No. 17-50282

In the United States Court of Appeals for the Fifth Circuit

PLANNED PARENTHOOD OF GREATER TEXAS FAMILY PLANNING AND PREVENTATIVE HEALTH SERVICES, INC.; PLANNED PARENTHOOD SAN ANTONIO; PLANNED PARENTHOOD CAMERON COUNTY; PLANNED PARENTHOOD GULF COAST, INC.; PLANNED PARENTHOOD SOUTH TEXAS SURGICAL CENTER; JANE DOE #1; JANE DOE #2; JANE DOE #4; JANE DOE #7; JANE DOE #9; JANE DOE #10; JANE DOE #11;

Plaintiffs-Appellees,

v.

DR. COURTNEY PHILLIPS, IN HER OFFICIAL CAPACITY AS EXECUTIVE COMMISSIONER OF HHSC; SYLVIA HERNANDEZ KAUFFMAN, IN HER OFFICIAL CAPACITY AS INSPECTOR GENERAL OF HHSC,

Defendants-Appellants.

On Appeal from the United States District Court
for the Western District of Texas, Austin Division,
No. 1:15-cv-01058

APPELLANTS' EN BANC BRIEF

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No. 17-50282

Planned Parenthood of Greater Texas Family Planning and Preventative Health Services, Inc.; Planned Parenthood San Antonio; Planned Parenthood Cameron County; Planned Parenthood Gulf Coast, Inc.; Planned Parenthood South Texas Surgical Center; Jane Doe #1; Jane Doe #2; Jane Doe #4; Jane Doe #7; Jane Doe #9; Jane Doe #10; Jane Doe #11;

Plaintiffs-Appellees,

v.

Dr. Courtney Phillips, in her official capacity as Executive Commissioner of HHSC; Sylvia Hernandez Kauffman, in her official capacity as Inspector General of HHSC,

Defendants-Appellants.

The undersigned counsel of record certifies that the following listed persons and entities as described in the fourth sentence of Rule 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges of this Court may evaluate possible disqualification or recusal.

Plaintiffs-Appellees	**Former or present counsel**
• Planned Parenthood of Greater Texas Family Planning and Preventative Health Services, Inc. • Planned Parenthood San Antonio • Planned Parenthood Cameron County • Planned Parenthood South Texas Surgical Center • Planned Parenthood Gulf Coast, Inc.	• Jennifer Sandman • Maithreyi Ratakonda • Roger Evans • Alice Clapman • Richard Muniz • Thomas H. Watkins • Helene Krasnoff

• Jane Does # 1, 2, 4, 7, 9, 10, and 11	
Defendants-Appellants	**Former or present counsel**
• Dr. Courtney Phillips, in her official capacity as Executive Commissioner of HHSC • Sylvia Hernandez Kauffman, in her official capacity as Inspector General of HHSC	• Ken Paxton • Jeffrey C. Mateer • Brantley D. Starr • Scott A. Keller • Kyle D. Hawkins • James E. Davis • Heather Gebelin Hacker • Beth Klusmann • Angela V. Colmenero • Andrew B. Stephens • Amanda J. Cochran-McCall • Adam A. Biggs • Marc E. Rietvelt • Patrick K. Sweeten • Shelley Dahlberg

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STATEMENT REGARDING ORAL ARGUMENT

The Court directed the Clerk to set this matter for oral argument in its order granting rehearing en banc.

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INTRODUCTION

In 2015, several hours of undercover video footage were filmed at a Planned Parenthood mega-clinic in Houston, revealing the clinic's shocking ethical lapses. Planned Parenthood staff were filmed sifting through fetal body parts in a Pyrex dish and negotiating with individuals posing as employees of a tissue-procurement firm who wanted intact second-trimester fetal cadavers they could sell to researchers. These staff members openly discussed how a clinic doctor violated federal regulations by performing abortions to harvest fetal tissue for her own research, which she would then take home in her cooler. Most distressing of all, Planned Parenthood employees discussed their ability to modify the abortion procedure, depending on the mother's pain tolerance, to obtain better fetal-tissue samples—another plain violation of federal regulations and an obvious threat to women's health.

Upon receiving and reviewing the video documenting Planned Parenthood's unlawful and unethical conduct, the Texas Office of the Inspector General concluded that Planned Parenthood was no longer qualified to remain in the state Medicaid program, and it initiated proceedings to terminate the State's agreement with Texas Planned Parenthood affiliates. Planned Parenthood had a right to challenge that termination through state administrative proceedings, but it chose not to do so. It instead enlisted a handful of patients and filed this lawsuit. The district court entered a preliminary injunction enjoining the State's termination of Planned Parenthood—the patients' preferred Medicaid provider.

At issue before the en banc Court is whether that injunction is permissible. It is not, for all the reasons set out in the State's panel-stage briefing and adopted by the panel, and for the additional reason now before the en banc Court: The Medicaid Act does not create a private right of action that allows individuals to challenge a state agency's determination that a service provider is not "qualified" under the Act. The individuals' lawsuit thus ends before it begins, because when "the statute does not create an enforceable federal right, then . . . there is no likelihood of success on the merits." *Does v. Gillespie*, 867 F.3d 1034, 1039 (8th Cir. 2017).

For the reasons set out in this brief and in the Appellants' panel-stage briefing, the en banc Court should overrule *Planned Parenthood of Gulf Coast, Inc. v. Gee*, 862 F.3d 445 (5th Cir. 2017), which held that 42 U.S.C. section 1396a(a)(23) creates a private right of action. It should reverse the judgment below, vacate the injunction, and render a judgment of dismissal with prejudice as to the individuals' claims.

Jurisdictional Statement

This Court continues to properly exercise appellate jurisdiction under 28 U.S.C. section 1292. *See* Appellants' Br. 2.

Issues Presented

Appellants' panel-stage briefing laid out the issues on appeal. *See* Appellants' Br. 2-3. In addition to those issues, the en banc Court should address the following issue, which is the focus of this En Banc Brief:

Whether the Court should overrule *Planned Parenthood of Gulf Coast, Inc. v. Gee* and hold that 42 U.S.C. section 1396a(a)(23) does not create a private right of action.

STATEMENT OF THE CASE

I. Statutory Framework

A. Congress enacted the Medicaid Act in 1965 to expand access to health care for low-income individuals and families. *See* 42 U.S.C. Ch. 7, Subch. XIX; *Harris v. McRae*, 448 U.S. 297, 301 (1980). The Act creates a federal-state partnership for the delivery of medical services. *Harris*, 448 U.S. at 301. Under that partnership, the individual States develop a "State plan for medical assistance." 42 U.S.C. § 1396a. The federal government, in turn, makes payments to States to pay for half or more of their costs in furnishing services to recipients. *Id.* States are given "broad discretion . . . to determin[e] the extent of medical assistance." *Beal v. Doe*, 432 U.S. 438, 444 (1977). That discretion is constrained by several dozen specific requirements that a state plan must satisfy in order to receive federal funding. Most of these requirements are set out in 42 U.S.C. section 1396a(a).

If a state plan satisfies the requirements of section 1396a(a), then the federal Secretary of Health and Human Services "shall approve" the plan. *Id.* § 1396a(b). Likewise, if a once-approved state plan ceases to substantially comply with section 1396a(a)'s requirements, then the Secretary must cut off at least a portion of Medicaid funding. *See id.* § 1396c.

Among section 1396a(a)'s many requirements is the qualified-provider provision at the heart of this case. It states that to be approved by the Secretary, state plans must "provide that any individual eligible for medical assistance . . . may obtain such

assistance from any [provider] qualified to perform the service or services required . . . who undertakes to provide him such services." *Id.* § 1396a(a)(23).

B. Texas, like every other State, has chosen to participate in the Medicaid program. To provide the required services, Texas forms provider agreements with physicians and facilities whereby those providers treat Medicaid patients in exchange for reimbursement from the State. All Texas Medicaid providers are required to execute a standard Medicaid-provider agreement, which states that providers must comply with all requirements in the State's provider manual plus state and federal Medicaid rules. ROA.6553. The State has a robust Medicaid network covering 4.3 million beneficiaries. ROA.4510. Texas Medicaid recipients have access to 141,000 providers, including 29,000 primary care physicians and over 3,300 obstetrician/gynecologists. ROA.4511, 4515.

Consistent with federal law, and to ensure the safety of its Medicaid subscribers, Texas law imposes rigorous standards and requirements on Medicaid providers. First and foremost, all Medicaid providers must adhere to accepted medical and ethical standards. *See* ROA.6273 (a provider violates Texas Medicaid rules when it fails to provide healthcare services to Medicaid clients in accordance with "accepted medical community standards."). Providers who fail to do so are unqualified to participate in the Texas Medicaid program. *See* ROA.6555 (providers may be terminated for failure to comply with the provisions of the provider agreement or any applicable Medicaid rules, or "any circumstances indicating that the health or safety of

clients is or may be at risk"). Providers must further ensure that all their employees and agents comply with these requirements. ROA.6553.

