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
Case No. 1:15-cv-01058-SS

BRIEF OF 18 UNITED STATES SENATORS AS *AMICI CURIAE* IN SUPPORT OF PLAINTIFFS-APPELLEES

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INTERESTS OF *AMICI CURIAE*

This brief is submitted on behalf of 18 United States Senators. The Senators represent 16 different States that participate in the Medicaid program, who have an interest in ensuring that the federal Medicaid Act is implemented in accordance with congressional intent and that Medicaid-eligible patients enjoy the right to choose a qualified, willing provider conferred upon them by 42 U.S.C. § 1396a(a)(23). *See Planned Parenthood of Gulf Coast, Inc. v. Gee*, 862 F.3d 445, 470 (5th Cir. 2017), *cert. denied*, 139 S. Ct. 408 (2018). The *amici curiae* include:

- Senator Ron Wyden (Oregon)
- Senator Patty Murray (Washington)
- Senator Dianne Feinstein (California)
- Senator Jeanne Shaheen (New Hampshire)
- Senator Richard Blumenthal (Connecticut)
- Senator Sherrod Brown (Ohio)
- Senator Mazie K. Hirono (Hawaii)
- Senator Tammy Baldwin (Wisconsin)
- Senator Edward J. Markey (Massachusetts)
- Senator Jacky Rosen (Nevada)

- Senator Sheldon Whitehouse (Rhode Island)
- Senator Chris Van Hollen (Maryland)
- Senator Kamala D. Harris (California)
- Senator Tammy Duckworth (Illinois)
- Senator Jack Reed (Rhode Island)
- Senator Amy Klobuchar (Minnesota)
- Senator Cory A. Booker (New Jersey)
- Senator Kirsten Gillibrand (New York)

STATEMENT OF COMPLIANCE WITH RULE 29

All parties have consented to the filing of this brief. No counsel for a party authored any part of this brief. And no one other than the *amici curiae* or their counsel contributed money that was intended to finance the preparation or submission of this brief.

SUMMARY OF THE ARGUMENT

Congress enacted the free-choice-of-provider provision in the Medicaid Act, 42 U.S.C. § 1396a(a)(23), because it intended to confer a fundamental individual right on Medicaid-eligible patients: "the choice of one's own doctor and other provider of health services." *Social Security Amendments of 1967: Hearings on H.R. 12080 Before the Senate Comm. on Fin.*, 90th Cong. 1600 (1967) (statement of Sen. Metcalf). This right, which Congress intended to "be enjoyed by all Americans," would be hollow without the corresponding ability to vindicate that right through a private enforcement action under 42 U.S.C. § 1983. *Id.* The plain text of the free-choice-of-provider provision and its legislative history manifest the clear intent of Congress not only to confer the right to choose a qualified medical provider on individual patients, but also to permit them to challenge in court State Medicaid plans that infringe upon that right.

Consistent with this clear intent, five of the six Courts of Appeals to consider the issue have correctly held that the free-choice-of-provider provision confers a right on Medicaid-eligible patients and thus is enforceable under 42 U.S.C. § 1983, for the following four reasons:

First, the language of the provision and its legislative history evince Congress' clear intent to confer on Medicaid patients the right to choose their own qualified medical providers without State interference. The statutory free-choice-of-provider provision is "consistent with the policy that . . . patient[s] under medical care programs should be afforded freedom of choice in obtaining health services from any qualified institution, agency, or person." 111 Cong. Rec. 15,790-91 (1965) (statement of Sen. Williams). It is precisely this kind of "individually focused terminology" and "'rights-creating' language" that demonstrates an unambiguous intent to confer an individual entitlement by Congress. *Gonzaga Univ. v. Doe*, 536 U.S. 273, 287 (2002) (citation omitted).

Second, it is apparent from the text of the provision that the right to choose a provider "qualified to perform the service or services required," 42 U.S.C. § 1396a(a)(23), is not "so 'vague and amorphous' that its enforcement would strain judicial competence." *Blessing v. Freestone*, 520 U.S. 329, 340-41 (1997). Enforcing this right falls "well within judicial competence" because "the term 'is tethered to an objective benchmark'—'qualified to perform the service or services

required.'" *Planned Parenthood of Gulf Coast, Inc. v. Gee*, 862 F.3d 445, 459 (5th Cir. 2017) (emphasis added) (citations omitted), *cert. denied*, 139 S. Ct. 408 (2018). Accordingly, courts have properly recognized that the term "qualified" refers to being "capable of performing the needed medical services in a professionally competent, safe, legal, and ethical manner." *Id.* at 462 (citation omitted). The Texas Planned Parenthood affiliates, as nationally-recognized providers—by whom the district court found there was no evidence of wrongdoing—fall squarely within this definition as Congress intended it to be applied.

