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, *et al.*,

Plaintiffs – Appellees,

v.

CHARLES SMITH, in his official capacity as Executive Commissioner of HHSC, *et al.*,

Defendants – Appellants.

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

BRIEF OF THE LOUISIANA AND MISSISSIPPI AS *AMICI CURIAE* IN SUPPORT OF APPELLANTS

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INTRODUCTION AND INTEREST OF *AMICI*

Last year, the *en banc* Fifth Circuit, by a 7-7 vote, affirmed a divided panel on an important issue: whether 42 U.S.C. § 1396a(a)(23) confers a private right of action on Medicaid beneficiaries to challenge a state's disqualification of a provider, even though the provider *voluntarily forfeited* state administrative remedies and judicial review. Louisiana and Mississippi urge this Court to reverse *Planned Parenthood Gulf Coast v. Gee*, 862 F.3d 445, *r'hrg den*., 879 F.3d 699 (5th Cir. 2017)("*PPGC I*").[1]

As a condition of participation, Medicaid requires states in a State Plan approved by the federal government to establish provider qualifications and legal remedies for providers who are disqualified, suspended, or terminated from participating as a state provider. States are specifically required to provide an administrative appeal process in their State Plans. But *Gee* encourages providers facing administrative action—ranging from denial of admission to suspension or disqualification—to abandon these remedies and instead recruit an individual recipient to challenge the agency action in federal court, eviscerating those federally-mandated state remedies and substituting the federal judiciary as the gatekeeper for screening state Medicaid program administrative actions and providers.

[1] *Amici* refer to the *Planned Parenthood Gulf Coast v. Gee*, 862 F.3d 445, *r'hrg den.,* 876 F.3d 699 (5th Cir. 2017) as "*PPGC I*" because multiple cases are pending in this Court involving both plaintiff and defendant Dr. Gee.

The ruling should be reversed for five reasons: First, the opinion changes the terms under which states participate in Medicaid, perverting the entire scheme. Second, the ruling increases the likelihood that federal courts will be unnecessarily entangled in state policy-making and administrative enforcement. Third, it flaunts Supreme Court precedent, which limits implied causes of action. Fourth, it exposes states to debilitating fiscal consequences in the form of federal litigation costs and §1988 attorney fees, costs that are multiplied because these are state dollars, not federally-matched dollars. (*PPGC I* not only allows this, but *incentivizes* it.[2]) And finally, the ruling allows providers to manufacture Article III standing.

Allowing private enforcement destroys the careful balance Congress established between states and federal agencies. State-regulated Medicaid providers may simply use patients as "stalking horses" to bypass state administrative processes and rush to federal courts. That, in turn, entails "redundant and intrusive oversight" that is better handled by state agencies and state courts. *Planned Parenthood of Greater Tex. Family Planning & Preventative Health Svcs. v. Smith*, 913 F.3d 551, 571 (5th Cir. 2019) (Jones, J., concurring), *en banc r'hrg granted,* 2019 U.S. App.

[2] In *June Medical Services L.L.C. v. Gee* (*June I*), before this Court reversed, Plaintiffs requested an award of § 1988 attorney fees for *$4.7 million*. 3:14-cv-525, Doc. 292 ([Proposed] Order Granting Plaintiffs' Petition for Attorney's Fees.) That case involves a constitutional challenge to a single statute. In *Scott v. Schedler*, 2:11-cv-00926-JTM-JCW, Doc. 485, (Findings and Recommendations filed 9/20/13), the plaintiffs requested $2.8 million. Every §1988 fee request initiates a second round of litigation. Because *PPGC I* has not concluded, a fee award has not yet been requested.

Lexis 3556 (Feb. 4, 2019) ("*PPGT*") This Court has seen two cases involving the same issue just since *PPGC I* was decided, and another is now pending.[3] As long as *PPGC I* remains the law of this Circuit, Louisiana, Mississippi, and Texas—and this Court—will face the recurring problem of litigating and second-guessing state administrative decisions in federal court, displacing state agencies and courts from their proper role. Indeed, "[n]ot only are the lawsuits themselves a financial burden on the States, but the looming potential for complex litigation inevitably will dissuade state officials from making decisions that they believe to be in the public interest." *Gee v. Planned Parenthood Gulf Coast*, 139 S. Ct. 408, 409 (2018) (Thomas, J., dissenting from denial of certiorari). The decision should be reversed.

