UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 15-3271, 16-4068

PLANNED PARENTHOOD OF ARKANSAS & EASTERN OKLAHOMA, d/b/a PLANNED PARENTHOOD GREAT PLAINS; JANE DOE #1; JANE DOE #2; JANE DOE #3,
Appellees,
v.
CINDY GILLESPIE, Director,
Arkansas Department of Human Services,
in her official capacity,
Appellant.

On Appeal from the United States District Court
for the Eastern District of Arkansas (Hon. Kristine Baker)

APPELLANT'S OPPOSITION TO REHEARING *EN BANC*

LESLIE RUTLEDGE
Arkansas Attorney General

LEE P. RUDOFSKY
Arkansas Solicitor General

CHARLES LYFORD
Assistant Attorney General

Office of the Arkansas Attorney General
323 Center St., Suite 200
Little Rock, AR 72201
(501) 682-6302
lee.rudofsky@arkansasag.gov

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Regulations

Introduction

The Arkansas Department of Human Services ("DHS") determined that Planned Parenthood's practices related to obtaining and selling fetal body parts were unethical and violated professionally recognized standards of healthcare.[1] The Medicaid Act authorizes 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) (grounds for exclusion from Medicaid program include failing "to meet professionally recognized standards of health care"). So DHS terminated Planned Parenthood's Medicaid provider agreements.

As required by the Medicaid program, DHS provided Planned Parenthood with an opportunity both for administrative appeal and appeal to state court.[2] Planned Parenthood intentionally chose not to pursue either remedy. APX 936. Instead, Planned Parenthood recruited three patients to file suit to enforce 42 U.S.C. §1396a(a)(23). APX 439. Perhaps Planned Parenthood chose this path in an attempt to avoid state court in favor of federal court. Perhaps Planned

[1] Undercover videos exposed 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. *See* APX 115-17, 141, 167, 286, and (for the videos) the back cover of Volume 1 of the Appendix.

[2] DHS informed Planned Parenthood in two termination 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.

Parenthood wished to avoid the arbitrary and capricious standard it would have faced in a direct challenge to DHS's disqualification decision. In any event, Planned Parenthood's decision to bypass the normal procedures for a medical provider to challenge a misconduct-based disqualification gave rise to the following question: Did Congress in 42 U.S.C. §1396a(a)(23)(A) intend to confer on every Medicaid patient in the United States the right to collaterally challenge the exclusion for misconduct of a specific medical provider from the Medicaid program?

The correct answer to that question, as the Panel concluded, is "no." Unless Congress "speak[s] 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) (internal quotations omitted). After conducting a detailed analysis, the Panel concluded that the provision in question did not meet this high burden of manifesting *unambiguous* congressional intent. *See* Op. 6-12. That careful analysis best comports with recent Supreme Court precedent, long-standing rules of statutory interpretation, and common sense. Appellees' argument to the contrary mischaracterizes the Panel's analysis and exaggerates its implications.

First, Appellees fault the Panel for consulting the whole statute for interpretive clues as to whether Congress intended subsection (a)(23)(A) to confer

on a patient a right to collaterally challenge DHS's misconduct-based disqualification of a provider from the Medicaid program. *See* Pet. for Reh'g 12-16. Appellees argue the Panel was required to isolate the subsection at issue and take it out of the context of the statute as a whole. But of course no precedent requires such a radical approach to statutory interpretation. No court has suggested that the normal rules of statutory interpretation are for some reason suspended in these cases. The Panel quite appropriately refused to ignore the full context of the statute.

Second, Appellees note the existence of a circuit split on the question of whether §1396a(a)(23)(A) authorizes a private right of action. But they overstate the seriousness of the split. And they understate the relevance of the Supreme Court's decision in *Armstrong v. Exceptional Child Center*, 135 S. Ct. 1378 (2015), which post-dates nearly all circuit court decisions they cite. The Supreme Court has candidly acknowledged a continuing evolution toward "reject[ing] attempts to infer enforceable rights from Spending Clause statutes." *Gonzaga Univ.*, 536 U.S. at 280-81. *Armstrong* is another step in this evolution, and this Court was correct to draw on *Armstrong's* analysis and logic in applying the unambiguous-intent requirement.