Third, the statute specifies that States "must" honor the free-choice-of-provider right in their Medicaid plans in order to receive federal funding, 42 U.S.C. § 1396a(a)(23), which "unambiguously" imposes a "mandatory, rather than precatory" obligation on the States. *Blessing*, 520 U.S. at 341. When "Congress places requirements in a statute, [it] intend[s] for the States to follow them. If they fail in this, the Federal courts can order them to comply with the congressional mandate." 139 Cong. Rec. S3173-01 (daily ed. Mar. 18, 1993) (statement of Sen. Riegle). In fact, legislative history confirms that Congress sought to ensure that "[s]tates are required to permit the

individual to obtain his medical care from any institution, agency, or person, qualified to perform the service or services." S. Rep. No. 90-744, at 183 (1967), *reprinted in* 1967 U.S.C.C.A.N. 2834, 3021; *see* H.R. Rep. 90-544, at 122 (1967).

Finally, Congress did not preclude individual actions pursuant to 42 U.S.C. § 1983 brought to enforce the free-choice-of-provider right granted by section 1396a(a)(23) when it created the federal enforcement scheme of the Social Security Act, 42 U.S.C. §§ 301 to 1397mm (the "SSA")—of which the Medicaid Act, 42 U.S.C. §§ 1396 to 1396w-5, is a part. *See Gonzaga Univ.*, 536 U.S. at 297. A 1994 amendment to the SSA makes clear that the enforcement mechanisms it grants to the Federal Government do not replace an individual's private right of action under the provisions of the Medicaid Act. Indeed, 42 U.S.C. § 1320a-2 expressly provides that "[i]n an action brought to enforce a provision of [the SSA], such provision is not to be deemed unenforceable because of its inclusion in a section of [the Act] requiring a State plan or specifying the required contents of a State plan." Congress thus expressed its intent to permit the administrative and individual

remedies available to providers and patients, respectively, under the free-choice-of-provider provision to work collaboratively.

ARGUMENT

I. THE INTENT, TEXT AND JUDICIAL INTERPRETATION OF THE FREE-CHOICE-OF-PROVIDER PROVISION AND THE MEDICAID ACT CONFIRM THAT CONGRESS UNAMBIGUOUSLY INTENDED TO CONFER A PRIVATE RIGHT OF ACTION ON INDIVIDUAL MEDICAID RECIPIENTS

By enacting the free-choice-of-provider provision within the Medicaid Act, Congress created a federal right for individual Medicaid-eligible patients that is enforceable through 42 U.S.C. § 1983. To determine whether or not a statute confers a substantive right upon individuals, courts ask whether: (1) Congress intended to unambiguously confer a right on the plaintiff, *Gonzaga Univ.*, 536 U.S. at 283; (2) the plaintiff demonstrates "that the right assertedly protected by the statute is not so 'vague and amorphous' that its enforcement would strain judicial competence," *Blessing*, 520 U.S. at 340-41; and (3) "the provision giving rise to the asserted right [is] couched in mandatory, rather than precatory, terms," *id.* at 341. As this Court and five other Circuit Courts have correctly held, the free-

choice-of-provider provision, section 1396a(a)(23), satisfies this three-part standard for creating an enforceable right.

A. Congress Unambiguously Conferred the Right to Choose One's Own Doctor on Medicaid-Eligible Patients

Congress unambiguously intended to confer an individual right on Medicaid-eligible patients when it enacted the free-choice-of-provider provision within the Medicaid Act. The provision mandates that:

> any individual eligible for medical assistance . . . may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required . . . who undertakes to provide him such services.

§ 1396a(a)(23) (emphasis added). Congress used "individually focused terminology" in this provision that contains the necessary "'rights-creating' language critical to showing the requisite congressional intent to create new rights." *Gonzaga Univ.*, 536 U.S. at 287 (quoting *Alexander v. Sandoval*, 532 U.S. 275, 288-89 (2001)); *see also Planned Parenthood Ariz. Inc. v. Betlach*, 727 F.3d 960, 966 (9th Cir. 2013) ("That Congress intended the free-choice-of-provider requirement to create an individual right is evident . . . ."), *cert. denied*, 134 S. Ct. 1283 (2014).

The history of the provision's enactment confirms this. Congress created the Medicaid and Medicare programs through the Social Security Amendments of 1965. *See* Health Insurance for the Aged Act, Pub. L. No. 89-67, tit. I, § 102(a) (1965), 79 Stat. 286, 291-332 (currently codified at 42 U.S.C. §§ 1395-1395*ll* (Medicare)); *id.* § 121(a), 79 Stat. at 343-52 (currently codified at 42 U.S.C. §§ 1396-1396d (Medicaid)). Allowing participants to choose their own providers serves as a central tenet of Medicare, which Congress designed to aid the elderly. *See id.* § 102(a), 79 Stat. at 291 ("Free Choice by Patient Guaranteed") (currently codified at 42 U.S.C. § 1395a(a)). It was likewise a goal of Medicaid, which both supplemented Medicare and provided additional medical care for the poor. *See* H.R. Rep. No. 89-213, at 2-3 (1965).