The Texas Health and Human Services Commission (HHSC) administers the state Medicaid plan. The HHSC Office of the Inspector General (OIG) is charged with maintaining program integrity and "operat[ing] a Medicaid fraud and abuse control unit." 42 U.S.C. § 1396a(a)(61); *see also* ROA.4314-15 (describing OIG role). To combat fraud and waste, state law authorizes OIG to take enforcement actions against and even terminate a Texas Medicaid provider's agreement when OIG establishes "by prima facie evidence" that a provider has committed a "program violation"; is "affiliated" with a provider that commits a program violation; or commits "an act for which sanctions, damages, penalties, or liability could be assessed by the OIG." 1 Tex. Admin. Code § 371.1703(c)(6)-(8). OIG may impose such sanctions, including termination of provider agreements, when the provider "fails to provide an item or service to a recipient in accordance with accepted medical community standards or standards required by statute, regulation, or contract, including statutes and standards that govern occupations." *Id.* § 371.1659(2). Texas law permits the termination of affiliates of terminated entities. ROA.1211 (citing 1 Tex. Admin. Code §§ 371.1703(c)(7), 1605(a) (providers responsible for own actions plus actions of "affiliates, employees, contractors, vendors, and agents")).

II. Factual Background

A. The undercover video

Planned Parenthood Federation of America has three affiliates in Texas ("Provider Plaintiffs") that receive Medicaid reimbursements: Planned Parenthood of Greater Texas (PPGT), Planned Parenthood South Texas (PPST),[1] and Planned Parenthood Gulf Coast (PPGC). ROA.1512-13. Together, these providers serve only 0.3% of all Texas Medicaid patients. ROA.4518. In 2016, Texas paid approximately $3.4 million in total Medicaid reimbursements to the Provider Plaintiffs. ROA.4315.

On April 9, 2015, over eight hours of undercover video were filmed at PPGC's facility in Houston. ROA.5846-6208 (video transcript); ROA at DX-2.[2] Two individuals posing as employees of a fictitious tissue-procurement company wore hidden cameras and met with PPGC's employees to discuss entering into a business arrangement to procure liver, thymus, and neural tissue from fetuses aborted in the second trimester of pregnancy. *See* ROA.5846-6208 (video transcript); ROA at DX-2.

As an overview, the video showed Melissa Farrell—PPGC's Research Director—admitting that:

- "some of our doctors in the past have [had] projects, and they're collecting the specimens" for their own fetal-tissue research projects after performing abortions;

[1] Named Plaintiffs Planned Parenthood San Antonio, Planned Parenthood Cameron County, and Planned Parenthood South Texas Surgical Center are subsidiaries of PPST. ROA.3231. This brief will refer to these related entities collectively as PPST.

[2] DX-2 refers to a thumb drive containing video footage, which is part of the record on appeal.

- these doctors altered the abortion procedure "in a way that they get the best specimen";
- a particular doctor "would look at the schedule and pick which" specific patients to perform abortions on "[b]ecause she wanted certain gestational age" for her fetal-tissue specimens;
- this doctor "knows what's involved in modifying what we need to do to get you the specimens that are intact because she's done it";
- and this doctor would take the specimens she obtained for her own studies "home with her in her cooler."

These statements, especially when considered in context, show violations of federal research regulations. Farrell stated, in response to a question about whether PPGC doctors could change the abortion procedure to obtain more intact specimens, that as long as the modification did not affect patient safety or leave tissue inside the patient, the doctors could do it and had in fact already done so:

> [S]ome of our doctors in the past have [had] projects, and they're collecting the specimens *so they do it in a way that they get the best specimen.* So I know it can happen.

ROA.5884 (emphasis added); ROA at DX-2 at 8:04:08-8:05:35. In discussing a particular doctor (Dr. Regan Theiler), Farrell admitted:

> [O]ne of the researchers that I can think about, she was performing the procedures and would look at the schedule and pick which ones and let staff know, hey, can we try to enroll these. Because she wanted certain gestational age.

ROA.5976; ROA at DX-2 at 9:46:47-9:47:26. Farrell explained that this doctor was an example of one of their doctors who could "modify[]" abortion procedures to obtain more "intact" specimens "because she's done it":

> So she knows what's involved in modifying what we need to do to get you the specimens that are intact because she's done it. And—I'm surprised I didn't think about her a minute ago. Yeah, Dr. Theiler would be a good one. And she was doing those here.

ROA.5978; ROA at DX-2 at 9:48:05-9:48:27. Farrell added:

> [E]ven then it was either they would collect it and Research would go up and just get this box full of containers or Dr. T[hei]ler would collect her own, take it home with her in her cooler.

ROA.6180; ROA at DX-2 at 14:30:19-14:30:25.

During another portion of the video, PPGC staff and the individuals wearing cameras were sifting through fetal body parts to judge whether intact specimens were possible. PPGC staff—including Tram Nguyen, director of PPGC's abortion-performing ambulatory surgical center—alluded to abortion doctors obtaining intact fetal-tissue samples while circumventing the federal partial-birth-abortion ban, 18 U.S.C. § 1531, by claiming they did not "intend" to remove the fetus intact:

> TR[A]M: Yeah, you can get that. But it's big, yeah. Organs come out really well. Like Dr. B[]said, you never intend to complete the procedure intact. You intend to but—You intend to, but it happens.
>
> ROBERT SARKIS: You just have an intent statement, right?
>
> TR[A]M: That's correct, there's an intent statement [laughter] that you have to document.

ROA.6150-51; ROA at DX-2 at 14:03:11-14:03:50.

The footage also indicates that PPGC was willing to modify procedures to obtain more intact specimens in ways that could increase pain to patients. In the context of discussing whether PPGC doctors could obtain intact fetal specimens, Nguyen stated:

> TR[A]M: Yeah. And, you know, the other, the other thing that plays a tremendous part in this all is the dilation that you've obtained. And also how—lack of a better word, how cooperative the patient is during the procedure.
>
> ROBERT SARKIS: Oh, really. But are they under conscious sedation or what's the—
>
> TR[A]M: Yeah. Conscious sedation, but there's also times where it's just *you've pretty much maxed out and that's their tolerance.*

ROA.6159-60 (emphasis added); ROA at DX-2 at 14:10:50-14:12:30.[3]

B. OIG's evaluation of the video evidence and termination proceedings.

The unedited video footage was provided to OIG. ROA.4323. Based on an initial assessment of the video and other information, OIG determined that Planned Parenthood did not comply with Texas Medicaid requirements. Accordingly, OIG sent a preliminary Notice of Termination to the Provider Plaintiffs that began—but did not complete—the process of terminating their Medicaid provider agreements. ROA.1202-06, 1239-43, 1310-14. That letter gave the Provider Plaintiffs notice that they could (1) request an informal resolution meeting to address the initial findings

[3] More detailed analysis of the video is found in Appellants' Br. 34-41.

in the Notice, and/or (2) submit evidence and argument to OIG regarding whether the Notice was warranted. ROA.1205-06, 1242-43, 1313-14.

They did neither. Instead, the Provider Plaintiffs and ten anonymous patients ("Individual Plaintiffs") filed a complaint in federal district court on November 23, 2015, challenging the preliminary notice under the qualified-provider provision. ROA.31-59. Those proceedings were stayed pending the conclusion of the termination process. ROA.777-81.

During this process, the Texas Inspector General watched the entire unedited video five times, in addition to reviewing a transcript of the video. ROA.4328, 4356. The Inspector General also consulted with OIG's Chief Medical Officer, who also reviewed the unedited video footage and informed the Inspector General that the video demonstrated that PPGC violated accepted medical and ethical standards. ROA.4326. Meanwhile, the U.S. House of Representatives and U.S. Senate both investigated Planned Parenthood. *See* Majority Staff Report of S. Comm. on Judiciary, 114th Cong., Human Fetal Tissue Research: Context and Controversy (Comm. Print 2016), https://perma.cc/F9MF-3ZBU; ROA.7328-7798 (U.S. House Select Investigative Panel report); ROA.8883. OIG received additional evidence attached to a referral letter from the U.S. House Select Investigative Panel. ROA.1210, 4341-42; ROA.8883-93. Again, the Provider Plaintiffs chose not to submit any evidence during the administrative process.

Shortly thereafter, OIG sent the Provider Plaintiffs a Final Notice of Termination. ROA.1209-14. Each Planned Parenthood affiliate in Texas has several clinics,

each with their own provider number for reimbursement. As a result, over 50 provider agreements were slated for termination. ROA.1214. The Final Notice stated that the termination was based on statements in the video indicating that the Provider Plaintiffs violated accepted medical and ethical standards in numerous ways. ROA.1210-11. The Final Notice explained that the termination was also based on a misrepresentation to Texas law-enforcement officials about PPGC's activity related to fetal-tissue procurement, as documented in the House Panel's referral letter. ROA.1211 (citing, *e.g.*, Tex. Penal Code § 37.08; 1 Tex. Admin. Code §§ 371.1661, 371.1655(24)).

OIG also found that the Provider Plaintiffs' practices violate federal research regulations. Among other things, federal law generally provides that abortion procedures cannot be modified solely for purposes of obtaining fetal tissue. *See* 42 U.S.C. § 289g-1(b)(2)(A)(ii) (human fetal tissue may be used for research only if "no alteration of the timing, method, or procedures used to terminate the pregnancy was made solely for the purposes of obtaining the tissue"). Nor can a researcher take part in "any decisions as to the timing, method, or procedures used to terminate the pregnancy made solely for the purposes of the research." *Id.* § 289g-1(c)(4); *accord* 45 C.F.R. § 46.204(i). If the physician performing the abortion has any interest in the research to be conducted with the fetal tissue, federal law requires this to be fully disclosed to the patient. 42 U.S.C. § 289g-1(b)(2)(C)(i). It is also "unlawful for any person to knowingly acquire, receive, or otherwise transfer any human fetal tissue

for valuable consideration if the transfer affects interstate commerce." *Id.* § 289g-2(a); *accord* Tex. Penal Code § 48.02(b).