At bottom, Appellees cannot avoid the common sense of the Panel's decision. As the Panel noted, there are two methods already provided for

remedying improper disqualifications by DHS: (1) the opportunity for the provider to bring a direct administrative and state court appeal, and (2) the withholding of funds by the Secretary of the federal Department of Health & Human Services. *See* Op. 17. The Panel explained that the private enforcement right advocated by Appellees "would result in a curious system for review of a State's determination that a Medicaid provider is not qualified" for the program:

> Under [Appellees'] vision, while the [medical] provider is litigating its qualifications in the state courts, or after the provider unsuccessfully appeals a determination that it is not qualified, individual patients separately could litigate or relitigate the qualifications of the provider in federal court under §1983. Each adjudicator must apply a rather imprecise standard, asking whether the provider is 'qualified to perform the services required.' The potential for parallel litigation and inconsistent results gives us further reason to doubt that Congress in §(23)(a) unambiguously created an enforceable federal right for patients.

Op. 10.

It makes sense that Congress intended to allow medical *providers* the opportunity to pursue a direct challenge—administratively and in State court—to their disqualification from the Medicaid program. Providers have the biggest incentive to pursue such a challenge, and they have the factual and specialized knowledge necessary to determine whether their disqualification was justified or unjustified. A provider's challenge would be a single case and would not risk inconsistent judgments.

It also makes sense that Congress intended the federal Department of Health and Human Services to hold a power-of-the-purse check on state agency disqualification decisions. This forces collaboration and consultation between the specific state and federal agencies that have expertise relevant to the disqualification question.

What does *not* make sense is the notion that Congress intended (*sub silentio*) to also authorize millions of lay patients to bring lawsuits collaterally challenging a misconduct-based disqualification decision made by a state agency. Lay patients would have no factual knowledge or medical expertise to determine whether a medical provider was properly or improperly disqualified. Moreover, as has actually occurred here, authorizing such an approach would wrongly incentivize a medical provider to eschew and avoid a direct challenge to its disqualification.

Background

The Medicaid program is an example of cooperative federalism. 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. 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).

A. States' Power to Exclude Unqualified Medical 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 may or must exclude a provider as disqualified. Specifically, 42 U.S.C. §1396a(p)(1) provides that "[i]n addition to any other authority, a State may exclude any individual or entity for purposes of participating under the State plan under this subchapter for any reason for which the Secretary [of the federal Department of Health and Human Services] could exclude the individual or entity from participation in a program under subchapter XVIII of this chapter under section 1320a-7, 1320a-7a, or 1395cc(b)(2) of this title."

The cross-referenced statutes provide a complex and intricate web of over 50 reasons for the Secretary or a state agency to exclude an entity from the qualified Medicaid provider pool. 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 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 of health care").[3]

Before a State may disqualify a medical provider for misconduct, it must under federal law give the provider an opportunity to challenge the decision. Op. 9. For example, 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 terminated providers can appeal an administrative decision to the state's courts. Ark. Code Ann. §20-77-1718.

[3] 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* 42 C.F.R. §431.51(c)(2); *Guzman v. Shewry*, 552 F.3d 941, 949 (9th Cir. 2009) (concluding that federal statutes and regulations "plainly contemplate[] that states have the authority to suspend or to exclude providers from state health care programs for reasons other than those upon which the Secretary of HHS has authority to act . . . ."); *First Med. Health Plan, Inc. v. Vega-Ramos*, 479 F.3d 46, 53 (1st Cir. 2007) (explaining that 42 U.S.C. §1396a(p)(1) "preserves the state's ability to exclude entities from participating in Medicaid . . . ").