In 1965, Congress included a free-choice-of-provider provision within the Medicare program because "[t]he choice of one's own doctor and other provider of health services is a right which should be enjoyed by all Americans." 111 Cong. Rec. 15,791 (1965) (statement of Sen. Williams); *see also* 42 U.S.C. § 1395a(a) ("Any individual entitled to insurance benefits under this subchapter may obtain health services from any institution, agency or person qualified . . . to provide him such

services."). That provision was "consistent with the policy that ha[d] been enunciated in the proposed legislation; that is, that the patient under medical care programs should be afforded freedom of choice in obtaining health services from any qualified institution, agency, or person." 111 Cong. Rec. 15,790-91 (1965) (statement of Sen. Williams). It responded to concerns from certain advocacy groups and legislators about excessive government control over medical choices and medical providers. *See, e.g.*, 111 Cong. Rec. 505 (1965) (statement of Rep. Pelly) ("[T]he doctors have been fearful—and rightly so—of steps that would eventually lead to government medicine . . . . I think the American people and most Members of Congress want free choice of hospital and doctor.").[1]

In 1967, Congress added the free-choice-of-provider provision to the Medicaid Act, thus codifying the decision to provide low-income patients with a meaningful choice among qualified providers. The Senate Finance Committee explained that its members "[stood] by the

[1] *See, e.g.*, *President's Proposals for Revision in the Social Security System: Hearings Before the H. Comm. on Ways & Means on H.R. 5710*, 90th Cong. 2273 (1967) (Letter from Asociación de Hospitales de Puerto Rico); *Social Security Amendments of 1967: Hearings on H.R. 12080 Before S. Comm. on Fin.*, 90th Cong. 1597-1604 (1967) (Statement of E. J. Felderman, M.D., President of the Association of New York State Physicians and Dentists).

quotation . . . that the choice of one's own doctor and other provider of health services is a right which should be enjoyed by all Americans . . . [a]nd they still stand on that." *Social Security Amendments of 1967: Hearings on H.R. 12080 Before the S. Comm. on Fin.*, 90th Cong. 1600 (1967) (statement of Sen. Metcalf); *see also* S. Rep. No. 90-744, at 183, *reprinted in* 1967 U.S.C.C.A.N. at 3021 ("Under the current provisions of law, there is no requirement on the State that recipients of medical assistance under a State title XIX program shall have freedom in their choice of medical institution or medical practitioner. In order to provide this freedom, a new provision is included in the law to require States to offer this choice . . . . Under this provision, an individual is to have a choice from among qualified providers of service.").[2]

By adding the free-choice-of-provider provision to the Medicaid Act in 1967, Congress intentionally and unambiguously "grant[ed] a specific class of beneficiaries—Medicaid-eligible patients—an

[2] *Accord President's Proposals for Revision in the Social Security System*, *supra*, at 541 (statement of Carl Ackerman, Chairman of the Board of Directors, National Association of Blue Shield Plans) ("Members of Congress and staff members of the Department of Health, Education, and Welfare have stated repeatedly that the major purpose of title XIX [Medicaid] is to integrate the medically indigent individual into the community in terms of his access to sources of medical care. In other words, we endorse the principle . . . permitting the individual eligible for medical assistance free choice of physician or hospital.").

enforceable right to obtain medical services from the qualified provider of their choice."[3] *See, e.g.*, 113 Cong. Rec. H10,725 (daily ed. Aug. 17, 1967) (statement of Gov. Nelson A. Rockefeller) ("We have also given the people a program which provides for free choice of physician."); 113 Cong. Rec. H16,864 (daily ed. Dec. 13, 1967) ("[P]eople covered under the Medicaid program will have free choice of qualified medical facilities and practitioners . . . .").[4]

In 1972, family planning services were added to Medicaid as a required benefit. Congress thus mandated that States receiving Medicaid funding cover family planning services, which, as a required benefit, were subject to Medicaid's free-choice-of-provider provision. *See* Social Security Amendments of 1972, Pub. L. No. 92-603, § 299E, 86

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[3] *Planned Parenthood of Kan. v. Andersen*, 882 F.3d 1205, 1224-26 (10th Cir. 2018), *cert. denied*, 139 S. Ct. 638 (2018).

[4] *See also* H.R. Rep. 90-544, at 19 (1967) (recognizing that the "people covered under the Medicaid program would have free choice of qualified medical facilities and practitioners"); *id.* at 5 (emphasizing that the bill was "to modify the program of medical assistance to establish certain limits on Federal participation in the program and to add flexibility in administration" by, *inter alia*, "[allowing] recipients free choice of qualified providers of health services"); H.R. Rep. No. 90-1030, at 64 (1967) (Conf. Rep.) (adopting language from the Senate bill to "assure that any individual eligible for medical assistance will be free to obtain such assistance from the qualified institution, agency, or person of his choice").