The Final Notice stated that Provider Plaintiffs had the option to ask for an administrative hearing to appeal the termination. ROA.1213. The Notices also stated that if no hearing was requested in writing within 15 days of receipt, the termination would become final and unappealable on the 30th day after receipt of the Notice. ROA.1213. Provider Plaintiffs failed to request a hearing.

III. Procedural History

A. District court proceedings

After the Provider Plaintiffs received the Final Notice of Termination, district court proceedings resumed. Plaintiffs filed a motion for preliminary injunction and an amended complaint which also challenged the Final Notice. ROA.1143-79, 3227-48. On January 17-19, 2017, the district court held an evidentiary hearing on Plaintiffs' preliminary-injunction motion. ROA.22, 23. During the hearing, Plaintiffs presented testimony from the Provider Plaintiffs' CEOs; Farrell, PPGC's Research Director; Dr. Paul Fine, PPGC's Medical Director; and two rebuttal witnesses. ROA.4093, 4507.

Not a single witness for the Plaintiffs had ever watched the video in evidence, despite offering testimony on what it depicted. ROA.4144, 4149-50, 4201-02, 4269-70, 4622-24. Not even Plaintiffs' counsel had watched the entire video. ROA.4622-24. Plaintiffs offered no evidence that this recording had been edited or altered to

depict something that had not occurred or to remove a comment from its context. *See* ROA.4091-4675.

Defendants presented testimony from the Inspector General and OIG's Chief Medical Officer. ROA.4310, 4313-48 (Inspector General's direct testimony), 4390-97 (Chief Medical Officer's direct testimony). Defendants further presented an expert in obstetrics/gynecology and a bioethics expert. ROA.4310, 4403-21 (Professor Orlando Snead's direct testimony), 4476-89 (Dr. Mikeal Love's direct testimony). Defendants also presented testimony from state officials regarding the provision of Texas Medicaid services and other women's health programs. ROA.4310, 4440-47 (Leslie French Henneke's direct testimony), 4507, 4509-20 (Jami Snyder's direct testimony). The undercover video was admitted into evidence. ROA.4333. Portions of the video were played during witness testimony—particularly during the testimony of the Inspector General, where he identified specific portions of the video relied upon to form OIG's conclusions. Defendants offered multiple pieces of evidence showing the video's reliability and authenticity. ROA.4329-30, 8863-65; *see also* ROA.1605-10, 2390. On cross-examination, Farrell admitted that she was depicted in the video. ROA.4203-04. The district court overruled the Plaintiffs' authenticity objection to the video, stating, "I don't think you can dream of a good enough objection to keep it out." ROA.4333.

On January 19, 2017, the district court entered a temporary restraining order enjoining the Provider Plaintiffs' termination. ROA.3551. A month later, the district court issued a preliminary injunction against the termination of all the Provider

Plaintiffs' Medicaid provider agreements. ROA.3776-3819. The district court issued the preliminary injunction on behalf of the Individual Plaintiffs only. ROA.3796, 3932.

Relying on this Court's decision in *Planned Parenthood of Gulf Coast, Inc., v. Gee*, the district court found that the Individual Plaintiffs had a right of action. ROA.3795-96. The court applied no deference to the agency's decision and considered evidence outside the administrative record. The district court credited the Plaintiffs' post hoc explanations of the statements in the video over the video itself, which was the only evidence in the administrative record since the Provider Plaintiffs chose not to participate in administrative proceedings. ROA.3799-3814. The district court simultaneously refused to consider any of the State's post-termination evidence or testimony. ROA.3798-99.

Both the panel majority and the dissent in *Gee* agreed that the providers themselves lack a cause of action. *Gee,* 862 F.3d at 460, 486. The State's motion to dismiss the rest of the case—the Provider Plaintiffs' non-existent Medicaid Act claim and improperly pleaded and meritless Equal Protection claim—is still pending in district court. ROA.3733-43, 3950.

B. Panel decision

The State timely appealed. ROA.3938; *see* Fed. R. App. P. 4(a)(4)(A). On appeal, the State argued that notwithstanding the Court's decision in *Gee*, the Individual Plaintiffs had no private right of action because *Gee* did not involve a final decision on the merits, and this case does. Appellants' Br. 22-27 & nn. 5-6. The State

also preserved the argument that there is no private right of action and that *Gee* was wrongly decided, Appellants' Br. 24 n.6, and argued that *Gee* could not provide a right of action in this case because it would conflict with *O'Bannon v. Town Court Nursing Center*, 447 U.S. 773, 786 (1980), Appellants' Br. 22-27; Reply Br. 2-5. The State further argued that even if there were a private right of action under the Medicaid Act, the district court abused its discretion by granting a preliminary injunction. Appellants' Br. 27-58; Reply Br. 7-21.

On January 17, 2019, a panel of this Court ruled in favor of the State and vacated the preliminary injunction. *Planned Parenthood of Greater Tex. Family Planning & Preventative Health Servs., Inc. v. Smith*, 913 F.3d 551 (5th Cir. 2019). The panel determined that it was "constrained" by *Gee*'s conclusion that the Individual Plaintiffs have a private right of action under 42 U.S.C. section 1396a(a)(23). *Id.* at 554. But the panel held that the district court abused its discretion by reviewing OIG's termination decision de novo, rather than under arbitrary-and-capricious review, and by considering evidence outside of the administrative record. *Id.* at 559, 565-69.[4] The Court remanded the case to the district court for application of the correct standard to the evidence in the administrative record alone. *Id.* at 569.

Judge Jones wrote a separate concurrence to outline the reasons that *Gee*'s holding was incorrect, and requested rehearing en banc to "reconsider whether Section

[4] Regardless of whether there is a private right of action for the Individual Plaintiffs under the qualified-provider provision, this portion of the panel's opinion is correct and should not be revisited en banc.

1396a(a)(23) creates a private right of action on behalf of Medicaid patients to challenge the termination of their providers' contracts by the States." *Id.* at 573. This Court granted rehearing en banc on its own motion on February 4, 2019.

Summary of the Argument

The candid video footage in the record shows that the State rationally—and rightfully—excluded the Provider Plaintiffs from the Texas Medicaid program. But the Plaintiffs cannot even get that far because they lack a right of action.

I. The text, structure, and context of the qualified-provider provision and the Medicaid Act do not show that Congress unambiguously intended to confer a private right of action on individual Medicaid recipients. The provision is one of 86 subsections detailing what State plans must provide in order to gain approval from the Secretary of Health and Human Services, and the overall statute is designed to provide guidance to the Secretary in approving plans. The Supreme Court—and this Court—have previously held that this structure and text do not show unambiguous intent to confer a private right of enforcement on individuals. Instead, the explicitly provided means of enforcement is through loss of funding by the federal government. This Court's contrary ruling in *Gee* disregards precedent showing there is no right of action under the qualified-provider provision and should be overruled.

II. Even if there were a private right of action under the qualified-provider provision, it would not extend so far as to give Medicaid recipients the right to services from a provider the State has disqualified, nor to allow Medicaid recipients to collaterally attack the disqualification of a Medicaid provider in federal court, as these

Plaintiffs are attempting to do. Such an action would again be contrary to the text of the statute and the Supreme Court's decision in *O'Bannon*. The qualified-provider provision refers only to providers the State has qualified, and the Medicaid Act grants broad authority to States to determine the qualifications of their providers. Moreover, the text of the statute makes clear that States may disqualify providers for reasons unrelated to their bare capability to provide medical services. The panel majority in *Gee* erred in interpreting "qualified" more broadly than the text of the statute permits, and in granting a right of action that permits plaintiffs to do precisely what the Supreme Court disallowed in *O'Bannon*. The practical results of permitting such an action only underscore that Congress intended no such thing. Thus, the Individual Plaintiffs lack a private right of action under this alternative ground, and *Gee* should be overruled for this additional reason.

III. Because Individual Plaintiffs lack a right of action, the Court should render a judgment of dismissal. There is no need to reach the merits. But if the Court were to do so, the State remains entitled to reversal for all the reasons identified in the panel decision and the State's panel-stage briefing. The district court's injunction is manifestly improper. It cannot be squared with *Pennhurst*'s clear-statement rule. It applied the wrong standard of review to the wrong evidence. The balance of harms, equities, and public interest all weigh against injunctive relief.

ARGUMENT

Section 1393a(a)(23) "does not create an enforceable federal right," and the Individual Plaintiffs therefore cannot win injunctive relief because they necessarily

have "no likelihood of success on the merits." *Gillespie*, 867 F.3d at 1039. Neither the text of the Medicaid Act, nor its context or structure, support a private right of action. In addition, even if a right of action could properly be inferred from the text, it could not provide a right for individual Medicaid recipients to demand care from an unqualified provider, or challenge their chosen provider's disqualification.

For these reasons, and for those set out in Appellants' panel-stage briefing, the Court should reverse the judgment below and render a judgment of dismissal as to the Individual Plaintiffs.

I. The Qualified-Provider Provision Does Not Create a Private Right of Action.

Private rights of action do not exist in the ether; they "must be created by Congress." *Alexander v. Sandoval*, 532 U.S. 275, 286 (2001) (citing *Touche Ross & Co. v. Redington*, 442 U.S. 560, 578 (1979)). So the Individual Plaintiffs must demonstrate that the Medicaid Act bestows on them the private right of action they assert. *See id.* They can do so by demonstrating either an express statutory command or, absent that, congressional "intent to create not just a private right but also a private remedy." *Id.* Without evidence of a congressional intent to create both a private right and a remedy, "a cause of action does not exist and courts may not create one, no matter how desirable that might be as a policy matter, or how compatible with the statute." *Id.* at 286-87.

