NO. _____

IN THE

Supreme Court of the United States

REBEKAH GEE, SECRETARY, LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS, *Petitioner*,

v.

PLANNED PARENTHOOD OF GULF COAST, INC.; JANE DOE #1; JANE DOE #2; JANE DOE #3, *Respondents*.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether individual Medicaid recipients have a private right of action under 42 U.S.C. § 1396a(a)(23) to challenge the merits of a state's disqualification of a Medicaid provider. (The question presented is essentially the same presented by the petition in *Andersen* v. *Planned Parenthood of Kansas and Mid-Missouri*, Case No. 17-1340.)

PARTIES TO THE PROCEEDING

There are no parties to the proceeding other than those listed in the caption. Petitioner is Rebekah Gee, Secretary, Louisiana Department of Health and Hospitals. Respondents are Planned Parenthood of Gulf Coast, Incorporated, Jane Doe #1, Jane Doe #2, and Jane Doe #3.

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OPINIONS BELOW

The opinion of the United States Court of Appeals for the Fifth Circuit dated June 29, 2017, 1a–81a, is reported at 862 F.3d 445. The opinion of the Fifth Circuit dated September 14, 2016, 82a–128a, is reported at 837 F.3d 477. The amended opinion of the United States District Court for the Middle District of Louisiana dated October 29, 2015, App. 129a–226a, is reported at 141 F. Supp. 3d 604. The order of the Fifth Circuit denying rehearing *en banc* by a 7-7 vote, App. 229a–235a, is reported at 876 F.3d 699.

JURISDICTION

The amended judgment of the court of appeals was entered June 29, 2017. App. 1a. The court of appeals order denying rehearing *en banc* by a 7-7 vote was entered November 28, 2017. App. 229a–235a. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTE INVOLVED

42 U.S.C. § 1396a provides, in relevant part:

> (a) CONTENTS A State plan for medical assistance must—
>
> (23) provide that (A) *any individual eligible for medical assistance* (including drugs) *may obtain such assistance from any institution*, agency, community pharmacy, or person, *qualified to perform the service or services required* (including an organization which provides such services, or arranges for their availability, on a prepayment basis), *who undertakes to provide him such services* . . . .

42 U.S.C. § 1396a(a)(23) (emphasis added).

INTRODUCTION

By a 7-7 vote, the Fifth Circuit declined *en banc* review of "an issue of great importance": whether 42 U.S.C. § 1396a(a)(23) confers a private right of action on Medicaid beneficiaries to challenge the merits of a state's disqualification of a provider. App. 230a (Elrod, J., joined by Jolly, Jones, Smith, Clement, Owen, and Southwick, JJ., dissenting). As the dissenting judges noted, the sharp division results from differing views of *O'Bannon* v. *Town Court Nursing Center*, 447 U.S. 773 (1980), and of Medicaid's statutory framework, with new and debilitating fiscal consequences to states. App. 230a–235a.

The Fifth Circuit's decision muddles any hope for a uniform interpretation of 42 U.S.C. § 1396a(a)(23) or *O'Bannon*. For example, the Eighth Circuit has expressly reached the exact opposite conclusion as the Fifth Circuit did here, holding, on indistinguishable facts, that a Medicaid patient has no private right to challenge a state's disqualification of their preferred provider. *Does* v. *Gillespie*, 867 F.3d 1034, 1041–46 (8th Cir. 2017) (relying on *Gonzaga University* v. *Doe*, 536 U.S. 273 (2002)). The Fifth Circuit's decision also conflicts with the Second Circuit's holding that § 1396a(a)(23) provides no substantive right to support a claim for procedural due process. *Kelly Kare, Ltd.* v. *O'Rourke*, 930 F.2d 170, 178 (2d Cir. 1991) (following *O'Bannon*).