Stat. 1329, 1462 (titling section "Family Planning Services Mandatory Under Medicaid").

Since 1972, the free-choice-of-provider provision itself and the Medicaid Act in general have been amended several times. Over the years, Congress has allowed for limited exceptions to the free-choice-of-provider provision, but has expressly preserved free choice in the context of family planning. For example, Congress amended the Medicaid Act in 1981 to allow waivers of the free-choice-of-provider provision for managed care plans mandated by States. *See* 42 U.S.C. § 1396n(b); Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2174, 95 Stat. 357, 809-11. But it clarified in 1986 that family planning services were exempted from those waivers. *See, e.g.*, Sara Rosenbaum et al., *Medicaid Managed Care and the Family Planning Free-Choice Exemption: Beyond the Freedom to Choose*, 22 J. Health Pol. Pol'y & L. 1192, 1196 (1997) (reviewing the legislative history); 42 U.S.C. § 1396n(b) ("No waiver under this subsection may restrict the choice of the individual in receiving services under section 1396d(a)(4)(C) of this title[, which governs family planning]."). A year later, Congress went further, specifically preserving freedom of choice

among family planning providers even when patients elected to opt into managed care organizations. *See* Rosenbaum et al., *supra*, at 1196; *see also* 42 U.S.C. § 1396a(a)(23)(B) (exempting the family planning services outlined in § 1396d(a)(4)(C) from abridgment of choice in the managed care setting).

This legislative trajectory evinces Congress' clear and consistent intent—from the 1960s to today—to create and to preserve the right of women to choose a quality family planning provider without State interference. Put simply, the purpose of the 1965, 1972, 1986, and 1987 amendments was to take politics out of this deeply personal medical decision and to limit States' control over a patient's choice of a qualified provider. In the years since those amendments, the Supreme Court and five Circuit Courts have correctly interpreted section 1396a(a)(23) of the Medicaid Act to effectuate Congress' clear intent to confer each individual Medicaid beneficiary with the right to choose his or her own qualified provider.[5] Congress plainly meant what it said in the

[5] *See O'Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773, 785 (1980) ("Title 42 U.S.C. § 1396a(a)(23) gives recipients the right to choose among a range of *qualified* providers, without government interference. By implication, it also confers an absolute right to be free from government interference with the choice to [access a provider] that continues to be qualified."); *see also Andersen*, 882 *(cont'd)*

Medicaid Act: patients have the right to choose from any qualified family planning providers, and that right must be protected.

B. The Right to Choose a Qualified Provider Is Not So Vague and Amorphous That Its Enforcement Would Strain Judicial Competence

The right to choose a qualified medical provider "is not so 'vague and amorphous' that its enforcement would strain judicial competence," *Blessing*, 520 U.S. at 340-41 (citation omitted), because the meaning of the phrase "qualified to perform the service or services required" is clear from the statute's text and structure, 42 U.S.C. § 1396a(a)(23). This right is also "administrable and falls comfortably within the judiciary's core interpretive competence" because the "proper interpretation of § 1396a(a)(23) is a legal question fully capable of judicial resolution." *Comm'r of Ind. State Dep't of Health*, 699 F.3d at 974; *see also Betlach*, 727 F.3d at 968 (holding that the "standard" under section 1396a(a)(23) "is not subjective or amorphous, and requires no balancing" and thus its

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F.3d at 1224-26; *Gee*, 862 F.3d at 459-62; *Betlach*, 727 F.3d at 966-67; *Planned Parenthood of Ind., Inc. v. Comm'r of Ind. State Dep't of Health*, 699 F.3d 962, 974 (7th Cir. 2012), *cert. denied*, 133 S. Ct. 2738 (2013); *Harris v. Olszewski*, 442 F.3d 456, 461-63 (6th Cir. 2006). Additionally, though the Fourth Circuit has not addressed whether Medicaid beneficiaries have a private right enforceable under section 1983, a district court in that jurisdiction joined the five Circuit Courts to hold that they do in *Planned Parenthood South Atlantic v. Baker*, 326 F. Supp. 3d 39 (D.S.C. 2018). *See id.* at 44.

enforcement "is no different from the sorts of qualification or expertise assessments that courts routinely make in various contexts").

Legislative history underscores the plain meaning of the statutory text and emphasizes the lengths to which Congress has gone to make quality family planning services available to women. For these reasons, this Court and others had no difficulty concluding that "qualified" means "capable of performing the needed medical services in a professionally competent, safe, legal, and ethical manner." *Gee*, 862 F.3d at 462 (citation omitted). Here, the Planned Parenthood affiliates are nationally-recognized providers that provide Medicaid services through licensed clinicians to thousands of patients, and the district court found there was no evidence they engaged in wrongdoing and that the terminations of their provider agreements were factually and legally unsupported. *See Planned Parenthood of Greater Tex. Family Planning & Preventative Health Servs., Inc. v. Smith*, 236 F. Supp. 3d 974, 990 (W.D. Tex. 2017). They are plainly "qualified."