Of course, there is no express cause of action within the four corners of the Medicaid Act, and Plaintiffs do not allege otherwise. Instead, Plaintiffs bring their cause

of action under 42 U.S.C. section 1983, alleging a violation of the qualified-provider provision of the Medicaid Act, 42 U.S.C. section 1396a(a)(23). ROA.31-50. Actions under section 1983 may be brought against state actors to enforce rights created by federal statutes. *Maine v. Thiboutot*, 448 U.S. 1, 9 (1980). But Plaintiffs "must assert the violation of a federal *right*, not merely a violation of federal *law*." *Blessing v. Freestone*, 520 US. 329, 340 (1997). Thus, in order for the Individual Plaintiffs to have a cause of action here, section 1396a(a)(23) must give rise to an enforceable private right.

There is no right of action here because the text, context, and structure of the Medicaid Act do not show an unambiguous congressional intent to confer one.

A. The qualified-provider provision does not show an unambiguous intent to confer a private right of action.

In a spending program like Medicaid, where "Congress intends to impose a condition on the grant of federal moneys [to States], it must do so unambiguously." *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981). Four years ago, *Armstrong v. Exceptional Child Center, Inc.* affirmed that the Supreme Court will not find an unenumerated right of action unless the text and structure of a statute show an unambiguous intent to create one. 135 S. Ct. 1378, 1387-88 (2015) (plurality op.); *see also Gonzaga Univ. v. Doe*, 536 U.S. 273, 286 (2002).

Armstrong made explicit what *Gonzaga* implied: the fact that a statute *benefits* a plaintiff does not mean it creates a private right of action. *Armstrong* and *Gonzaga*

thus overruled *Wilder v. Virginia Hospital Association*, which held that the core inquiry was whether the statute benefited the plaintiff. 496 U.S. 498, 509 (1990) (whether there is a private right of action "turns on whether the provision in question was intended to benefit the putative plaintiff" (internal quotation marks omitted)); *see also Blessing*, 520 U.S. at 340-41 (pre-*Gonzaga* test required inquiry into whether the statute benefited the plaintiff, whether the right protected was not so "vague and amorphous that its enforcement would strain judicial competence," and whether the right is "couched in mandatory, rather than precatory, terms" (internal quotation marks omitted)).

Gonzaga supplanted the *Wilder* and *Blessing* inquiry and explicitly rejected that "loose" standard. 536 U.S. at 282, 283. The Supreme Court "reject[ed] the notion that . . . anything short of an unambiguously conferred right [may] support a cause of action brought under § 1983." *Id.* at 283. *Armstrong* affirmed what *Gonzaga* established: "Our precedents establish that a private right of action under federal law is not created by mere implication, but must be 'unambiguously conferred.'" 135 S. Ct. at 1387-88 (plurality op.) (quoting *Gonzaga*, 536 U.S. at 283).

Thus, the Court should undertake a textual analysis consistent with the *Armstrong* and *Gonzaga* "unambiguous intent" standard. *See Gonzaga*, 536 U.S. at 286 ("[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 . . . under § 1983."). For the following reasons, the text and structure of section 1396a(a)(23)

do not show that Congress "unambiguously" intended to confer a private right of enforcement.

1. The context of the qualified-provider provision shows Congress did not unambiguously intend that it be enforced through a private right of action.

The structure of the Medicaid Act demonstrates that the qualified-provider provision does not unambiguously confer an individual right to the provider of one's choosing and a private right of action to enforce it. *Armstrong* analyzed another subsection of section 1396a, the equal-access provision, section 1396a(a)(30), but looked at the entirety of the Medicaid Act to provide context in considering whether there was an "unambiguously conferred" private right of action. *Armstrong*, 135 S. Ct. at 1388 (plurality op.). *Armstrong* concluded that there was no right of action for reasons that apply with equal force here.

Section 1396a(a) lists requirements for state plans, and, if the requirements are met, section 1396a(b) requires the Secretary to approve the state plan. The qualified-provider provision, 42 U.S.C. section 1396a(a)(23), is nested within section 1396a(a), which contains 86 subsections, including section 30 (equal-access provision). These subsections spell out what "State plan[s] for medical assistance must" have. *Id.* § 1396a(a). *Armstrong* noted that section 1396a(b) requires the Secretary to "approve any plan which fulfills the conditions specified in subsection (a)." 135 S. Ct. at 1387 (plurality op.). Section 1396a(a) should thus be read primarily as direction to the Secretary in approving state Medicaid plans. *Armstrong* concluded that the equal-access provision "lacks the sort of rights-creating language needed to imply a

private right of action" because it is part of section 1396a, which "is phrased as a directive to the federal agency charged with approving state Medicaid plans, not as a conferral of the right to sue upon the beneficiaries of the State's decision to participate in Medicaid." *Id.*

The context of the qualified-provider provision therefore creates a "significant difficult[y] with the contention that [it] unambiguously creates an enforceable federal right." *Gillespie*, 867 F.3d at 1041. And there is nothing about the language of the qualified-provider provision which would distinguish it from the equal-access provision and justify a different conclusion as to a right of action. It too is phrased as a directive to the Secretary in approving state plans: "[a] State plan for medical assistance must provide that any individual eligible for medical assistance . . . may obtain such assistance from any [provider] qualified to perform the service or services required . . . who undertakes to provide him such services. . . ." 42 U.S.C. § 1396a(a)(23)(A); *see also id.* § 1396a(b) ("The Secretary shall approve any plan which fulfills the conditions specified in subsection (a)"). Its language therefore "focuses neither on the individuals protected nor even on the funding recipients being regulated, but on the agencies that will do the regulating." *Sandoval*, 532 U.S. at 289. That cannot "confer the sort of '*individual* entitlement' that is enforceable under § 1983." *Gonzaga*, 536 U.S. at 287 (quoting *Blessing*, 520 U.S. at 343).

Even if a provision benefits a particular class, that does not "end the inquiry; instead, it must also be asked whether the language of the statute indicates that Congress intended that it be enforced through private litigation." *Univs. Research Ass'n,*

Inc. v. Coutu, 450 U.S. 754, 771 (1981). As the Supreme Court has noted, there is '"far less reason to infer a private remedy in favor of individual persons' where Congress, rather than drafting the legislation 'with an unmistakable focus on the benefited class,' instead has framed the statute simply as a general prohibition or a command to a federal agency." *Id.* at 772 (quoting *Cannon v. Univ. of Chicago*, 441 U.S. 677, 690-92 (1979)). Read together with section 1396a(b), section 1396a(a) is clearly framed as a directive to the Secretary as to the requirements of state plans he "must" approve. Under Supreme Court precedent, this kind of language does not indicate unambiguous congressional intent to create a private right of action.

2. The text of the qualified-provider provision does not use the "rights-creating" language necessary to support a private right of action.

Against that contextual backdrop, the text of the qualified-provider provision does not create any individual entitlement because the individual's choice of provider is dependent upon contingent events. A state plan is not required to allow recipients to choose *any* provider for services in order to be approved by the Secretary. Rather, the individual's choice is conditioned upon the fulfillment of three intervening requirements which are controlled by other actors. First, the State must elect to participate in Medicaid and furnish a plan, and the Secretary must approve it. *See Harris*, 448 U.S. at 301 (State's participation in the Medicaid program is "entirely optional"); 42 U.S.C. §§ 1396a(b), 1396c (Secretary approves state plans). Second, the provider must be "qualified to perform the service or services required," which is a determination made not by the recipient nor by the provider themselves, but by

the State and/or the Secretary. 42 U.S.C. § 1396a(a)(23); *see also id.* §§ 1320a-7(a)-(b), 1320a-7a, 1396a(a)(39), (41), 1396a(p); 42 C.F.R. § 1002.3. Third, the provider must "undertake to provide [the recipient] such services," which is the choice of the individual provider. Thus, even if the qualified-provider provision could be read outside of the context of section 1396a to provide an individual benefit for the recipient's choice of provider, there is no entitlement because others, including government actors, determine whether that benefit will ultimately be provided. *See Town of Castle Rock v. Gonzales*, 545 U.S. 748, 756 (2005) ("Our cases recognize that a benefit is not a protected entitlement if government officials may grant or deny it in their discretion.")

O'Bannon stated that under the qualified-provider provision, Medicaid recipients have a right "to choose among a range of *qualified* providers, without government interference. By implication, it also confers an absolute right to be free from government interference with the choice to remain in a home that continues to be qualified." 447 U.S. at 785. Other courts, including this Court, have relied on this to show Congress used "rights-creating" language. *See Gee*, 862 F.3d at 461; *Harris v. Olszewski*, 442 F.3d 456, 462 (6th Cir. 2006). But *O'Bannon* does not necessarily hold that there is a right, standing alone, which is *enforceable* through 42 U.S.C. section 1983. And if it did, that holding would be questionable under *Pennhurst*, which changed the way courts examine whether rights are created by Spending Clause legislation, *see* 451 U.S. at 18-19, 27-28, not to mention *Gonzaga* and *Armstrong*. Under *Gonzaga*, if a statutory provision fails to "clear[ly] and unambiguous[ly]" confer an

"*individual* entitlement," it is not enforceable under section 1983. 536 U.S. at 287 (quoting *Blessing*, 520 U.S. at 343), 290.[5]

3. The qualified-provider provision has an aggregate focus and Congress intended it be enforced through other means.

Further examination of the text and context of the qualified-provider provision reveals additional reasons that it fails to create a private right of action: The Act explicitly provides other means of enforcement, and the section of the Act the qualified-provider provision is part of has an aggregate—rather than individual—focus because it is centered on regulating HHS.