The Tenth Circuit, on the other hand, agrees with the Fifth Circuit that § 1396a(a)(23) creates a right enforceable under § 1983 for beneficiaries to challenge the disqualification of an individual provider. *Planned Parenthood of Kansas* v. *Andersen*, 882 F.3d 1205, 1224–25 (10th Cir. 2018). See Pet. for

Cert., No. 17-1340. And the Sixth, Seventh, and Ninth Circuits have all similarly interpreted § 1396a(a)(23) and held that it creates a right enforceable under § 1983 to challenge state action disqualifying classes of providers. *Harris* v. *Olszewski*, 442 F.3d 456, 461–62 (6th Cir. 2006) (§ 1396a(a)(23) "creates enforceable rights that a Medicaid beneficiary may vindicate through § 1983"); *Planned Parenthood of Ind., Inc.* v. *Comm'r of the Ind. State Dep't of Health*, 699 F.3d 962, 967–68 (7th Cir. 2012) (§ 1396a(a)(23) contains "individual-rights language, stated in mandatory terms" and thus creates a private right of action under § 1983); *Planned Parenthood Ariz., Inc.* v. *Betlach*, 727 F.3d 960, 965–72 (9th Cir. 2013) ("we hold that § 1396a(a)(23) may be enforced through individual § 1983 lawsuits").

The practical ramifications of these deeply conflicting decisions are substantial. More than 70 million individuals are currently enrolled in Medicaid. It cannot be the case that Medicaid recipients in some states have a private right of action when a state disqualifies a provider, or makes a decision impacting a pool of qualified providers, while recipients in other states have no judicial remedy. Indeed, as things stand now, if a state disqualifies an individual provider in the Fifth or Tenth Circuits, a recipient has a cause of action, but if a state disqualifies the exact same provider in the Eight Circuit, the private right of action is barred. Regardless of which Circuits have the better argument, these circumstances require national uniformity.

Moreover, the scope of the Fifth Circuit's deeply divided ruling is greater than those of other circuits because the claims here were filed before the provider's deadline for seeking administrative review, then maintained *after the provider deliberately forfeited its state administrative and judicial review*. That strategic choice, made to avoid a ripeness challenge, caused the decision to become final and an automatic stay to end. So the opinion below encourages providers facing administrative action—ranging from denial of admission to suspension or disqualification—to abandon state remedies and instead recruit beneficiaries to challenge the agency action in federal court, eviscerating federally-mandated state remedies and substituting the federal judiciary as the gatekeeper for pre-screening state Medicaid program administrative actions. The ruling allows providers to recruit beneficiaries to serve as litigation proxies. And it has debilitating fiscal consequences for states, who do not anticipate being hauled into federal court and faced with the costs of litigating hundreds of § 1983 claims (with the added liability of § 1988 attorney fee claims), every time an administrative qualification decision is made.

In other words, allowing private enforcement destroys the careful balance Congress established between the states and federal agencies. The Medicaid scheme requires states to establish provider qualifications and remedies for disqualification in a State Plan approved by CMS, the U.S. Department of Health & Human Services' Centers for Medicare and Medicaid Services, *not* individual litigants. Five circuits have now turned that scheme on its head, dramatically altering the agreement struck by states. Certiorari is warranted.

STATEMENT OF THE CASE

A. Overview of Medicaid § 1396a(a)(23)

Medicaid provides health coverage to more than 70 million Americans. States voluntarily participate in it, are the primary administrators of it, and provide substantial state matching funds. States effect this administration by adopting a federally approved Medicaid "plan." 42 U.S.C. § 1396a(a)–(b).

Congress enacted the Medicaid Act using its spending power. Ordinarily, the remedy for a state's noncompliance with a spending-power act is not a private right of action, but rather an action by the federal government to terminate the funds provided to the state. *Pennhurst State Sch. & Hosp.* v. *Halderman*, 451 U.S. 1, 28 (1981). Medicaid is no different. If a state plan does not meet statutory requirements or comply with CMS regulations, the plan or a proposed amendment to it may be rejected by the Health and Human Services Secretary. When a state fails to comply with its own plan or otherwise fails to comply with statutory requirements, the Secretary may withhold that state's federal Medicaid funding. 42 U.S.C. § 1396c. The Medicaid Act provides remedies for a state to challenge such an action. See 42 U.S.C. § 1316(a)(2) and (3); 42 C.F.R. §§ 430.18, 430.38, 430.76(a), and 430.83.