1. Reflecting Congress' Clear Intent, the Term "Qualified" Is Unambiguously Tethered to Medical Qualifications

The meaning of the phrase "qualified to perform the service or services required" in Medicaid's free-choice-of-provider provision is clear from the statutory text and is unambiguously tethered to qualifications to provide medical services. *See* 42 U.S.C. § 1396a(a)(23). Congress accompanied the term "qualified" with an unambiguous benchmark: the provider must be "qualified to perform the service or services required." *Id.* (emphasis added); *see also Betlach*, 727 F.3d at 969 ("[W]ere there any doubt as to how we should read the word 'qualified' in § 1396a(a)(23), Congress removed it by adding the further specification 'qualified to perform the service or services required.'" (citation omitted)). Reading the text together, it is clear that Congress intended for the term "qualified" to relate to a provider's ability to furnish the "service or services rendered" on behalf of an individual patient. *See* 42 U.S.C. § 1396a(a)(23). This Court, and other Courts of Appeals, have correctly interpreted the term "qualified," holding that it relates to a provider's ability to "'perform[] the needed medical services in a professionally competent, safe, legal' and ethical manner." *Gee*, 862

F.3d at 462 (citation omitted); *see also Andersen*, 882 F.3d at 1230 (endorsing the reasoning of Fifth, Seventh and Ninth Circuit courts).

Furthermore, the structure of the Medicaid Act makes clear that Congress intended the free-choice-of-provider provision to strictly limit exclusions of providers from State Medicaid plans. *See Richards v. United States*, 369 U.S. 1, 11 (1962) ("[A] section of a statute should not be read in isolation from the context of the whole Act . . . ."). As an initial matter, Congress included the free-choice-of-provider clause in a list of mandatory requirements that State Medicaid plans must satisfy. *See* 42 U.S.C. § 1396a(a)(23). Other sections of the Medicaid Act identify specific, narrow circumstances in which States have the authority to exclude providers, consistent with Congress' intent to ensure meaningful access to qualified providers. *See, e.g.*, 42 U.S.C. § 1396a(p). One such provision allows States to exclude a provider based on crimes committed in the delivery of services, abuse or neglect of patients, submission of false claims, or acceptance of kick-backs. *See* 42 U.S.C. § 1396a(p)(1) (cross-referencing 42 U.S.C. §§ 1320a-7, 1320a-7a, and 1395cc(b)(2), which list permitted exclusions); S. Rep. No. 100-109, at 1-2 (1987), *reprinted in* 1987 U.S.C.C.A.N. 682, 682 (explaining

that the overarching purpose of this provision is "to protect the beneficiaries of [the Medicaid and Medicare] programs from incompetent practitioners and from inappropriate or inadequate care"). Another allows States to hold providers to specific reimbursement, quality, and utilization standards, as long as these restrictions do "not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing those services." 42 U.S.C. § 1396n(b)(4).

Congress thus expressly crafted only narrow and specific exceptions to the free-choice-of-provider provision, underscoring its intent to maximize a patient's choice and the overall availability of qualified providers. Recent decisions have aptly concluded that Congress did not mean for these exceptions to permit a State to deem providers "unqualified" and thus excludable on a basis unrelated to their ability to provide medical services in a professionally competent and appropriate manner. *See Andersen*, 882 F.3d at 1210 ("States may not terminate providers from their Medicaid program for any reason they see fit, especially when that reason is unrelated to the provider's competence and the quality of the healthcare it provides."); *Gee*, 862

F.3d at 465 ("[States'] authority to define provider qualifications and to exclude providers on that basis . . . is circumscribed by the meaning of 'qualified' in this context.").

Moreover, family planning services have been singled out for specific, additional protection by Congress. Although the federal Department of Health and Human Services ("HHS") may waive the free-choice-of-provider provision to allow States to implement primary care case-management and similar managed care systems, *see* 42 U.S.C. § 1396n(b)(1), Congress has prohibited those waivers from encompassing family planning services. *See* 42 U.S.C. § 1396a(a)(23)(B) (mandating that the "enrollment of an individual . . . in a primary care case-management system[,] . . . a Medicaid managed care organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive services" for family planning (emphasis added)). Thus, the text of the statute clearly reflects Congress' intent to specifically protect a woman's ability to choose her own qualified provider of family planning services.

