to "lowball." APX 149-50.

The American Medical Association Safeguards strive to ensure that, even when tissue extraction is part of an abortion procedure, the health and safety of the pregnant woman is the only consideration. The standard provides that "decisions regarding the technique used to induce abortion . . . are based on concern for the safety of the pregnant woman" and not other concerns. APX 140; *see also* 42 U.S.C. § 289g-1 (allowing the federal government to "conduct or support research

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on the transplantation of human fetal tissue for therapeutic purposes," but prohibiting any "alteration of the timing, method or procedures used to terminate the pregnancy . . . solely for the purpose of obtaining the tissue"). The ultimate ethical principle—reflecting the professionally recognized standard—is that providers may not alter how or when abortions are performed to obtain the tissue desired.

The videos and transcripts show that Planned Parenthood officials knew that Planned Parenthood affiliates have altered abortion procedures to obtain intact fetal parts that fetch higher prices. For example, one video transcript documents an official of Planned Parenthood-Gulf Coast claiming that her organization had "deviate[d] from [its] standard" in order to accommodate firms that have "a specific need, for certain portion[s] of the products of conception." APX 175-76. In another transcript, Dr. Nucatola, Planned Parenthood Federation of America's medical director, explained that "[w]e've been very good at getting the heart, lung, liver, because we know that, so I'm not going to crush that part, I'm basically going to crush below, I'm gonna crush above, and I'm gonna see if I can get it all intact." APX 115. In a letter to Congress, Planned Parenthood acknowledged that "adjustments" to procedures that "facilitate fetal tissue donation" are made at "clinics that offer women this service." APX 351.

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The foregoing are simply examples of video and transcript evidence that justifies (1) DHS's decision that Planned Parenthood has unethical practices that fall below the standard of professionally recognized care, and (2) DHS's consequent exclusion of Planned Parenthood from the Medicaid program.

The District Court did not expressly explain its holding that the patient plaintiffs were likely to succeed on the merits. Rather, after summarizing the arguments of each party, it stated that "[t]he Court has reviewed the affidavits and exhibits before it and the legal theories advanced by both sides. The Court concludes that the [patient plaintffs] likely will succeed on the merits of their 42 U.S.C. § 1983 claim." Add. 67. To the best DHS can tell, the Court's decision was based on two things: (1) that the conduct in the video was performed by Planned Parenthood affiliates outside of Arkansas rather than the Planned Parenthood affiliate in Arkansas; and (2) that the District Court thinks DHS's view of the evidence in the videos "may overstate" what the videos show. Add. 63. Neither position is legally tenable.

First, especially in light of the fact that Planned Parenthood did not appeal DHS's decision and termination, the fact that the evidence in the videos might be open to different interpretation cannot possibly serve as a basis for patients to prevail on a 42 U.S.C. § 1396a(a)(23) claim. DHS is entitled to judge the evidence in the first instance. Where there is some evidence to justify DHS's decision, and

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where the provider has chosen not to appeal the decision administratively and in state court, it is inappropriate on this type of second-generation collateral challenge to second-guess DHS's weighing of the evidence. The fact that the District Court might have weighed the evidence differently than DHS did is irrelevant to the operative question – whether a Medicaid patient was restricted from using a *qualified* provider.

Second, especially in light of the fact that Planned Parenthood did not appeal DHS's decision and termination, the fact that the videos show conduct of agents of the Planned Parenthood Federation of America and other Planned Parenthood affiliates—as opposed to the Planned Parenthood affiliate in Arkansas—also cannot serve as a basis for patients to prevail on a 42 U.S.C. § 1396a(a)(23) claim. DHS is entitled to use its expertise and experience to determine whether to treat a provider federation as a unified whole or as truly distinct legal entities for purposes of evaluating unethical and otherwise wrongful conduct. DHS's view that Planned Parenthood Federation of America ("PPFA") and its affiliates function as a unified whole—and therefore that unethical and wrongful conduct by some affiliates can be attributed to the network (including the affiliate in Arkansas)—makes good sense based on what is known about how Planned Parenthood operates.