The Medicaid provision that has flummoxed the circuits is 42 U.S.C. § 1396a(a)(23). This section 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." 42 U.S.C. § 1396a(a)(23)(A) (emphasis added). By its terms,

this section does not allow a Medicaid recipient to pick *any* provider. But the provision does grant such a recipient broad ability to choose any provider the state has deemed "qualified" and who "undertakes to provide such service." *Id. Accord O'Bannon* v. *Town Court Nursing Ctr.*, 447 U.S. 773, 785 (1980).

Congress gave states considerable latitude to determine what makes a potential Medicaid provider "qualified." 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). These standards 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).

B. Louisiana's disqualification of Planned Parenthood Gulf Coast

During the summer of 2015, amidst the release of a series of undercover videos and allegations that Planned Parenthood and its affiliates were contracting with companies to sell aborted human fetal tissue and body parts, the Louisiana Department of Health and Hospitals and the Louisiana Inspector General began investigating the activities of Planned Parenthood Gulf Coast (PPGC), including the extent of its involvement or knowledge of the information and allegations contained in those videos.

The investigation began on July 15, 2015, when the Governor's Executive Counsel requested that the Inspector General initiate a joint investigation with the Department "to determine whether Planned Parenthood Gulf Coast ["PPGC"] is engaged in the illegal harvesting and trafficking of human body parts" or the violation of other provisions of state and federal law. The letter noted that Houston-based PPGC "is an affiliate of this parent organization" that is "currently building an abortion clinic on Claiborne Avenue in New Orleans, Louisiana." Press Release (July 15, 2015), available at https://goo.gl/3DmXjd.

On August 3, 2015, with the Louisiana joint investigation ongoing, in consultation with Texas, the Department informed PPGC it was terminating PPGC's Medicaid provider agreements on an at-will basis under La. Rev. Stat. Ann. § 46:437.11(D)(1), and PPGC had the right to request administrative review, during which time its contracts would remain valid. Because the investigation was ongoing, the Department delayed its decision on for-cause termination.

As the Medicaid Act requires, Louisiana has an appellate process for an excluded provider. 42 U.S.C. § 1396a(a)(4); 42 C.F.R. § 1002.213. The provider can first request an informal hearing in writing within 15 days after receiving the notice of exclusion. La. Admin. Code § 50:4203 At the informal hearing's conclusion, the provider can appeal to the Division of Administrative Law. La. Admin. Code § 50:4211. After exhausting these administrative remedies, the provider has the right to judicial review in state court, and the appeal stays the administrative

decision. La. Admin. Code §§ 50:4169, 4211. But, rather than initiate an administrative appeal, PPGC and three Jane Doe patients sued in federal district court under 42 U.S.C. § 1983, alleging a violation of 42 U.S.C. § 1396a(a)(23). At that time, the qualifications and professional competency of PPGC were not yet at issue. App. 8a n.3.

On September 14, 2015, the Department rescinded its at-will termination and informed the district court that all pending issues were moot. The following day, the Department notified PPGC that the Department was "terminating/revoking" PPGC's Medicaid provider agreements for cause under state law on grounds of misconduct, including fraud related to unreported qui tam claims, misrepresentations by PPGC to the Department during its investigation, and pending investigations by the Louisiana Inspector General into PPGC's conduct. App. 88a; 9/15/15 Department Ltr.

The notice informed PPGC that termination would take effect only after "final determination, judgment, completion, withdrawal from, or termination of all administrative and/or legal proceedings in this matter" and warned "[i]f you do not request an Informal Hearing or an Administrative Appeal, your termination will become effective thirty (30) days (including Saturdays and Sundays) from the date of your receipt of this letter." 9/15/15 Department Ltr. Rather than initiating the appeal process which would have continued the administrative stay, PPGC and the three Jane Doe Plaintiffs pushed forward with the lawsuit, amending to challenge the grounds for the for-cause terminations.