2. This Court, Along with Other Courts, Has Correctly Held That the Term "Qualified" Can Be Applied by the Judiciary

Interpretation of the term "qualified" by courts, rather than State legislatures, is appropriate and falls "well within judicial competence" because Congress ensured that the term "'is tethered to an objective benchmark'—'qualified to perform the service or services required.'" *Gee*, 862 F.3d at 459 (citation omitted). This Court, as well as the Seventh, Ninth, and Tenth Circuits, have agreed that the meaning of the term "qualified" is clear and unambiguously refers to the ability to provide services in a professionally competent and appropriate manner. *See Gee*, 862 F.3d at 462 (holding that "qualified" in the free-choice-of-provider provision means "capable of performing the needed medical services in a professionally competent, safe, legal, and ethical manner." (citation omitted)); *see also Comm'r of Ind. State Dep't of Health*, 699 F.3d at 978; *Betlach*, 727 F.3d at 967; *Andersen*, 882 F.3d at 1227. Thus, "courts addressing this provision confront 'a simple factual question no different from those courts decide every day.'" *Gee*, 862 F.3d at 459 (citation omitted).

Most recently, the Tenth Circuit in *Andersen*, 882 F.3d at 1227, correctly rejected the contention (also asserted by Texas and its *amici* here) that the Supreme Court's decision in *Armstrong v. Exceptional Child Care Center, Inc.*, 135 S. Ct. 1378 (2015)—which concluded that the determination of a provider's qualifications under a different provision of the Medicaid Act implicated "expert judgments and questions of state law"—should apply to section 1396a(a)(23). The *Andersen* court held that "the decision of whether a provider is qualified is much simpler" than the "judgment-laden standard" at issue in *Armstrong*.[6] *Andersen*, 882 F.3d at 1227. In so holding, the Tenth Circuit joined this Court, as well as the Sixth, Seventh and Ninth Circuits, in correctly concluding that "[c]ourts can determine whether providers are qualified by 'drawing on evidence such as descriptions of

[6] Indeed, this Court concluded in *Gee* that the free-choice-of-provider provision "suppl[ied] concrete and objective standards for enforcement." *Gee*, 862 F.3d at 459 (citation omitted). And, contrary to Texas's and its *amici*'s argument, the clear-statement rule set forth in *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1 (1981), demands no more than that. *Pennhurst* simply requires that Congress speak clearly enough that, when a State accepts federal funding with certain conditions, the State knows what it is signing up for. *See id.* at 17 ("The legitimacy of Congress' power to legislate under the spending power thus rests on whether the State voluntarily and knowingly accepts the terms of the 'contract.'"). And Congress spoke clearly here. The *Gee* Court thus correctly concluded that the States knowingly agreed to fund any provider "qualified to perform the service or services required" in a safe, competent, and ethical manner. 42 U.S.C. § 1396a(a)(23); *Gee*, 862 F.3d at 458-59.

the service required; state licensing requirements; the provider's credentials, licenses, and experience; and expert testimony regarding the appropriate credentials for providing the service.'" *Id.* at 1227 (quoting *Betlach*, 727 F.3d at 968); *see also Gee*, 862 F.3d at 459; *Comm'r of Ind. State Dep't of Health*, 699 F.3d at 978; *Harris*, 442 F.3d at 462.

C. The Language in the Free-Choice-of-Provider Provision Mandates That States Provide Patients with the Free Choice of Qualified Providers

The free-choice-of-provider provision also "unambiguously" imposes "a binding obligation on the States." *Blessing*, 520 U.S. at 341. Section 1396a(a)(23) makes this plain: States "must . . . provide" patients with access to any "qualified" and willing providers of their choice, 42 U.S.C. § 1396a(a)(23). The text of the free-choice-of-provider provision is unequivocal and "couched in mandatory, rather than precatory, terms." *Blessing*, 520 U.S. at 341; *see also Gee*, 862 F.3d at 459; *Comm'r of Ind. State Dep't Health*, 699 F.3d at 974; *Harris*, 442 F.3d at 462. Thus, the statute "affirmatively requires state plans to allow Medicaid-eligible people to obtain medical services from their willing and qualified provider of choice." *Andersen*, 882 F.3d at 1228.

Congress enacted the free-choice-of-provider provision in plain, mandatory, and non-discretionary terms, manifesting a clear intent to confer individual rights on Medicaid-eligible individuals. *See Gonzaga Univ.*, 536 U.S. at 280. When "Congress places requirements in a statute, [it] intend[s] for the States to follow them. If they fail in this, the Federal courts can order them to comply with the congressional mandate." 139 Cong. Rec. S3173-01 (daily ed. Mar. 18, 1993) (statement of Sen. Riegle). Here Congress meant what it said: States must respect Medicaid beneficiaries' right to access the qualified providers of their choice without interference in order to comply with the free-choice-of-provider provision. *See, e.g.*, S. Rep. No. 90-744, at 183 (1967), *reprinted in* 1967 U.S.C.C.A.N. 2834, 3021; H.R. Rep. 90-544, at 122 (1967) ("States are required to permit the individual to obtain his medical care from any institution, agency, or person, qualified to perform the service or services . . . .") (emphasis added).