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PPFA is organized as a membership corporation with national offices headquartered in Washington, D.C. and New York City.[18] PPFA possesses characteristics of a franchise operation, with affiliates paying an annual dues premium to the national office that is scaled to the size of the affiliate's budget, in return for which affiliates are entitled to use the Planned Parenthood brand, have representation at PPFA membership meetings, and access services provided by the national office.[19] Each local affiliate is organized as an independent, charitable nonprofit corporation governed by a local board.[20] The national office sets medical standards for the affiliate network for reproductive health care delivery; provides technical, managerial, legal and advocacy training and support for affiliates; and offers a central medical malpractice insurance policy for affiliates through a captive offshore insurer and other private insurers.[21] Affiliates commit to operate

[18] Rangan and Backman, *Planned Parenthood Federation of America*, Harv. Bus. Sch. Case Study No. 9-598-001 (1997; rev'd. 2002) at 3.

[19] *Id*. at 2; *see generally* Howard Yale Lederman, *Franchising and Franchise Law: An Introduction*, 92 MICH B.J. 34, 34 (2013) ("The franchisor licenses to the franchisee, for a defined period, the right to use the franchisor's business model and intellectual property—such as signs and logos, trademarks and service marks, business plans, and operations manuals—necessary to operate the business. The franchisor also provides marketing and sales assistance, training, and other support to promote and grow the brand.")

[20] Rangan & Backman, *supra* note 18 at 1-2.

[21] *Id.*at 2.

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according to PPFA standards for affiliation, which include medical standards and operating guidelines covering governance, managerial, and financial matters.[22]

PPFA directs activities, programs, services, and pronouncements of its affiliates. APX 380. PPFA mandates that each affiliate "conform[] to the purposes, written policies, and standards of PPFA;" "publicly support[] the purposes and policies of PPFA;" include the trade name "Planned Parenthood" in its name; "provide services consistent with the purposes of PPFA;" "participate in the Risk Management and Quality Management Programs approved by the Membership;" participate in public affairs activities; pay National Program Support; and provide medical services in conformity with the PPFA Medical Standards and Guidelines. APX 381-82. PPFA reviews annual audits and management letters of each affiliate, and it may impose administrative probation in certain situations. APX 388. PPFA "provide[s] the leadership required for policy and program initiatives," "administers the standards maintained by the Membership," "provides a structure that encourages Affiliates to participate in the planning and executing of policies and plans," "provid[es] leadership, support, and services," fundraises in the name of affiliates, and "provide[s] guidance and counsel on [some] legal matters." APX 392.

[22] *Id.*

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The interrelationship between PPFA and its affiliates is evidence that, even though separately incorporated, PPFA and its affiliates do not operate as independent entities. Rather, PPFA and its affiliates are part of an overarching enterprise of which PPFA is the central manager. In fact, the principal attorney representing the Arkansas Planned Parenthood affiliate in this case is an employee of PPFA's litigation division.

Planned Parenthood Federation's response to public outcry over the videos also underscores the unity of the organization. The letter that the organization president sent to Congress speaks generally of "Planned Parenthood" as a whole. Her letter states that "Planned Parenthood," not simply the individual affiliates, "adheres to the highest standards and follows all laws." APX 347. Her letter states that "Planned Parenthood," not simply individual affiliates, "is proud to have a role in fetal tissue research." *Id.* Her letter states that "we," through the affiliates, "provide health services to millions of women and men every year." *Id.* Her letter states that various Planned Parenthood "health centers" across the country "are part of the Planned Parenthood network." *Id.* Her letter states that "we are committed to continual improvement and meeting the highest medical and ethical standards in all we do . . . ." *Id.* Finally, her letter assures Congress that PPFA has "asked our senior medical leadership to conduct a review of the policies and practices that guide the affiliates . . . and our oversight . . . ." *Id.* ("If this review identifies ways

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we can improve our practices while staying true to our core mission, we will promptly implement them.").