ARGUMENT

PPGC I conflicts with the structure and plain terms of the Medicaid program and multiple Supreme Court precedents. Although the Supreme Court denied certiorari in *PPGC I,* the problem is not going away.

Congress intentionally gave states latitude to determine whether a potential Medicaid provider is *and continues to be* "qualified" to participate in that state's Medicaid program. It did so for good reason. More than 70 million Americans are

[3] *Planned Parenthood Gulf Coast v. Gee,* 3:18-cv-00176, Doc. 43, Order denying State's Motion to Dismiss ("*PPGC II*"). In *PPGC II,* the Doe Plaintiffs—who are patients of PPGC—conflate or confuse the private right of action this Court recognized in PPGC I with alleged rights of hypothetical future patients of Planned Parenthood Center for Choice, even though PPCfC is not an abortion provider in Louisiana, is not a Medicaid provider, and has no patients.

enrolled in Medicaid, and, relatedly, millions of provider contract with states to provide a variety of covered services. The overall structure and requirements in 42 U.S.C. § 1396(a) reinforce the conclusion that Congress did not intend for federal courts to micromanage bits and pieces of a complex integrated spending program, which at its core relies on state administration.

I. Medicaid does not contemplate federal judicial oversight of state administrative decisions.

Medicaid is fundamentally a *state* program administered with state funds supplemented with federal grants.[4] Congress enacted the Medicaid Act using its spending power and requires each state to have an approved Medicaid State Plan. Among a long list of additional requirements, 42 U.S.C. § 1396a(a)(23) requires State Plans to allow eligible Medicaid recipients to obtain "assistance from any institution, agency, community pharmacy, or person, *qualified* to perform the service or services required . . . who undertakes to provide him such services." (emphasis added). By its plain terms, this section does not allow a Medicaid recipient to pick *any* provider. But it does demand that a State, through its Plan, allow recipients to choose from any provider the state has deemed "qualified" and who "undertakes to

[4] *See Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 541-42 (2012). To receive funding, states must comply with federal criteria governing matters such as who receives care and what services are provided at what cost.

provide such service." *Id. Accord, e.g.*, *O'Bannon* v. *Town Court Nursing Ctr.*, 447 U.S. 773, 785 (1980).

Other provisions in the Act govern the scope of states' authority to establish qualifications, require a state appeal process for decisions regarding the rejection, suspension, or termination of a provider, require that the Secretary be notified of provider terminations, and provide information and access to information respecting sanctions taken against health care practitioners and providers. 42 U.S.C. § 1396a(a)(41) & (49), 42 U.S.C. § 1369a(p); 42 U.S.C. §§ 1396b(kk)(1)-(9). Congress did more than just provide the states with broad discretion; it expressly stated that the federal provisions would not "be interpreted to preclude or limit the ability of a State to engage in provider and supplier screening or enhanced provider and supplier oversight activities beyond those required by the Secretary." 42 U.S.C. § 1396a(kk)(9).

A State may exclude a provider "for any reason for which the Secretary could exclude the individual or entity from participation in a program under" a variety of specified statutes. 42 U.S.C. § 1396a(p)(1). *See, e.g.*, 42 U.S.C. § 1396a-7 (listing grounds for exclusion); 42 C.F.R. §§ 1002.2(a)–(b); 42 C.F.R. § 431.51(c)(2) (allowing states to set "reasonable standards" for provider qualifications). Because the program involves the use of federal funds, Congress quite naturally expects States to have standards for disqualification that go beyond competency to provide

services. These standards, predictably, include criminal activity, fraud and abuse, and other instances of malfeasance. 42 U.S.C. § 1396a(p)(1). They also include "reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity." 42 U.S.C. § 1320a-7(b)(4).

Under the express language of the statute, a State develops a State Plan and the Secretary approves it. Pursuant to its approved Plan, the State screens, approves and contracts with, and supervises the participation of all providers and supplier in the State's program. The structure and plain terms of the Act show that Congress did not intend for federal courts to restructure its program by judicially interposing private rights of action in the Medicaid Act where none are expressly granted.