II. THE FEDERAL ENFORCEMENT SCHEME OF THE SOCIAL SECURITY ACT DOES NOT PRECLUDE A PRIVATE RIGHT OF ACTION

The enforcement mechanisms Congress designed for the Federal Government do not, expressly or by implication, foreclose an

individual's right of action under section 1396a(a)(23) and section 1983. Where a statutory, individual right meets the three factors outlined in *Blessing*, that right is presumptively enforceable under section 1983 unless Congress has foreclosed a private right of action (1) "expressly"; or (2) "impliedly, by creating a comprehensive enforcement scheme that is incompatible with" such a private right of action. *Gonzaga Univ.*, 536 U.S. at 297 (quoting *Blessing*, 520 U.S. at 341). Congress has not done so here.

First, the text of the SSA makes clear that Congress did not intend the enforcement mechanisms it provides to the Federal Government to replace an individual's private right of action to enforce the provisions of that Act (including 42 U.S.C. § 1396a(a)(23)). Section 1320a-2 of the SSA provides:

> In an action brought to enforce a provision of [the SSA], such provision is not to be deemed unenforceable because of its inclusion in a section of [the SSA] requiring a State plan or specifying the required contents of a State plan. This section is not intended to limit or expand the grounds for determining the availability of private actions to enforce State plan requirements other than by overturning any such grounds applied in *Suter v. Artist M.*, 112 S. Ct. 1360[, 503 U.S. 347] (1992), but not applied in prior Supreme Court decisions respecting such enforceability . . . .

42 U.S.C. § 1320a-2.[7]

Prior to *Suter v. Artist M.*, 503 U.S. 347 (1992), Congress and the Supreme Court recognized a dual-enforcement scheme for Medicaid, in which both the Federal Government and individual beneficiaries had distinct mechanisms to enforce the requirements of the SSA. *See* H.R. Rep. No. 102-631, at 364 (1992) ("Prior to this decision, the Supreme Court has recognized in a substantial number of decisions, that beneficiaries of Federal-State programs could seek to enjoin State violations of Federal statutes by suing under 42 U.S.C. § 1983."). As the Supreme Court reasoned in *Wilder v. Virginia Hospital Ass'n*, 496 U.S. 498 (1990), Medicaid's "administrative scheme cannot be considered sufficiently comprehensive to demonstrate a congressional intent to withdraw the private remedy of § 1983" because "'[g]eneralized powers' . . . to audit and cut off federal funds [are] insufficient to foreclose reliance on § 1983 to vindicate federal rights." *Wilder*, 496 U.S. at 522 (quoting *Wright v. City of Roanoke Redev. & Hous. Auth.*, 479 U.S. 418, 428 (1987)).

[7] This provision applies to the entirety of the SSA, 42 U.S.C.§§ 301 to 1397mm, which includes the Medicaid Act, 42 U.S.C. §§ 1396 to 1396w-5.

The text of section 1320a-2 itself makes clear the intent of Congress to return to the dual scheme of enforcement cited approvingly in *Wilder*. It states that the placement of a provision of the SSA within a section of the Act setting forth requirements for State plans does not bar individuals from pursuing individual lawsuits to enforce their rights under such a provision.[8] *See* 42 U.S.C. § 1320a-2. By its very terms, then, section 1320a-2 refutes the argument that Congress intended to preclude individual rights of action stemming from State plan requirements that HHS may itself enforce.

The legislative history of section 1320a-2 also evinces Congress' intent to protect individuals' private rights of action under the Medicaid Act and the rest of the SSA—including section 1396a(a)(23). Prior to its decision in *Suter*, the Supreme Court read the Medicaid Act to confer private rights of action on individuals seeking to enforce their rights under certain of its provisions via a section 1983 lawsuit.[9] Only two

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[8] Section 1396(a)(23) appears in such a section, which sets forth certain specifications for State Medicaid plans. *See* 42 U.S.C. § 1396a(a).

[9] *See* 139 Cong. Rec. S3173-01 (daily ed. Mar. 18, 1993) (statement of Sen. Riegle) ("[When] Congress places requirements in a statute, we intend for the States to follow them. If they fail in this, the Federal courts can order them to comply with the congressional mandate. For 25 years, this was the reading that the Supreme Court had given to our actions in Social Security Act State plan *(cont'd)*

years after *Suter* altered that landscape, Congress moved to restore the right, enacting section 1320a-2. Contemporaneous legislative history, including the House Conference Report, demonstrates that the purpose of the provision was to codify the right of individuals to pursue section 1983 claims to vindicate their rights under the Medicaid Act.[10] Indeed, as Senator Donald Riegle explained at the time, the amendment's goal was to "restore[] the right of individuals to turn to Federal courts when States fail to implement Federal standards under the Social Security Act." 138 Cong. Rec. S17,689 (daily ed. 1992) (statement of Sen. Riegle).

In passing section 1320a-2, Congress also recognized that the administrative remedies specified in the Medicaid Act are not so comprehensive that they are incompatible with the protection section 1983 provides. In fact, they are not suitable replacements for that protection at all. The Medicaid Act and regulations promulgated

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programs. The *Suter* decision represented a departure from this line of reasoning.").