C. Proceedings in the district court

The Department filed a motion to dismiss under Federal Rules of Civil Procedure 12(b)(1) and 12(b)(6). On October 16, 2015, the district court heard oral argument. In response to the Department's ripeness challenge, PPGC informed the court that it would not seek administrative review, opting instead to voluntarily forfeit all state administrative and judicial remedies conferred by the State Plan and to abandon an automatic stay protecting both itself and its patients. The sole purpose was to maintain this lawsuit. Two days later, the day before PPGC's deadline to request administrative review (assuming it had not renounced its right), the district court denied the motion to dismiss and granted Respondents' renewed motion for temporary restraining order, which was converted into a preliminary injunction by agreement of the parties to allow for an immediate appeal. App. 129a–226a; 227a–228a.

D. The Fifth Circuit's split decision

The Fifth Circuit initially affirmed in an opinion issued September 14, 2016. App. 82a–128a. The Department timely requested rehearing *en banc*. On June 26, 2017, the panel withdrew and replaced the original opinion and again affirmed the district court, this time in a 2-1 split opinion. App. 1a–81a. The panel majority concluded that § 1396a(a)(23) afforded individual plaintiffs "a private right of action under § 1983," App. 19a, following decisions of the Sixth, Seventh, and Ninth Circuits. App. 21a–23a.

In so holding, the panel majority spent considerable time distinguishing this Court's decision in *O'Bannon*, "which held that a Medicaid beneficiary does not have a right under 42 U.S.C. § 1396a(a)(23) to challenge *the merits* of a State's assertion that a provider of Medicaid services is no longer qualified to provide Medicaid services or to challenge the State's termination of a provider's Medicaid agreements on the basis of the provider's noncompliance with state and federal regulatory requirements." App. 53a (Owen, J., dissenting). The panel majority held that *O'Bannon* was "inapposite." App. 24a. Whereas the patient-plaintiff in *O'Bannon* alleged a "deprivation of due process rights," the individual plaintiffs here "assert the violation of a substantive right." *Id.* The panel correctly noted that the right guaranteed by § 1396a(a)(23) "is vested in Medicaid recipients rather than providers," so providers cannot bring independent actions. App. 25a. But the panel then went further and said that interpreting *O'Bannon* to foreclose recipient lawsuits "would render the right guaranteed by § 1396a(a)(23) nugatory."

The panel majority also distinguished *Armstrong* v. *Exceptional Child Center, Inc.*, 135 S. Ct. 1378 (2015). In *Armstrong*, a plurality held that a similar Medicaid provision, 42 U.S.C. § 1396a(a)(30)(A), "lacks the sort of rights-creating language needed to imply a private right of action," because it "is phrased as a directive to the federal agency . . ., not as a conferral of the right to sue." *Id.* at 1398. In contrast, said the panel majority, § 1396a(a)(23) "is phrased in individual terms that are specific and judicially administrable, as recognized by the Sixth, Seventh, and Ninth Circuits." App. 28a. Having concluded that the individual plaintiffs had a right of

action under § 1396a(a)(23), the panel majority further held that the individual plaintiffs had a likelihood of success and could show irreparable harm, warranting injunctive relief. App. 29a–50a.

Judge Owen dissented "because the majority opinion conflicts with" *O'Bannon*. In Judge Owen's view, "none of the bases on which [the panel majority] attempts to distinguish *O'Bannon* withstands scrutiny." *Id.* "The decision in *O'Bannon* controls here." App. 57a.

Judge Owen rejected the majority's due-process versus substantive-right distinction. That argument "reflect[s] a failure to appreciate that there is no right to due process unless there is a substantive right that may be vindicated if adequate process is accorded." App. 58a. Because the Department's grounds for termination were well within the scope of federal statutes and regulations (i.e., meritorious), the individual plaintiffs had no statutory right to challenge that decision. App. 64a–76a

Judge Owen also rejected the conclusion that a ruling for the Department would render the right supposedly guaranteed by § 1396a(a)(23) nugatory. App. 76a. Even if individual Medicaid recipients cannot bring a court action, the Department's review is hardly unreviewable. PPGC was entitled to state administrative proceedings, state-court review, and possibly even a § 1983 claim based on other grounds. *Id.* However, "the Medicaid statutory scheme contemplates that only the provider can contest a determination that it is not qualified. There is no need to give Medicaid patients that right." App. 78a.