PPFA appears to concede that its "policies and practices" "guide the affiliates" and that PPFA exercise "oversight of these activities." *Id.* Indeed, it is hard to read the aforementioned letter without clearly understanding that Planned Parenthood operates as a unified network. The affiliates exist as separate entities on paper, but not in reality. This is especially so when it comes to medical services and the public's perception of Planned Parenthood. Planned Parenthood entities take their united reputation and exposure seriously, permitting PPFA's board to order affiliates to cease and desist from any practice that is "contrary to the Medical Standards of PPFA" or puts Planned Parenthood "in serious jeopardy of increased liability." *Id.* at 390.

Given all this, it was appropriate for DHS to find that the unethical and improper conduct of Planned Parenthood justified the termination of its affiliate in Arkansas. If Planned Parenthood seeks to present a unified front to the public when it comes to the medical services it provides, it is reasonable for DHS to treat Planned Parenthood as a unified, integrated organization when assessing whether it meets the appropriate standard of care and ethical requirements to be part of the Medicaid program. Courts have often treated affiliated corporations as a single entity when the facts and circumstances warrant it. *See, e.g. In re*

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Phenylpropanolamine (PPA) Product Liab. Litig., 344 F. Supp. 2d 686, 691 (W.D. Wash 2003) (personal jurisdiction); *Bowoto v. Chevron Texaco Corp.*, 32 F. Supp. 2d 1229, 1237 (N.D. Cal. 2004 (tort liability). *See also Browning-Ferris Indus. of Cal., Inc., et al.*, Case No. 32-RC-109684, 2015 WL 5047768 at *2 (N.L.R.B. Aug. 27, 2015) (treating a company as a "joint employer" of one of its contractors because it "share[s] or codetermine[s] those matters governing the essential terms of employment").

IV. The Plaintiffs Cannot Prove Irreparable Harm.

As the District Court acknowledged, "[a] plaintiff seeking [preliminary] injunctive relief must establish that the claimant is 'likely to suffer irreparable harm in the absence of preliminary relief.'" Add. 55 (quoting *Winter v. Natural Def. Council, Inc.*, 555 U.S. 7, 20 (2008). And this Court has made clear that "[t]o succeed in demonstrating a threat of irreparable harm, 'a party must show that the harm is certain and great and of such imminence that there is a clear and present need for equitable relief.'" *Roudachevski v. All-Am. Care Ctrs., Inc.*, 648 F.3d 701, 706 (8th Cir. 2011) (quoting *Iowa Utils. Bd. v. Fed. Commc'ns Comm'n*, 109 F.3d 771, 779 (8th Cir. 1996)). Certainly, "speculative harm does not support a preliminary injunction." *S.J.W. ex rel. Wilson v. Lee's Summit R-7 School District*, 696 F.3d 771, 779 (8th Cir. 2012) (citing *Minn. Ass'n of Health Care Facilities, Inc. v. Minn Dep't of Pub. Welfare*, 602 F.2d 150, 154 (8th Cir. 1979)). But even

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harm that is certain and imminent does not constitute irreparable harm unless it is also great." *See Roudachevski*, 648 F.3d at 706; *see also Munson v. Gilliam*, 543 F.32d 48, 52 (8th Cir. 1976) (finding no irreparable harm where injury was "not great").

The District Court's principal conclusion here is that the three patient plaintiffs satisfied their burden of proving the likelihood of irreparable harm simply by stating that "they wish to continue with [Planned Parenthood] as their family planning provider of choice" and that they "could not afford to pay for their normal services out of pocket." Add. 58. Essentially, the District Court concluded that the mere fact that the three patient plaintiffs might—during the pendency of this litigation—not be able to use the provider they prefer constituted irreparable harm. Add. 58-59 ("The Court finds that . . . denial of that freedom is more likely than not exactly the injury that Congress sought to avoid when it enacted 42 U.S.C. § 1396a(a)(23) . . . .").