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' Centers 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 Medicaid Act, Congress set forth a long and complex list of items—in 83 subsections[4]—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), a(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 charged with ensuring that States substantially comply with their plans. *See* 42 U.S.C. §1396c.

[4] 42 U.S.C. §1396a(a)(23) is one of the 83 subsections. In relevant part, it 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 provide him [or her] such services."

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. And 42 U.S.C. §1396c authorizes the Secretary to withhold all or part of a State's federal Medicaid funding if he finds that "the plan has been so changed that it no longer complies with the provisions of section 1396a" or that "in the administration of the plan there is a failure to comply substantially with any such provision." *Id.* (allowing the Secretary to discontinue payments "until [he] is satisfied that there will no longer be any such failure to comply"). However, before withholding any funds, the Secretary must provide the state agency "reasonable notice and opportunity for hearing." *Id.* The Secretary may also waive certain compliance requirements. *See* 42 U.S.C. §1396n(b).

Argument

The Panel decision was straightforward. It correctly explained that "[i]t is now settled that nothing 'short of an unambiguously conferred right' will support a cause of action under § 1983." Op. 7 (citing *Gonzaga Univ.*, 536 U.S. at 283). And the Panel gave three reasons that 42 U.S.C. §1396a(a)(23)(A) does not clearly and unambiguously manifest such Congressional intent.

First, §1396a(a)(23)(A) does not have the type of individual-rights language that unambiguously confers enforceable rights. The Panel acknowledged that the statutory subsection "refers to 'any *individual* eligible for medical assistance'" and that a State plan must "provide for an individual to obtain assistance from a qualified provider." Op. 11. But the Panel noted that §1396a(a)(23)(A) is phrased as a directive to the federal agency charged with approving State Medicaid plans, telling the agency what a plan must contain before it can be approved. *See* Op. 9. This is not the sort of focus and phrasing that *unambiguously* confers a federal right. *See id.*

Indeed, the focus and phrasing is far different than the two prime examples given in *Gonzaga* of text that is "phrased 'with an *unmistakable focus* on the benefited class.'" *See Gonzaga Univ.*, 536 U.S. at 284, n.3. (explaining that Title VI of the Civil Rights Act of 1964 and Title IX of the Education Amendments of 1972 state "No person in the United States shall" be discriminated against on various bases under certain programs or activities receiving federal funds). And the Panel's analysis mirrors the reasoning on this issue by the plurality in *Armstrong*. *See* Op. 16-17; *Armstrong*, 135 S. Ct. at 1387-88.

Second, the Panel explained that Congress provided for two other mechanisms to ensure the State did not improperly disqualify medical providers and thus to ensure that Medicaid recipients could continue seeing any qualified

provider. A medical provider has the right to an administrative and then state-court appeal. And the Secretary can withhold funds if CMS determines the State agency was acting illegally. As explained in *Gonzaga* and *Armstrong*, the availability of these two remedial mechanisms suggests that Congress, at the least, did not intend to create an enforceable right for individual patients. *See* Op. 9-10. This is especially true, according to the Panel, because allowing a multiplicity of patient lawsuits would likely cause parallel litigation and lead to inconsistent results. *See* Op. 10.[5]

Third, relying heavily on this Court's 2013 case in *Midwest Foster Care & Adoption Ass'n v. Kincade*, the Panel explained that the Medicaid Act is part of a substantial compliance regime. 712 F.3d 1190 (8th Cir. 2013). That is, States only need to *substantially comply* with their plans to receive funding. And this Court was clear in *Midwest Foster Care* that a compliance regime like this one—where funding is linked to substantial compliance with certain plan conditions—is not indicative of enforceable individual rights. *See* 712 F.3d at 1200-1201.

[5] There is a substantial risk of inconsistent results because whether someone is qualified to perform the services is "a rather imprecise standard." Op. 10. While Appellees and the Dissent suggest a qualification determination would be easy—essentially only involving a question of a current medical license—that misunderstands the term "qualified" as used in the statute. Section 1396a(p)(1) authorizes disqualification from the Medicaid program based on any number of judgment-laden decisions, all related to medical expertise and experience. Those disqualified for such reasons are not "qualified" as that term is used in subsection (a)(23)(A).