E. The Fifth Circuit's 7-7 split *en banc*

The Department again sought *en banc* review. This time, the *en banc* court denied that request, in a 7-7 decision that equally split the *en banc* judges. App. 229a–35a. Because the order is a simple denial, there is no written opinion of the seven judges who agreed with the panel majority. But Judge Elrod, writing for herself and Judges Jolly, Jones, Smith, Clement, Owen, and Southwick, wrote a detailed dissent urging why *en banc* review was warranted. To begin, the panel majority's opinion "disregard[ed]" this Court's binding opinion in *O'Bannon*. App. 230a (Elrod, J., dissenting). As this Court explained in *O'Bannon*, "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." App. 231a (quoting *O'Bannon*, 447 U.S. at 786). And the panel majority's attempts to distinguish *O'Bannon* failed when compared to what this Court actually said in that decision. App. 231a–33a.

Indeed, said Judge Elrod, "the panel majority opinion's reasoning is not only at odds with *O'Bannon* but also with the entirety of the statutory framework in 42 U.S.C. § 1396a." App. 233a. Yet the majority pursued its "disjointed reasoning" to avoid "the procedural elephant in the case: PPGC chose to forego its administrative remedies prior to filing this lawsuit." App. 234a. And the district court's "preliminary injunction below was issued on the claims of the individual Doe plaintiffs, not on Planned Parenthood's claims." *Id.*

The result is that "a Medicaid provider can now make an end run around the administrative exhaustion requirements in a state's statutory scheme" by recruiting individual Medicaid recipients to assert the provider's claims under the guise of a § 1396a(a)(23) claim. App. 234a–35a.

REASONS FOR GRANTING THE PETITION

This case raises an issue of jurisprudential significance that has sharply divided the circuits: whether individual Medicaid recipients have a private right of action under 42 U.S.C. § 1396a(a)(23) to challenge the merits of a state's disqualification of a Medicaid provider or providers. This question split the Fifth Circuit 7-7 below; it has enormous consequences for states attempting to regulate providers and fund Medicaid programs; and it deeply impacts the Medicaid enforcement scheme Congress intended, not to mention the federal courts who will now be substitute decision-makers. Certiorari is warranted.

I. The federal courts of appeals are in conflict over whether individual Medicaid beneficiaries have a private right of action under 42 U.S.C. § 1396a(a)(23) to challenge the merits of a state's disqualification of a Medicaid provider.

The circuits are deeply divided over whether Medicaid recipients can bring a § 1983 action to challenge under § 1396a(a)(23) the merits of a state's disqualification of a Medicaid provider or providers. This division results from disagreement over the meaning of this Court's decision in *O'Bannon* and of § 1396a(a)(23) itself.

As explained at length above, the Fifth Circuit followed decisions of the Sixth, Seventh, and Ninth Circuits and held that a Medicaid recipient has a private right of action under § 1396a(a)(23) to challenge the merits of a state's decision to disqualify a Medicaid provider. App. 21a–24a. To reach that result, the panel majority distinguished this Court's decision in *O'Bannon* as "inapposite." App. 24a. Whereas *O'Bannon* alleged a "deprivation of due process rights," said the panel, the individual plaintiffs here "assert the violation of a substantive right." *Id.*

The Eighth Circuit reached the exact opposite conclusion in *Does* v. *Gillespie*, 867 F.3d 1034 (8th Cir. 2017). There, the court rejected a suit brought by beneficiaries who, like the plaintiffs here, brought a § 1983 action to challenge Arkansas' termination of a particular Medicaid provider. Section 1396a(a)(23), said the court, is phrased "not as a conferral of the right to sue upon the beneficiaries of the State's decision to participate in Medicaid," but rather "as a directive to the federal agency charged with approving state Medicaid plans." *Id.* at 1041 (citations omitted). A "statute phrased as a directive to a federal agency typically does not confer enforceable federal rights on the individuals." *Id.* (citing *Univs. Research Ass'n, Inc.* v. *Coutu*, 450 U.S. 754, 756 n.1 (1981)).