II. *PPGC I* cannot be reconciled with two lines of Supreme Court precedent.

PPGC I conflicts with two lines of directly relevant Supreme Court lines of authority. First, it is impossible to reconcile *PPGC I* with *O'Bannon*. The *O'Bannon* Court directly addressed the scope of § 1396a(a)(23) and held that a Medicaid beneficiary "has *no* enforceable expectation of continued benefits to pay for care in an institution that has been determined to be unqualified." 447 U.S. at 785 (emphasis added). Section 1396a(a)(23) does not "confer a right on a recipient to continue to receive benefits for care [from a provider] that has been decertified." *Id. O'Bannon* should have controlled the outcome in *PPGC I* and foreclosed § 1983 suits premised on § 1396a(a)(23). *PPGC I*, 862 F.3d at 473–75 (Owen, J., dissenting).

Second, *PPGC I* conflicts with other Supreme Court authority establishing principles for identifying individual rights in federal spending statutes. The remedy for a state's noncompliance with a spending-power act, like the Medicaid Act, is generally not a private right of action, but rather an action by the federal government to terminate the state's federal funding. *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 28, (1981).

As the Supreme Court held in *Gonzaga University v. Doe*, an individual claiming a private cause of action must therefore show "an unambiguously conferred *right* to support a cause of action." 536 U.S. 272, 283 (2002). That the statute confers an individual *benefit* is not enough. *Id.* And § 1396a(a)(23)(A) does not include express right- or duty-creating language. It only directs the Secretary to ensure state plans provide that an individual "may obtain [medical] assistance from any institution . . . qualified to perform the service…who undertakes to provide . . . such services." 42 U.S.C. § 1396a(a)(23)(A). That is insufficient to create a private right of action enforceable by § 1983.

In *Armstrong v. Exceptional Child Center*, similarly, a Supreme Court plurality held that there was no private right of action arising from an analogous Medicaid statute "phrased as a directive to the federal agency charged with approving state Medicaid plans." 135 S. Ct. 1378, 1387 (2015) (discussing 42 U.S.C. § 1396a(a)(30)(A)). The "express provision of one method of enforcing a substantive

rule suggests that Congress intended to preclude others." *Id.* at 1385 (cleaned up). The same is true here regarding § 1396a(a)(23), which contemplates that when a state violates the Medicaid Plan requirements or fails to comply with its own plan, the *Secretary* has enforcement authority, *not* private litigants and particularly not in actions brought in federal courts.

Third, *PPGC I* conflicts with the Eighth Circuit's decision in *Does v. Gillespie*, which held that § 1396a(a)(23) does not give rise to "an enforceable federal right that supports a cause of action under § 1983[.]" 867 F.3d 1034, 1046 (8th Cir. 2017). The *Does* majority relied on *Gonzaga* and *Armstrong*, *id.* at 1040–43, while a concurring opinion by Judge Shepherd emphasized *O'Bannon*, *id.* at 1046–49.[5]

As Judge Jones' concurrence observes, denial of *en banc* review in *PPGC I* by an equally divided Court does not supply this Court's definitive view. *PPGT*, 913 F.3d at 570 (Jones, J., concurring) ("A refusal to vote a case en banc . . . reflects no endorsement by the majority of active judges."). This case provides a new opportunity for a majority of this Court's judges both to course correct and provide a definitive view.

[5] Four Circuits have held § 1396a(a)(23) confers enforceable individual rights. The Second Circuit sided with the Eighth Circuit in principle. *Kelly Kare, Ltd.* v. *O'Rourke*, 930 F.2d 170, 178 (2d Cir. 1991).

III. PPGC I interferes with state Medicaid administration.

The practical consequences of *PPGC I* for state Medicaid administration are especially important. This is not a situation where Texas, Louisiana, and Mississippi can adjust to this Court's statutory interpretation and move on. To the contrary, *PPGC I* creates a new, ongoing, and costly burden on states in this Circuit that will only grow worse.

The course, charted by *PPGC I*, means a provider "charged with misfeasance by state regulating authorities may simply bypass state procedures, which are required by the Medicaid statute, and use patients as stalking horses for federal court review of its status." *Id.* at 569 (Jones, J., concurring). It will not be a hard choice – one carries the potential for an award of attorney fees, and the other does not.