There are two flaws with the District Court's analysis. *First*, as noted above, the patient plaintiffs' right under 42 U.S.C. § 1396a(a)(23)—if there is a right at all—does not encompass using a provider that is not in the Medicaid program. Rather, it is to be able to freely choose among a pool of qualified providers in the state Medicaid program. The patient plaintiffs still may do so. In FY2015, over

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200 qualified providers in Pulaski County[23] billed Medicaid for services also listed in Planned Parenthood's Medicaid procedure codes. APX 814. Some providers cover the entire suite of services provided by Planned Parenthood, and many providers cover a large majority of the services provided by Planned Parenthood. APX 816. As relates to the three specific patient plaintiffs before this Court, there is a pool of qualified providers, including the County Health Clinic, that provide the Medicaid services the patient plaintiffs seek (birth control, an annual wellness exam, and, in the case of one of the three patients, STD testing). For example, in FY2015 there were 16 qualified providers in Pulaski County that billed Medicaid for all the services used by Jane Doe #1 at Planned Parenthood, APX 815, and seven qualified providers that billed Medicaid for the services used by Jane Doe #2 at Planned Parenthood.[24] APX 816. Both of these patient plaintiffs used other providers (specifically, the County Health Clinic) for years—more than ten years in the case of Jane Doe # 2—for family planning services. APX 27, 649, 659.

[23] All three patient plaintiffs use the Planned Parenthood facility in Pulaski County (Little Rock, Arkansas).

[24] This conservative methodology understates the number of qualified providers who provide these services, because DHS's calculations were limited to FY2015 and to instances where a provider filed a claim and sought payment. No estimate of the number of providers available for the services used by Jane Doe #3 was performed because DHS's system did not show any claims filed by Planned Parenthood for Jane Doe #3.

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Second, and more fundamentally, irreparable harm may not be presumed merely from a statutory violation, even one enforceable by a private right of action. Rather, courts must apply the usual test of whether a particular harm is concrete, great, and imminent enough to constitute irreparable harm. *See Flynn v. Siren-BookStrand, Inc.*, 2013 WL 53159595 at *5 (D. Neb. 2013). In the specific context and on the specific facts of this case, the three patient plaintiffs do not show the type of harm that is concrete, great, and imminent enough to constitute irreparable harm. Not being able to exercise a "preference" for a terminated provider during the pendency of the litigation does not meet this test—unless the patient plaintiffs could show a concrete and grave harm that is caused by not being able to exercise their preference. They cannot.

The patient plaintiffs do not allege that they could not find qualified providers for the services they seek. Indeed, the two patient plaintiffs who were on Medicaid prior to visiting Planned Parenthood concede they have used other providers in the past and could do so again. APX 24.[25] The District Court did **not**

[25] While the CEO of Planned Parenthood of the Heartland states in her declaration her "fear that the remaining providers will be . . . unable to absorb [Planned Parenthood's Medicaid] patients," APX 19, that is precisely the type of speculation that cannot constitute irreparable harm. Based on extensive research in Arkansas's database of paid Medicaid claims, DHS determined that Planned Parenthood billed for family planning/reproductive health services provided to 309 Medicaid beneficiaries in FY2015, while the remaining Medicaid providers billed for family planning/reproductive health services provided to 47,831 patients in the same time

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find that patient plaintiffs would be unable to locate qualified providers to provide the services they sought. Instead, the District Court concluded that potentially longer lead times for making appointments and longer waits once at an appointment at other providers constitutes the type of imminent, concrete, and great harm required for a finding of irreparable harm. Add. 58 ("The Court . . . finds unpersuasive [DHS's] position that, alleged long wait time even when appointments are secured, and overall scheduling issues, is not harm great enough to meet the Jane Does' burden of proof on irreparable harm . . . ."). The District Court is wrong.