Section 1396c provides that the Secretary "shall" make no further payments to a State whose plan is noncompliant with section 1396a—which includes section 1396a(a)(23). The *Armstrong* Court explained that "such language 'reveals no congressional intent to create a private right of action.'" 135 S. Ct. at 1387 (plurality op.) (quoting *Sandoval*, 532 U.S. at 289, and citing *Universities Research Ass'n*, 450 U.S. at 772). Rather, the "explicitly conferred means of enforcing compliance with § 30(A) by the Secretary's withholding funding, § 1396c, suggests that other means of enforcement are precluded." *Id.*

The Medicaid Act also conditions funding on a State's substantial compliance with its requirements, meaning section 1396a has an "aggregate" focus, which does

[5] Regardless, even if *O'Bannon* identified an unambiguously created, enforceable individual entitlement under the qualified-provider provision, it did not identify a right for "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." 447 U.S. at 785; *see also* Part II *infra*.

not give rise to individual rights. *Gonzaga*, 536 U.S. at 288. A statutory provision lacks the "sort of 'rights-creating' language critical to showing the requisite congressional intent to create new rights" where it focuses on regulating an agency or institution and is not focused on individuals. *Id.* at 287.

In *Gonzaga*, the Supreme Court declined to recognize a private right of action to enforce the Federal Educational Rights and Privacy Act (FERPA) because the Act was directed at the Secretary of Education, directing the Secretary to withhold funds from institutions that fail to comply with FERPA's requirements. *Id.* The Supreme Court contrasted FERPA with Title IX, which is focused on individuals ("No person . . . shall, on the basis of sex . . . be subjected to discrimination," 20 U.S.C. § 1681(a)), and noted that in inferring a private right of action under Title IX, the Court distinguished it from legislation directed at regulating agencies. *Id.* at 287-88.

FERPA's focus in guiding the Secretary to withhold funding from non-compliant state agencies is similar to the Medicaid Act. 42 U.S.C. section 1396c directs the Secretary to approve state plans which comply with section 1396a(a). Section 1396a(a)(23)(A), in turn, provides that "[a] State plan for medical assistance must provide that any individual eligible for medical assistance . . . may obtain such assistance from any [provider] qualified to perform the service or services required . . . who undertakes to provide him such services. . . ." This "focus is two steps removed from the interests of individual [patients] and clearly does not confer the sort of '*individual* entitlement' that is enforceable under § 1983." *Gonzaga*, 536 U.S. at 287 (quoting *Blessing*, 520 U.S. at 343).

This Court came to a similar conclusion when analyzing section 1396a(a)(30) (the equal-access provision), which requires state plans to set reimbursement rates at levels 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." *Equal Access for El Paso v. Hawkins,* 509 F.3d 697, 703 (5th Cir. 2007) (quoting 42 U.S.C. § 1396a(a)(30)(A)). The Court read that provision "in the context of the entire statute" and concluded that "[i]t speaks only to the state and *the Secretary* in their functions of proposing and approving a state plan." *Id.* For similar reasons, because the statute at issue here has the same context, "speaks only in terms of institutional policy and practice, has an 'aggregate' rather than an individualized focus, and is not concerned with whether the needs of any particular person or class of individuals have been satisfied," it does not create a private individual right enforceable under section 1983. *Id.*

That the qualified-provider provision contains the word "individual" does not divorce it from the rest of the section listing requirements for state plans to be approved by the Secretary. It also does not evidence unambiguous congressional intent to create an individual right. As the Eighth Circuit noted, the reference to an "individual" is "nested within one of eighty-three subsections and is two steps removed from the Act's focus on which state plans the Secretary 'shall approve.'" *Gillespie*, 867 F.3d at 1042. Even if the use of the word "individual" in this context could create an inference of intent to create an individual right, the rest of the context of the

statute, as discussed above, does not. And "[w]here structural elements of the statute and language in a discrete subsection give mixed signals about legislative intent, Congress has not spoken—as required by *Gonzaga*—with a 'clear voice' that manifests an 'unambiguous intent' to confer individual rights." *Id.* at 1043 (cleaned up) (quoting *Gonzaga*, 536 U.S. at 280).

4. This Court's precedents do not support a private right of action.

Aside from Supreme Court case law, this Court's precedents also fail to provide support for a private right of action here. Before *Armstrong*, this Court concluded that other subsections of section 1396a(a) conferred a private right of action on Medicaid recipients. *See Romano v. Greenstein*, 721 F.3d 373 (5th Cir. 2013) (section 1396a(a)(8)); *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581 (5th Cir. 2004) (section 1396a(a)(10)). But these conclusions are now out-of-date and inconsistent with this Court's acknowledgment of the evolution of Supreme Court precedent in *Equal Access for El Paso,* 509 F.3d 697.

In *Equal Access for El Paso*, this Court examined whether the equal-access provision, section 1396a(a)(30), conferred a private right of action to recipients. The Court did not apply the *Blessing* factors, and determined that the Court's previous holding in *Evergreen Presbyterian Ministries Inc. v. Hood*, 235 F.3d 908 (5th Cir. 2000), which disallowed a section 1983 claim by providers to enforce section 1396a(a)(30) but permitted it for recipients, was abrogated by *Gonzaga*. *Equal Access for El Paso*, 509 F.3d at 704. The Court also recognized that *Gonzaga* supplanted the analysis of *Blessing* and *Wilder*:

> We may no longer, as we did in *Evergreen*, resolve the ambiguities in *Blessing*, *Wilder*, and the Equal Access provision in favor of finding a Congressional intent to authorize Medicaid recipients to bring Equal Access provision suits under § 1983. We are forced by *Gonzaga* to abjure the notion that anything short of an unambiguously conferred private individual "right," rather than the broader or vaguer "benefits" or "interests," may be enforced under § 1983. Accordingly, we may not follow *Evergreen*'s essential inference that, because Congress's aim in the Medicaid Act was to protect the interests of health care recipients as its primary, ultimate beneficiaries, Congress necessarily meant for recipients to enforce the Equal Access provision in private suits under § 1983.

Id.

The Supreme Court in *Armstrong* read *Gonzaga* the same way that this Court did in *Equal Access for El Paso*. *Armstrong* expressly rejected *Wilder* and the "ready implication of a § 1983 action that *Wilder* exemplified." 135 S. Ct. at 1386 n.*.

Last year, a panel of the Court suggested that *Wilder* had not been overruled in *Legacy Community Health Services, Inc. v. Smith*, 881 F.3d 358, 371-73 (5th Cir. 2018). But that case should not be applied here. In *Legacy*, the Court decided there is a private right of action for federally qualified health centers to bring an action for reimbursement under 42 U.S.C. section 1396a(bb) after applying the *Blessing* factors. *Id.* *Legacy* rejected the State's argument that *Armstrong* counseled against a private right of action for two reasons. First, *Armstrong* involved a challenge by beneficiaries to a reimbursement scheme, but the beneficiaries were not the subject of the reimbursement provision. Second, the Court viewed Texas's interpretation of *Armstrong* as going too far because it would mean that *Wilder* is overruled. *Id.*

The Court's first reason is inapplicable to this case. The Plaintiffs' claim does not involve a clear-cut contract-like dispute over direct mandatory reimbursements—it involves a choice of providers which are necessarily narrowed by multiple intervening factors controlled by others. *See* Part I.A.2 *supra*. And the Court's second reason seems to be incompatible with *Armstrong*'s explicit—and *Gonzaga*'s implicit—repudiation of *Wilder*. *See Armstrong*, 135 S. Ct. at 1386 n.*; *see also Gonzaga*, 536 U.S. at 300 n.8 (Stevens, J., dissenting) (concluding *Gonzaga* "*sub silentio* overrule[d] cases such as . . . *Wilder*."); *Gillespie*, 867 F.3d at 1040 (recognizing that *Armstrong* overruled *Wilder*).

The Court's other precedents pertaining to private rights of action in the Medicaid Act are unpersuasive in light of *Armstrong*. *Romano*, decided in 2013, is plainly out-of-step with *Armstrong*. It focused on the individual subsections at issue and ignored their context in the overarching statute in deciding they had no "aggregate focus" and did not "speak only in terms of institutional policy and practice." *Romano*, 721 F.3d at 379 (footnote omitted) (quoting *Gonzaga*, 536 U.S. at 288). This is contrary to *Armstrong*, which pointed out that section 1396a(a)

> is phrased as a directive to the federal agency charged with approving state Medicaid plans, not as a conferral of the right to sue upon the beneficiaries of the State's decision to participate in Medicaid. . . . We have held that such language "reveals no congressional intent to create a private right of action."

Armstrong, 135 S. Ct. at 1387 (plurality op.) (quoting *Sandoval*, 532 U.S. at 289).