[10] *See, e.g.*, H.R. Rep. No. 103-761, at 926 (1994), *reprinted in* 1994 U.S.C.C.A.N. 2901, 3257 ("The intent of this provision is to assure that individuals who have been injured by a State's failure to comply with the Federal mandates of the State plan titles of the Social Security Act are able to seek redress in federal courts to the extent they were able to prior to the decision in *Suter v. Artist M.* . . . .").

thereunder provide that (1) States must maintain an administrative review process under which providers may seek review of an exclusion decision, *see* 42 C.F.R. §§ 1002.210, 1002.213, 1002.214 (2018);
(2) States must provide a hearing before an administrative agency "to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness," 42 U.S.C. § 1396a(a)(3); and (3) HHS may withhold funds from noncompliant States, *see* 42 U.S.C. § 1396c.

None of these administrative remedies provides an adequate avenue for individuals seeking to protect the right—expressly granted by Congress—to choose one's own qualified provider. First, the provider review process guarantees individual beneficiaries no voice in that process. Second, the hearing requirement in section 1396a(a)(3) applies only to an individual who has been denied Medicaid coverage or benefits in the first place—not a beneficiary of Medicaid who is denied the right to see a qualified provider.[11]

[11] In any event, at least one Circuit Court has held that section 1396a(a)(3) does not preclude a section 1983 action even for claims that (unlike the free-choice-of-provider provision) could be redressed through section 1396a(a)(3). *See Roach v. Morse*, 440 F.3d 53, 57 (2d Cir. 2006) (Sotomayor, J.) ("[The] congressional *(cont'd)*

The majority of Circuits that have analyzed this issue have recognized that Congress did not intend to foreclose a private right of action by including certain other enforcement mechanisms in the Medicaid Act. *See, e.g.*, *Andersen*, 882 F.3d at 1129 (noting that "the federal Secretary's withholding Medicaid funds would not redress [plaintiffs'] injuries at all"); *Comm'r of Ind. State Dep't of Health*, 699 F.3d at 974-75 (holding that "[n]othing in the Medicaid Act suggests, explicitly or implicitly, that 'Congress specifically foreclosed a remedy under § 1983'" and reasoning, in part, that "Congress did not provide a means of private redress here[] [a]nd private enforcement of § 1396a(a)(23) in suits under § 1983 in no way interferes with the Secretary's prerogative to enforce compliance using her administrative authority"); *Harris*, 442 F.3d at 463 ("That the Federal Government may withhold federal funds to non-complying States is not inconsistent with private enforcement. Neither is the Act's requirement that States 'grant[] an opportunity for a fair hearing before the State agency to any

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requirement that states establish administrative review procedures does not imply that § 1983 plaintiffs need exhaust them.").

individual whose claim for medical assistance under the [State] plan is denied' . . . ." (alterations in original) (citations omitted)).[12]

Moreover, as some Courts of Appeals have recognized, "[t]he Medicaid Act does not provide other methods for private enforcement of the Act in federal court." *Harris*, 442 F.3d at 462; *see also Comm'r of Ind. State Dep't of Health*, 699 F.3d at 974-75. Unlike section 1396a(a)(30)(A) at issue in *Armstrong*, the free-choice-of-provider provision "fairly read in the context of the Medicaid Act" does not "'display[] a[n] intent to foreclose' the availability of equitable relief." *Armstrong*, 135 S. Ct. at 1386 (citation omitted). To the contrary, Congress intended patients to "have a right to challenge termination decisions to protect themselves against wrongful deprivation of access to qualified and willing providers, that is, to protect their guaranteed right expressly given by § 1396a(a)(23)." *Andersen*, 882 F.3d at 1231.

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[12] A panel of this Court held in 2017 that section 1396a(a)(23) created a right of action under section 1983 but did not explicitly address the question of whether the administrative schemes set forth in the Medicaid Act were incompatible with the private right of action. *See Gee*, 862 F.3d at 459-60. Similarly, the U.S. Court of Appeals for the Ninth Circuit has also held that section 1396a(a)(23) creates a private right of action. *See Betlach*, 727 F.3d at 968. In that case, the defendant State did not argue that Congress had foreclosed a private right of action, either expressly or via an alternative enforcement mechanism. *See id.*

In passing section 1320a-2, Congress expressed its view that administrative remedies in the Medicaid Act are compatible with a private enforcement suits brought under section 1983. Besides the clear text of the free-choice-of-provider provision itself, the legislative history behind it demonstrates congressional intent to allow individuals to protect their right to a qualified provider of their choice in court alongside the administrative remedies available to providers. The majority of Courts of Appeals analyzing this issue in the context of section 1396a(a)(23) have adopted that analysis and, consistent with Congress' intent, found a private right of action exists here. This Court should do the same.

CONCLUSION

For the foregoing reasons, this Court should affirm the judgment below.

Respectfully submitted,

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