Whether or not the three patient plaintiffs will face longer wait times after arriving for an appointment at other providers—and how much longer those wait times might be—is entirely speculative. It depends on what provider they each choose to use, the time of year, and what services they want. Only one of the patient plaintiffs (Jane Doe #2) complained about long wait times at a former Medicaid provider (the County Health Clinic). See APX 27. Jane Doe #1, on the other hand, did not complain of long wait times after arriving at appointments. APX 24. This is likely because the wait times she experienced at the County Health Clinic—the same Clinic Jane Doe #2 used—were not much longer than the wait times at Planned Parenthood. Jane Doe #1 explained that the wait times at the

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frame. APX 817. That means all other Medicaid providers would have to absorb less than 1 percent of an increase in the number of patients served. *Id.*

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County Health Clinic were usually 30-45 minutes, while wait times at Planned Parenthood were usually 15 minutes but have been up to 30 minutes. *See* APX 651 (Question 9f) and APX 648 (Question 6C).

Even if the wait time claim was not speculative, waiting (even waiting a "long time") at appointments is certainly annoying, but it is not irreparable harm. Jane Doe #2 has received the same medical services she receives from Planned Parenthood from the County Health Clinic for over ten years, despite her complaint about the longer wait times after showing up at an appointment. APX 659. She could do the same during the pendency of this litigation.

Whether or not other providers will require a longer lead time for appointments—and how much longer—is also entirely speculative. It depends on what provider each patient plaintiff chooses to use, the time of year, and what services the patient wants. Two of the Jane Does complained about long lead times for appointments at former providers. Jane Doe #1 states that the longest lead time she needed to make appointments at the County Health Clinic was 3-4 weeks in advance, and the usual lead time she needed to make an appointment at the private ob/gyn was 1 to 2 weeks in advance. APX 650 (Question 8e).[26] But she also admits that she had to make appointments up to a week in advance at

[26] Jane Doe # 2 states in her declaration that she had to make appointments at the County Health Clinic "several weeks" in advance. APX 27.

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Planned Parenthood. APX 648 (Question 6B). Indeed, the evidence in front of the District Court suggested that Jane Doe #1's experience appeared to understate the lead time needed for an appointment with Planned Parenthood. APX 835 (noting that in September of 2015, the Planned Parenthood website reflected the next open appointments as two weeks out).

The difference in lead times needed to schedule an appointment may slightly increase the difficulty of juggling family and work responsibilities, but these vicissitudes are common to everyone who needs to obtain healthcare.[27] They are certainly not the type of great and concrete harm that would justify irreparable harm or necessitate the extraordinary relief of a preliminary injunction.

CONCLUSION

For the foregoing reasons, this Court should reverse the District Court's decision and vacate the preliminary injunction.

[27] Despite complaining of long lead times at the County Health Clinic, Jane Doe #2 managed to successfully get the same services at the County Health Clinic—for over a decade—that she now gets at Planned Parenthood. APX 659. Jane Doe #1 similarly managed to get the services she needed for five years prior to visiting Planned Parenthood. APX 649-50.

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CERTIFICATES OF COMPLIANCE & SERVICE FOR ELECTRONIC COPY

Pursuant to FRAP 32(a)(7)(C), undersigned counsel certifies that this brief complies with the type-volume limitations of FRAP 32(a)(7). Excluding those portion of the brief exempted from limitations by FRAP 32(a)(7)(B)(iii), the brief contains 13,387 words. The brief was prepared with Microsoft Word 2010 and typed using Times New Roman 14-point font.

I further certify that on this 30th day of November, 2015, I electronically filed the forgoing brief with the Clerk of the Court for the United States Court of Appeals for the Eighth Circuit by using the CM/ECF system. I certify that counsel for the appellees are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

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/s/ C. Joseph Cordi, Jr.