Louisiana alone took 182 disqualification actions in fiscal year 2017, and 175 through March 31, 2018, of fiscal year 2018. Under *PPGC I*, any beneficiary of services from any of those providers may sue the State in federal court—in different districts around the State and at a cost of millions of dollars per case in litigation costs and, especially, plaintiff attorney fees.[6]

Further consequences are easy to predict. "Authorizing lawsuits by patients to challenge their providers' terminations burdens state agencies with redundant and

[6] *See* n.2, *infra*. Even on the lower end of the scale of attorney fee awards, the States will have significant budgetary exposure.

intrusive oversight while the high cost of federal litigation displaces more efficient uses of state resources." Id. at 571. What's more, "State officials are not even safe doing nothing, as the cause of action recognized by [*PPGC I*] may enable Medicaid recipients to challenge the *failure* to list particular providers, not just the removal of former providers." *PPGC I*, 139 S. Ct. 408, 409 (2018) (Thomas, J., dissenting from denial of certiorari).

Allowing § 1983 suits to challenge the merits of Medicaid qualification decisions is especially galling because states like Texas, Louisiana, and Mississippi have detailed systems of administrative review. The Medicaid Act *requires* states to have such a process for an excluded provider. 42 U.S.C. § 1396a(a)(4); 42 C.F.R. § 1002.213.

This Court's ruling in *PPGC I* renders this process superfluous. Equally important, the ruling bypasses a state administrative process where state-specific and complex legal, medical, and ethical rules associated with abortion and fetal tissue research are resolved by Medicaid administrators deeply familiar with the relevant regulations and facts and administrative law judges familiar with state APAs. Because the program is a state program, it is governed by a detailed set of state laws and regulations, as well as potentially relevant state-specific jurisprudence. Interjecting federal judicial oversight not only creates an opportunity for federal courts to interfere with state sovereignty but actively promotes it.

State judges are "intimate[ly] familiar[] with the agencies, the regulation of the practice of medicine, and state administrative law[.]" *Id*. Yet states, both in *PPGC I* and the present case, instead faced federal litigation led by patients challenging the merits of a decision *the provider* elected *not* to challenge. There is no sense in that.

The present case establishes one saving grace, which is that federal review is still held to a deferential "arbitrary and capricious" standard of review. But as Judge Jones demonstrated, that outcome is "a second-best solution" to the problems of Medicaid administration that *PPGC I* created. *Id.* at 570-71. The *best* solution is to overrule *PPGC I* and keep cases like this one in state forums.

IV. PPGC I violates basic notions of federalism.

As noted, every state's Medicaid program rests on a system of state regulations and procedures that are codified in state law and regulations after federal government approval. Just as Congress intended, no two states have the same system; states may experiment to see what works. Medicaid is a paradigm of cooperative federalism, creating "laboratories of democracy" where states may try novel approaches to benefit their citizens.

The practical consequences of *PPGC I* is to stand state systems on their head. Rather than a state program, administered by states and adjudicated by state administrative officials all applying state law, the systems become wards of the

federal judiciary. This naturally leads to federal-state tensions or outright trampling of state sovereignty. This is precisely the kind of conflict and disrespect for states that the Supreme Court intended to eliminate when it held the remedy in a statutory scheme like Medicaid is not a private right of action, but termination of a state's federal funding. *Pennhurst,* 451 U.S. at 28.

In *Seminole Tribe of Florida v. Florida*, the Supreme Court held that federal courts should hesitate before casting aside the limitations of a "detailed remedial scheme" for the enforcement against a state of a "statutorily created right." 517 U.S. 44, 74 (1996). *Armstrong,* of course, created an even higher standard than *Seminole Tribe* for implying a private right of action. Nonetheless, there is undeniably a detailed remedial scheme here. That scheme is created by the state within the state administrative system, and it is created at the direction of Congress and with the approval of the federal government. *PPGC I* imposes even greater disrespect to states given this context.

Finally, this disruption of federalist cooperation appears to be motivated not by the text of the statute or Medicaid's structure. *PPGC I*, 139 S. Ct. at 410 (Thomas, J., dissenting). Yet "these cases are not about abortion rights. They are about private rights of action under the Medicaid Act." *Id.* "[N]eutrally applying the law is all the more important when political issues are in the background." *Id.*

CONCLUSION

Louisiana and Mississippi respectfully ask this Court to reverse *PPGC v. Gee*, reverse the judgment below, and dismiss the case with prejudice as to the individuals' claims.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on March 14, 2019, I filed the foregoing document through the Court's CM/ECF system, which will serve an electronic copy on all registered counsel of record.

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CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitation of Fed. R. App. P. 29(a)(5) because the brief contains 2,929 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

2. This brief complies with the typeface requirements of Fed. R. App. R. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because the brief has been prepared in a proportionally spaced typeface using Microsoft Word 14-point Times New Roman font.

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