In *Dickson*, which was decided in 2004, the Court did consider the context. But it relied on 42 U.S.C. section 1320a-2 to conclude that, for purposes of determining whether a provision is enforceable under section 1983, it is not dispositive that section 1396a lists requirements for state plans the Secretary must approve. 391 F.3d at 603. Section 1320a-2 was evidently designed to reverse a particular part of the holding of *Suter v. Artist M.*, 503 U.S. 347 (1992)—its suggestion that "when a provision of the Adoption Assistance and Child Welfare Act required a state plan and specified the mandatory elements of a plan, it required only that a State have a plan approved by the Secretary which contained those features, not that the plan actually be in effect." *Gillespie*, 867 F.3d at 1044 (citing *Suter*, 503 U.S. at 358). Congress otherwise expressed its intent *not* to (1) "expand the grounds for determining the availability of private actions to enforce State plan requirements," (2) overturn any other reasoning in *Suter* that had been "applied in prior Supreme Court decisions respecting such enforceability," or (3) alter *Suter*'s holding that the provision at issue in that case is "not enforceable in a private right of action." 42 U.S.C. § 1320a-2.[6]

Thus, consistent with section 1320a-2, *Suter*'s discussion of the requirement of unambiguous notice to States about the conditions on the receipt of federal funds and the availability of alternative means for enforcement are still good law. Moreover, section 1320a-2 has little applicability here. Because section 1320a-2 was enacted several years before *Gonzaga*, it "does not address the same question that a court

[6] Other courts have noted that section 1320a-2 is "hardly a model of clarity." *See Sanchez v. Johnson*, 416 F.3d 1051, 1057 n.5 (9th Cir. 2005).

must decide today. [It] speaks to when a 'provision' is 'deemed unenforceable'; we must decide whether a statute unambiguously 'confers an individual right' that can be enforced under § 1983." *Gillespie*, 867 F.3d at 1045.

Even if—at most—section 1320a-2 means that Congress intended for provisions in the Social Security Act to not be deemed unenforceable solely because they are part of a statute outlining the requirements for state plans, that does not render that context irrelevant. On the contrary, the context is key because Congress must "create new rights in clear terms that show unambiguous intent before they are enforceable under § 1983. Conflicting textual cues are insufficient." *Id.* And that is illustrated by *Armstrong*'s reliance on those factors, which shows that *Dickson*'s pre-*Armstrong* reasoning is outdated.

A final note about section 1320a-2: its presence in the Social Security Act shows that Congress knows how to provide guidance on the enforceability of the provisions of the Social Security Act and abrogate case law accordingly. When Congress knows how to say something and chooses not to, its silence is "strong evidence that it did not intend to do so." *Blue Cross & Blue Shield of Tex., Inc. v. Shalala*, 995 F.2d 70, 74 (5th Cir. 1993) (footnote omitted). Congress has never explicitly expanded the enforceability of the Medicaid Act in general or section 1396a in particular; that counsels heavily against finding any intent to provide a private right of action here. *See Marx v. Gen. Revenue Corp.*, 568 U.S. 371, 384 (2013) (The "use of explicit language in other statutes cautions against inferring a limitation in [another]. These statutes

confirm that Congress knows how to limit a court's discretion . . . when it so desires." (citing *Small v. United States*, 544 U.S. 385, 398 (2005) (Thomas, J., dissenting) (explaining that "Congress' explicit use of [language] in other provisions shows that it specifies such restrictions when it wants to do so")). And as *Gonzaga* and *Armstrong* require, congressional intent to create a private right of action must be unambiguous.

It is no wonder, then, that only twice since *Pennhurst* has the Court found spending legislation to give rise to enforceable rights, as noted in *Gonzaga*. 536 U.S. at 280. One of those decisions—*Wilder*—was later repudiated. *Armstrong*, 135 S. Ct. at 1386 n.* (citing *Gonzaga*, 536 U.S. at 283)). And in the other, the Court found an enforceable right under a rent-ceiling provision of the Public Housing Act because the provision "unambiguously conferred 'a mandatory [benefit] focusing on the individual family and its income," and "Congress spoke in terms that 'could not be clearer' and conferred entitlements 'sufficiently specific and definite to qualify as enforceable rights under *Pennhurst*.'" *Gonzaga,* 536 U.S. at 280 (quoting *Wright v. Roanoke Redevelopment & Hous. Auth.*, 479 U.S. 418, 430, 432 (1987)). The qualified-provider provision is no exception. Just like the provisions at issue in *Gonzaga* and *Armstrong*, it does not show unambiguous intent to create a private right of action.

B. *Gee*'s conclusion that the qualified-provider provision may be privately enforced under section 1983 is inconsistent with *Gonzaga* and *Armstrong* and should be overruled.

In *Gee*, a panel of this Court determined that the qualified-provider provision creates a private right of action for Medicaid recipients to enforce through section

1983. 862 F.3d at 459-60. But this decision heavily relied on holdings from the Sixth, Seventh, and Ninth Circuits that pre-dated *Armstrong*. *See id.* at 457-60. As a result, the reasoning in those decisions—as well as *Gee*—is unpersuasive.

The Sixth Circuit held that recipients of incontinence products under Medicaid had a right under 42 U.S.C. section 1396a(a)(23) to challenge the State's decision to enter into a single-source contract to provide those products in *Harris v. Olszewski*, 442 F.3d 456. The Court used the *Blessing* factors to assess the statute, and applied *Wilder* in placing the burden on the State to rebut the presumption created by the *Blessing* factors. *Id.* at 461. It used *Gonzaga* to complement, rather than replace, the *Blessing* factors, even though *Gonzaga* itself did not apply those factors. *Id.* But rather than searching for affirmative "unambiguous intent" to create a private right of action in a subsection of a statute aimed at regulating the Secretary, *Harris* merely determined that a private right to enforce the qualified-provider provision was "not inconsistent" with the fact that the Act allows the federal government to withhold funds for non-compliance, and no "other provisions of the Medicaid Act explicitly or implicitly foreclose the private enforcement of this statute through § 1983 actions." *Id.* at 462, 463. And it relied on *Wilder*'s conclusion that there was a private right of action "stemming from similar statutory language in the Medicaid Act." *Id.* at 463. Given *Armstrong*'s repudiation of *Wilder*, *Harris*'s reasoning is obsolete, and the Court should not consider it.

Gee's reliance on the Seventh and Ninth Circuit decisions is similarly out-of-date. The Seventh Circuit held that the qualified-provider provision creates a private

right of action because "[n]othing in the Medicaid Act suggests, explicitly or implicitly, that 'Congress specifically foreclosed a remedy under § 1983.'" *Planned Parenthood of Ind., Inc. v. Comm'r of Ind. State Dep't of Health*, 699 F.3d 962, 974 (7th Cir. 2012) (quoting *Gonzaga*, 536 U.S. at 284 n.4). It also relied on *Wilder*, which puts the burden in the wrong place. *Id.* at 975. Under *Armstrong*, the Court's job is not to look for anything *foreclosing* a section 1983 remedy—it is to look for unambiguous intent to *create* that remedy. 135 S. Ct. at 1387-88 (plurality op.); *see also id.* at 1386 (dismissing dissent's argument that the Court should presume a congressional intent to contemplate private enforcement "unless it *affirmatively* manifests a contrary intent"). The Seventh Circuit's reasoning is contrary to *Armstrong*.

The Ninth Circuit's decision suffers from similar flaws. It held—and the State apparently did not dispute, unlike Texas does here—that it was "evident" that Congress intended the qualified-provider provision to "unambiguously confer[] such a right upon Medicaid-eligible patients." *Planned Parenthood Ariz., Inc. v. Betlach*, 727 F.3d 960, 966 (9th Cir. 2013). For this proposition, the Court relied on (1) the statute's use of the word "individual," and (2) the fact that *Harris* and *Planned Parenthood of Indiana* so concluded. *Id.* at 966-67.

Aside from its heavy reliance on these pre-*Armstrong* decisions, *Gee* itself conflicts with *Armstrong* by disregarding it. *Gee* held that the State's reliance on *Armstrong* to show that the plaintiffs lacked a private right of action was "misplaced" because it concerned a different subsection of section 1396a(a). *Gee*, 862 F.3d at 461. But the majority overlooked that *Armstrong*'s conclusion was not specific to the

equal-access provision, but instead was supported by grounds that apply equally to the qualified-provider provision. *See* Part I.A.1 *supra*. *Armstrong* also relied on section 1396a(b), which also applies to the qualified-provider provision. *Armstrong*, 135 S. Ct. at 1387 (plurality op.); *see also* Part I.A.1 *supra*. There is no basis to distinguish *Armstrong*, and *Gee* therefore erred by not applying it.

The Tenth Circuit's decision relying on *Gee* is incorrect for similar reasons. In considering whether there is a private right of action under the qualified-provider provision (section 1396a(a)(23)), the Tenth Circuit declined to follow *Armstrong* because it involved a claim brought under the Supremacy Clause and because its Spending Clause reasoning was only joined by a plurality. *Planned Parenthood of Kan. v. Andersen*, 882 F.3d 1205, 1229 (10th Cir. 2018). But the Court was incorrect on both counts. First, *Gonzaga* held that implied-right-of-action reasoning applies in the section 1983 context. *See* 536 U.S. at 283 ("[W]e further reject the notion that our implied right of action cases are separate and distinct from our § 1983 cases. To the contrary, our implied right of action cases should guide the determination of whether a statute confers rights enforceable under § 1983.") And second, *Armstrong* stated its "repudiat[ion]" of *Wilder* in a footnote to the majority opinion. 135 S. Ct. at 1386 n.*.

The panel majority in *Gee* came to the wrong conclusion, and its reasoning suffers from fatal flaws because the Court failed to apply *Gonzaga* and *Armstrong* and relied on cases decided before *Armstrong*. The Court should overrule *Gee* and hold that there is no private right of action under the qualified-provider provision.

II. *O'Bannon* Forecloses a Private Right of Action and Requires That *Gee* Be Overruled.

Even if the structure and text of the qualified-provider provision did not foreclose a private right of action for enforcement, Supreme Court precedent makes clear that the Individual Plaintiffs have no right to the type of enforcement they seek here—to receive Medicaid services from providers the State has disqualified. The private right of action Plaintiffs propose would allow individual Medicaid recipients to challenge the disqualification of a provider. But again, the text of the provision forecloses such a right, and finding such a right would squarely conflict with *O'Bannon*.