A. The Panel Properly Considered the Whole Statute in Interpreting 42 U.S.C. §1396a(a)(23)(A).

Appellees argue that rehearing en banc is justified because the Panel consulted the whole statute for interpretive clues as to whether Congress unambiguously intended subsection (a)(23)(A) to confer on a patient a right to collaterally challenge DHS's misconduct-based disqualification of a medical provider from the Medicaid program. Appellees contend this approach conflicts with Supreme Court precedent. *See* Pet. for Reh'g 12. But the Supreme Court has made clear that the entire statute is relevant and should be examined when determining whether Congress has unambiguously manifested its intent to confer individual federal rights in a particular statutory subsection. *See Gonzaga Univ.*, 536 U.S. at 286 (noting one should look to "the text *and structure* of a statute") (emphasis added); *id.* at 289-90 (part of the analysis includes the "mechanism that Congress chose to provide for enforcing [the] provisions" at issue).[6] This should not be surprising. It is statutory-interpretation 101.

[6] *See also Armstrong*, 135 S. Ct. at 1387 (plurality opinion) (explaining that a statutory subdivision in the Medicaid Act "lacks . . . rights-creating language" by looking at the whole statute and concluding "[i]t is phrased as a directive to the federal agency" regarding approval of plans); *id.* at 1389 (Breyer, J., concurring) (analyzing other sections of the statute to determine what Congress intended to confer in one particular subsection).

Appellees' position is based on a misreading of *Blessing v. Freestone*, 520 U.S. 329 (1997). Appellees (and Judge Melloy's dissent) cite *Blessing* as saying "[w]e [do] not ask whether the federal . . . legislation generally [gives] rise to rights; rather, we focus[] our analysis on a specific statutory provision . . . ." *See* Pet. for Reh'g 12; Dissent 26. But in context, this portion of *Blessing* stands for nothing more than that a plaintiff must identify a specific provision of a large statute that it believes confers a specific right. The plaintiff may not rely on a large statute to "generally" provide unspecified rights. *See Blessing*, 520 U.S. at 342 ("It was incumbent upon [plaintiffs] to identify with particularity the rights they claimed, since it is impossible to determine whether Title IV-D, as an undifferentiated whole, gives rise to undefined 'rights.'"). Neither *Blessing* nor other precedent requires this Court to blind itself to the whole statutory scheme when analyzing whether a particular subsection unambiguously confers a federal right.

Appellees also misread the Panel's decision by contending that it issued a "blanket conclusion that structural elements of the Medicaid Act" will always "outweigh" the language in a particular subsection. Pet. for Reh'g 13. This reading allows Appellees to claim a conflict with Eighth Circuit cases that found

certain parts of the Medicaid Act to create enforceable rights. *Id.*[7] The problem for Appellees is that the Panel decision was far more nuanced than they suggest. The decision does not imply a sweeping conclusion that *no* subsection of §1396a(a) unambiguously confers a federal right. Indeed, the Panel makes clear that each subsection must be analyzed individually—as to its unique language and its context in the overall statutory scheme. For example, the Panel found it particularly important that States are required to afford medical providers an opportunity for an administrative appeal and a state-court challenge. *See* Op. 17. This is not a structural element of the Medicaid Act common to all subsections; indeed, its relevance is limited to only subsection (a)(23)(A).

Taking another tack, Appellees contend that the three reasons relied on by the Panel to conclude Congress had not spoken clearly and unambiguously have been rejected by the Supreme Court and this Court. *See* Pet. for Reh'g 14-16. This is not true. At most, these cases show that the Panel could not have relied on any one of those reasons *standing alone*. But no case has considered all three reasons together. The combination of all three reasons justifies the Panel's conclusion.

[7] As the Panel explained, these cases were decided pre-*Armstrong* and most did not even mention the more rigorous, unambiguous-intent standard of *Gonzaga*. Op. 13-16.