Even if there were a privately enforceable right created by the qualified-provider provision, it would at most be a right to challenge the denial of the choice to receive services from a (1) qualified provider (2) who undertakes to provide the required services to the recipient. *See* 42 U.S.C. § 1396a(a)(23) ("A State plan for medical assistance must provide that any individual eligible for medical assistance . . . may obtain such assistance from any [provider] qualified to perform the service or services required . . . who undertakes to provide him such services."). Under the plain text of the statutory language, a Medicaid patient could have no enforceable right to demand services from an unqualified provider, nor from an unwilling provider. And the Supreme Court has held that the qualified-provider provision "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." *O'Bannon*, 447 U.S. at 785.

In *O'Bannon*, the Medicaid and Medicare provider agreements of a nursing facility were terminated by a state agency because the facility no longer met statutory and regulatory standards. *Id.* at 775-76. While the facility's administrative appeal was pending, the facility and six Medicaid patients filed suit in federal district court. *Id.* at 777. The patients asserted that they were entitled to a hearing before the facility could be decertified. But the Supreme Court concluded they were not entitled to a hearing under the Due Process Clause because they had no underlying substantive right to challenge the State's decertification of the home. *Id.* at 784-85. In the Supreme Court's view, "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.* at 786.

In *Gee*, the panel majority interpreted *O'Bannon* to mean only that patients do not have a right to services from a provider that has been disqualified for reasons "*connected to the state's enforcement of its health and safety regulations*." 862 F.3d at 461 (footnote omitted). In other words, it found that the qualified provider-provision "gives individuals the right to demand care from a qualified provider when access to that provider is foreclosed by reasons *unrelated* to that provider's qualifications." *Id.* at 462.

Because the panel majority believed that "[t]he Medicaid statute does not define the term 'qualified,'" it supplied its own definition, rather than taking cues from the rest of the Act. *Id.* The panel majority stated that '"[t]o be 'qualified' in the relevant

sense is to be capable of performing the needed medical services in a professionally competent, safe, legal, and ethical manner.'" *Id.* (footnote omitted) (quoting *Planned Parenthood of Ind.*, 699 F.3d at 978, and citing *Betlach*, 727 F.3d at 969). The panel majority rejected the State's argument that the qualified-provider provision only gave patients a right to services from a provider the State has qualified. The panel majority claimed that otherwise, "any right to which the Individual Plaintiffs are entitled to under § 1396a(a)(23) would be hollow," since their choice of providers would necessarily be limited by which providers the State qualifies. *Id.* at 463 (footnote omitted). The panel also suggested that if the State has not taken action to prevent the provider from providing *all* medical services in the State by revoking their medical license, it could not disqualify a provider from Medicaid. *See id.* at 465, 466, 469.

This analysis is flawed for at least three reasons. First, it overlooks the text of the Medicaid Act, which gives States the power to determine provider qualifications, and uses the term "qualified" elsewhere to refer to providers the States have qualified. Second, it overlooks that the Medicaid Act has provided alternate means of addressing any claim that providers are being wrongfully disqualified through both administrative remedies for the providers and the Secretary's withholding of Medicaid funds if a state plan is out of compliance. Third, it did not consider the practical ramifications of allowing patients to litigate a provider's qualifications, which show that it is unlikely that Congress would have intended such a result, and counsels against judicial creation of such a right of action.

A. *Gee*'s overly broad definition of "qualified" is incorrect because it is inconsistent with the statutory text.

1. *Gee*'s suggestion that the qualified-provider provision gives patients the right to any provider capable of practicing medicine is contradicted by the Act. Congress clearly intended that both the Secretary and the States have authority to exclude providers. 42 U.S.C. §§ 1320a-7(a)-(b), 1396a(a)(39), 1396a(p)(2). It also intended to permit wholly state-law-based exclusions. It gave the Secretary authority to exclude providers who have been excluded on state-law grounds. *Id.* § 1320a-7(b)(5). It also gave States the authority to exclude providers for the reasons outlined in sections 1320a-7 or 1395cc(b)(2), "[i]n addition to any other authority." *Id.* § 1396a(p)(1); *see also* 42 C.F.R. § 1002.3(b) ("Nothing contained in this part should be construed to limit a State's own authority to exclude an individual or entity from Medicaid for any reason or period authorized by State law."). As the Ninth Circuit has noted, the Act "plainly contemplates 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." *Guzman v. Shewry*, 552 F.3d 941, 949 (9th Cir. 2009). Otherwise, "[section 1320a-7(b)(5)] would not vest the Secretary with any authority not already provided elsewhere in the statute, and its inclusion would be redundant." *Id.*

The word "qualified" in section 1396a(a)(23) cannot be read to mean "qualified" in the sense of merely being able to provide medical services, otherwise any licensed medical provider would be eligible to participate in Medicaid, and that is not

the case. *See, e.g., id.* § 1320a-7(a)-(b) (license revocation is only one of twenty different grounds the Secretary may use to disqualify a Medicaid provider). It would also make the federal and state requirements for providers superfluous. Indeed, even the term "Medicaid provider" would be unnecessary if recipients could simply demand treatment from any licensed health care provider.

This result would be contrary to basic principles of statutory construction. *See Corley v. United States*, 556 U.S. 303, 314 (2009) ("[O]ne of the most basic interpretive canons" is that a "statute should be construed so that effect is given to all its provisions, so that no part will be inoperative or superfluous, void or insignificant"); Antonin Scalia & Bryan A. Garner, *Reading Law: The Interpretation of Legal Texts* 174 (2012) ("If possible, every word and every provision is to be given effect (*verba cum effectu sunt accipienda*). None should needlessly be given an interpretation that causes it to duplicate another provision or to have no consequence." (footnote omitted))

2. The term "qualified" is not defined in the qualified-provider provision. But that does not mean the use of the word "qualified" is untethered from the rest of the statutory scheme. The Medicaid Act provides that primarily States—and in some cases, the Secretary—determine whether providers are qualified. *See* 42 U.S.C. §§ 1320a-7, 1396a(a)(39), 1396a(p); 42 C.F.R. § 1002.3; *see also* 1 Tex. Admin. Code § 352 (setting qualifications for Medicaid providers).

Congress used the word "qualified" in other sections in the Act, which sheds light on its meaning. The "commonsense canon" of *noscitur a sociis* "counsels that

a word is given more precise content by the neighboring words with which it is associated." *United States v. Williams*, 553 U.S. 285, 294 (2008). And the Act's other definitions of "qualified" are consistent with both the idea that "qualified" in the qualified-provider provision means something more than just "able to provide medical services," as well as with the State's authority to determine whether a provider is "qualified."

For instance, in section 1396r-1(b)(2), Congress defined "qualified provider," for purposes of providing prenatal care to presumptively qualified women, as "any provider that[] . . . is eligible for payments under a State plan approved under this subchapter, . . . is determined by the State agency to be capable of making determinations" as to presumptive eligibility, and receives funds under various federal or state programs. 42 U.S.C. § 1396r-1(b)(2). In section 1396r-1c, Congress similarly defined a "qualified entity" for purposes of providing family planning services to presumptively qualified individuals. *Id.* § 1396r-1c(b)(2)(A). That section also notes that "[n]othing in this paragraph shall be construed as preventing a State from limiting the classes of entities that may become qualified entities in order to prevent fraud and abuse." *Id.* § 1396r-1c(b)(2)(B). Congress used the same language to define "qualified entity" in a section pertaining to providing breast and cervical cancer treatment services to presumptively qualified individuals, and in a section pertaining to services for presumptively qualified children. *Id.* §§ 1396r-1a(b)(3), 1396r-1b(b)(2). Thus, "qualified," for purposes of the qualified-provider provision, should

be construed to mean a provider that the State has deemed qualified to participate in Medicaid.

3. *Gee* also suggested that if the State has not taken action to prevent the provider from providing *all* medical services in the State by revoking their medical license, it could not disqualify a provider from Medicaid. *See* 862 F.3d at 465, 466, 469. But this interpretation of "qualified" is untethered from the Act itself, which provides grounds for excluding providers that have nothing to do with their ability to provide medical services. For instance, section 1320a-7(b)(14) permits the Secretary (and section 1396a(p) permits States) to terminate a provider that has defaulted on student loans.

* * *

The text of the Act and the qualified-provider provision show that *Gee*'s interpretation of the term "qualified" is incorrect. The Medicaid Act requires recipients to receive services from a qualified—as determined by the State—provider. Thus, on its face, the qualified-provider provision cannot give rise to a right of action like Plaintiffs claim here. Even if there were an individual right enforceable through section 1983 in the qualified-provider provision, it would be only to the Medicaid-qualified provider of their choice. And since the Individual Plaintiffs' chosen providers—the Texas Planned Parenthood affiliates—have been disqualified by the State, the

Individual Plaintiffs have no right to receive Medicaid services from those providers, and no cause of action under the Medicaid Act.[7]

B. The Medicaid Act provides other means of challenging a provider's exclusion.

There is also no basis to infer congressional intent to create a private right of enforcement under the qualified-provider provision where other means of enforcement are explicit. Where a statutory scheme provides other means of enforcement, particularly administrative procedures, it "counsel[s] against finding a congressional intent to create individually enforceable private rights." *Gonzaga*, 536 U.S. at 290 (footnote omitted); *accord Armstrong*, 135 S. Ct. at 1387 (plurality op.). The Individual Plaintiffs argue that they have the right to challenge the disqualification of their chosen provider. But the statute's text reveals that Congress's intent was to give providers a means to challenge their disqualification through a comprehensive administrative process rather than through enforcement by individual Medicaid recipients.

In the Social Security Act, Congress provided both mandatory and discretionary grounds upon which providers could be disqualified by the Secretary from the Medicaid program. 42 U.S.C. § 1320a-7(a)-(b). Congress also mandated the process by which providers excluded by the Secretary could challenge that exclusion. *Id.*

[7]This is not to say the Individual Plaintiffs have no recourse available anywhere. *O'Bannon* noted that recipients may have legal recourse against a provider for losing its qualification. 447 U.S. at 787; *see also Planned Parenthood of Greater Tex.*, 913 F.3d at 567 n.15.

§ 1320a-7(f). Pursuant to its rulemaking authority granted by Congress, HHS requires States to provide similar administrative procedures for disqualified providers to challenge their exclusion. 42 C.F.R. §§ 1002.210, 1002.213. And Texas complies with this requirement. *See* 1 Tex. Admin. Code §§ 371.1613, 371.1615, 371.1703(f). Texas offered this process to the Planned Parenthood affiliates, but they chose not to pursue it and filed this lawsuit instead. ROA.1205-06, 1213, 1242-43, 1313-14; *see also* ROA.31-50.

Additionally, the Act's "explicitly conferred means of enforcing compliance with [the qualified provider provision is] by the Secretary's withholding funding [under] § 1396c." *Armstrong*, 135 S. Ct. at 1387 (plurality op.). This alone "suggests that other means of enforcement are precluded." *Id.* Thus, "[b]ecause other sections of the Act provided mechanisms to enforce the State's obligation under § 23(A) . . . it is reasonable to conclude that Congress did not intend to create an enforceable right for individual patients under § 1983." *Gillespie*, 867 F.3d at 1041. And as noted by the majority in *Armstrong*, this does not "leave these plaintiffs with no resort. . . . Their relief must be sought initially through the Secretary rather than through the courts." 135 S. Ct. at 1387. Even if that were unjust, "the argument is made in the wrong forum, for [courts] are not at liberty to legislate. . . . '[I]t is not for [the court] to fill any *hiatus* Congress has left in this area.'" *Touche Ross & Co.*, 442 U.S. at 579 (quoting *Wheeldin v. Wheeler*, 373 U.S. 647, 652 (1963)).

C. Other factors show that Congress did not intend to give individual Medicaid recipients the right to challenge a State's disqualification of a provider.

The practical ramifications of allowing individual recipients to challenge the merits of a State's decision to disqualify their Medicaid provider through the qualified-provider provision show that Congress did not intend to create such a cause of action. It is difficult to even draw a bright line as to whether the "merits" of a disqualification are at issue. In *Gee*, the panel split on that issue. *See* 862 F.3d at 480-81 (Owen, J., dissenting) (pointing out that the majority agreed that the patients, under *O'Bannon*, have no right to challenge a provider's disqualification on the merits, but then proceeded to give "short shrift" to the State's reasons for disqualifying Planned Parenthood and conclude that, "*on the merits*, those grounds were not likely to prevail"). And there are several other difficulties arising from such a right of action.

First, Medicaid recipients are not in the best position to litigate the merits of whether their chosen provider is "qualified" to provide medical services. Evidence showing a provider's ability to provide medical services would be exclusively in the hands of the providers, and recipients would have no direct access to that. Medicaid recipients are eligible to participate in the program due to indigency—they would therefore have no resources available for hiring attorneys or experts. Thus, the only way the individual recipients could even effectively litigate such a claim is if they are used as litigation proxies by the provider itself, as is the case here. *See Planned Parenthood of Greater Tex.*, 913 F.3d at 567 n.15, 568. In practice then, permitting such

a claim would allow providers to make an "end run around the administrative exhaustion requirements in a state's statutory scheme." *Planned Parenthood of Gulf Coast v. Gee*, 876 F.3d 699, 702 (5th Cir. 2017) (footnote omitted) (Elrod, J., dissenting from denial of rehearing en banc).

Second, such a right of action would allow for two potentially conflicting, parallel tracks of adjudication on the merits of the disqualification, if, as in *O'Bannon*, the provider pursued administrative remedies in state proceedings and the patients also filed suit in federal court. "It is highly doubtful that Congress intended a loophole whereby providers could use patients as litigation proxies to avoid the state's remedial procedures and develop separate, potentially conflicting judicial standards of compliance." *Planned Parenthood of Greater Tex.*, 913 F.3d at 568.[8] Providing a right of action will also burden the States with complex litigation whenever a State excludes—or simply does not include—the provider of a recipient's choice. *Gee v. Planned Parenthood of Gulf Coast, Inc.*, 139 S. Ct. 408, 409 (2018) (Thomas, J., dissenting from denial of cert.).

[8] The problem with parallel tracks of litigation over the same issue is compounded if the federal court does not apply a deferential standard of review of the state agency's decision, as the district court failed to do here. This provides an even stronger incentive for providers to make the "end run" around state administrative procedures and use their patients to get into federal court and obtain a more favorable standard of review. *See Planned Parenthood of Greater Tex.*, 913 F.3d at 567-68, 569 n.17. Thus, even if the Court were to find that the Individual Plaintiffs have a right of action here, the applicable standard of review should be arbitrary-and-capricious, and review should be limited to the administrative record. *See id.* at 565-69; *see also Abbeville Gen. Hosp. v. Ramsey*, 3 F.3d 797, 802 (5th Cir. 1993) (per curiam).

Further, interpreting the qualified-provider provision to create a right to choose any provider capable of providing medical services, thereby constraining the States' ability to disqualify providers, creates a conflict with Congress's intent to allow States to terminate Medicaid providers based on State law, *see* 42 U.S.C. § 1320a-7(b)(5), or "any other authority," *id.* § 1396a(p)(1). Aside from the plain meaning of the words, the legislative history of section 1396a(p) suggests that Congress intended the States to have broad authority to exclude providers. *See* S. Rep. No. 100-109, at 20 (1987), *reprinted at* 1987 U.S.C.C.A.N. 682, 700 ("This provision is not intended to preclude a State from establishing, under State law, any other bases for excluding individuals or entities from its Medicaid program."); *accord First Med. Health Plan, Inc. v. Vega-Ramos*, 479 F.3d 46, 53 (1st Cir. 2007) ("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."). At minimum, this discrepancy underscores that it is far from "unambiguous" that Congress intended to supply a private right of action that would have the effect of undermining the State's authority to exclude providers under state law vis-à-vis the qualified-provider provision. Thus, under *Gonzaga* and *Armstrong*, such a right may not be created.

III. Even If a Private Right of Action Exists, the State Still Prevails for the Reasons Set Out in Its Panel-Stage Briefing and for the Reasons Identified by the Panel.

For the reasons set out above, the Medicaid Act does not allow the Individual Plaintiffs to bring this action. The Court therefore should reverse the judgment below, vacate the injunction, and render a judgment of dismissal as to the Individual Plaintiffs. No further analysis is necessary.

But even if the en banc Court adheres to *Gee* and the rule it announced, the State remains entitled to reversal for the independent reasons relied on by the panel and those set out in the State's panel-stage briefing.

First, Texas's interpretation of the word "qualified" in the Medicaid "qualified-provider" provision is a permissible construction, and Congress did not provide a clear statement foreclosing this interpretation. If State law or interpretation is not "plainly prohibited" by the statutory language in the Medicaid Act, it is not invalid. *Detgen ex rel. Detgen v. Janek*, 752 F.3d 627, 631 (5th Cir. 2014). Therefore, under *Pennhurst*'s clear-statement rule, 451 U.S. at 17, the State's reasonable interpretation controls. *See* Appellants' Br. 27-30.

Second, even if the Court applies the *Gee* definition of "qualified," the State's evidence clearly shows that the Provider Plaintiffs violated medical and ethical standards, and are not "capable of performing medical services in a professionally competent, safe, legal, and ethical manner." *Gee*, 862 F.3d at 452. The State's decision to terminate the Provider Plaintiffs was objectively reasonable and well-supported by

the record. The Plaintiffs therefore cannot overcome arbitrary-and-capricious review. *See id.* 30-43. In fact, they cannot overcome even de novo review. *See id.* 43-54.

Third, Plaintiffs cannot satisfy the other factors necessary to secure injunctive relief. They have shown no likelihood of irreparable harm (*id.* 55-56), and the equities favor the State (*id.* 56-57). And it is obviously in the public's interest to allow the State to terminate an unethical and unqualified Medicaid provider. *Id.* Were that not enough, the district court's injunction was vastly overbroad because it enjoined the State from terminating all 50 Planned Parenthood-associated Medicaid providers in Texas when the Individual Plaintiffs only receive services at seven of them. *See id.* 57-58.

Conclusion

The Court should reverse the judgment below, vacate the injunction, and render judgment of dismissal as to the Individual Plaintiffs because they lack a private right of action. As to the Provider Plaintiffs, the Court should remand for the district court to resolve the State's pending motion to dismiss.

Respectfully submitted.

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Certificate of Service

On March 7, 2019, this brief was served via CM/ECF on all registered counsel and transmitted to the Clerk of the Court. Counsel further certifies that: (1) any required privacy redactions have been made in compliance with Fifth Circuit Rule 25.2.13; (2) the electronic submission is an exact copy of the paper document in compliance with Fifth Circuit Rule 25.2.1; and (3) the document has been scanned with the most recent version of Symantec Endpoint Protection and is free of viruses.

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