B. The Circuit Split Is Overstated and Outdated.

Appellees claim the Panel's decision marks a split with the Ninth, Seventh, Sixth, and Fifth Circuits. The truth is more complicated. While there is certainly tension between the cases, significant distinctions make the circuit split far more attenuated than Appellees suggest.

The Ninth Circuit case, *Planned Parenthood of Arizona v. Betlach*, 727 F.3d 960 (9th Cir. 2013), and the Seventh Circuit case, *Planned Parenthood of Ind., Inc. v. Comm'r of Ind. State Dep't of Health*, 699 F.3d 962 (7th Cir. 2012), can be analyzed together. They both found that 42 U.S.C. §1396a(a)(23) provided patients a private right 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." *Betlach*, 727 F.3d at 962. But they were clear that §1396a(a)(23) only applied because the cases 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, e.g.*, *id.* at 973.

The courts acknowledged that a state's power to exclude a provider under §1396a(p)(1) was an exception to the free-choice-of-qualified-provider rule in §1396a(a)(23). *See id.* Both courts 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." *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.* The scope of the private right of action in those cases was far more minimal than what Appellees envision here. Plaintiffs in those cases were not seeking a right to collaterally challenge misconduct-based disqualifications by the governing state agency.

The Sixth Circuit, in *Harris v. Olszewski*, 442 F.3d 456 (6th Cir. 2006), addressed whether §1396a(a)(23) conferred a federal right not to be steered to one particular medical provider. That court allowed a Medicaid patient to challenge a contract requiring all Medicaid patients to receive incontinence products from a single supplier. *Harris*, 442 F.3d at 459. But *Harris* has 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 disqualifying misconduct.

In any event, these cases pre-date *Armstrong*,[8] and none of these circuits have had the chance to opine on whether their analysis of subsection (a)(23)(A)

[8] While the opinion in *Gee* is post-*Armstrong* and addresses the same question presented here, a petition for rehearing en banc has been pending in that case for months. *Planned Parenthood of Gulf Coast, Inc. v. Gee*, 862 F.3d 445 (5th Cir. 2017), *pet. for reh'g filed*, No. 15-30987 (July 13, 2017). This Court should not assume what the final word from the Fifth Circuit will be.

would change in light of such an important and seminal case. This Court should not assume, as Appellees do, that these circuits will ignore *Armstrong*. In short, the depth and pervasiveness of the circuit split identified by Appellees is suspect. Moreover, the Panel specifically acknowledged the split and persuasively identified the flaws in the out-of-circuit decisions.

Conclusion

The Panel correctly concluded that 42 U.S.C. §1396a(a)(23) does not unambiguously confer on every patient in the United States a right to collaterally challenge a Medicaid provider's exclusion for misconduct. The Panel's conclusion and analysis were consistent with *Armstrong*, *Gonzaga*, and *Midwest Foster Care*. Appellees' suggestion that the Panel should have ignored the structure, context, and language of the Medicaid Act—and focused solely on subsection (a)(23)(A) in a vacuum and out of context—cannot be squared with these precedents. And the circuit split claimed by Appellees is blown far out of proportion. Rehearing en banc is unnecessary and should be denied.

Respectfully submitted,

LESLIE RUTLEDGE
Arkansas Attorney General

/s/ Lee P. Rudofsky

LEE P. RUDOFSKY
Arkansas Solicitor General

CHARLES LYFORD
Assistant Attorney General

OFFICE OF THE ARKANSAS
ATTORNEY GENERAL
323 Center St., Suite 200
Little Rock, AR 72201
(501) 682-6302
lee.rudofsky@arkansasag.gov

Attorneys for Appellants

CERTIFICATE OF SERVICE

I hereby certify that on October 24, 2017, I electronically filed the foregoing 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 Appellees are registered CM/ECF users and that service will be accomplished by CM/ECF.

/s/ Lee P. Rudofsky