Equally important, said the Eighth Circuit, "Congress expressly conferred another means of enforcing a State's compliance with § 23(A)—the withholding of federal funds by the Secretary." *Id.* (citing 42 U.S.C. § 1396c). Congress "also authorized the Secretary to promulgate regulations," and the Secretary "has required States to give providers the

right to appeal an exclusion from the Medicaid program." *Id.* (citing 42 U.S.C. § 1396a(a)(4) and 42 C.F.R. § 1002.213). Where "other sections of the Act provide mechanisms to enforce the State's obligation under § 23(A) to reimburse qualified providers who are chosen by Medicaid patients, it is reasonable to conclude that Congress did not intend to create an enforceable right for individual patients under § 1983." *Id.* (citing *Suter* v. *Artist M.*, 503 U.S. 347, 360–61, 363 (1992), and *Gonzaga*, 536 U.S. at 281). The opposite conclusion would create the anomaly that while a provider pursues administrative appeal and judicial review in the state courts, individual beneficiaries "separately could litigate or relitigate the qualifications of the provider in federal court under § 1983," creating the "potential for parallel litigation and inconsistent results." *Id.* at 1041–42 (citation omitted). In sum, § 1396a(a)(23) is "part of a substantial compliance regime" and thus "counsels against the creation of individually enforceable rights." *Id.* at 1042 (citation omitted).

The Second Circuit is also in conflict with the Fifth, though based on *O'Bannon* rather than a *Gonzaga* structural analysis. In *Kelly Kare, Ltd.* v. *O'Rourke*, 930 F.2d 170, 178 (2d Cir. 1991), a home-health-care provider's patients sued to enjoin the defendant county from terminating the patients' provider's Medicaid reimbursement contract. Analyzing *O'Bannon*, the Second Circuit had no difficulty concluding that Medicaid beneficiaries "do not have a cognizable liberty interest in choosing [a particular provider] as their health-care provider." *Id.* at 178.

O'Bannon, said the Second Circuit, distinguished between direct Medicaid benefits (e.g., financial assistance) and indirect benefits (e.g., freedom of choice), and held that state action that "incidentally burdens an indirect governmental benefit does not give rise to the level of a deprivation of a liberty interest." *Id.* (citing *O'Bannon*, 447 U.S. at 786–88). Section 1396a(a)(23) does not give beneficiaries "a property interest in their freedom to choose [a particular provider] as their provider" once the government has properly terminated the provider's Medicaid contract. *Id.*

In contrast, the Tenth Circuit is fully aligned with the Fifth, concluding that "§ 1396a(a)(23) affords [Medicaid beneficiaries] a private right of action under § 1983" to challenge the disqualification of a particular provider or providers. *Planned Parenthood of Kansas* v. *Andersen*, 882 F.3d 1205, 1224–25 (10th Cir. 2018). Like the Fifth Circuit, the Tenth disregarded *O'Bannon* as entirely inapposite to the circumstances presented here, *id.* at 1231, and it misanalyzed § 1396a(a)(23) under the *Gonzaga* rubric. *Id.* at 1025–28.

The Sixth, Seventh, and Ninth Circuits are mostly aligned with the Fifth Circuit, in that each has held that beneficiaries have a private right of action under § 1396a(a)(23), in the context of a government act that impacts a pool of qualified providers at large. *Harris* v. *Olszewski*, 442 F.3d 456, 461–62 (6th Cir. 2006) (§ 1396a(a)(23) "creates enforceable rights that a Medicaid beneficiary may vindicate through § 1983"); *Planned Parenthood of Ind., Inc.* v. *Comm'r of the Ind. State Dep't of Health*, 699 F.3d 962, 967–68 (7th Cir. 2012) (§ 1396a(a)(23)

contains "individual-rights language, stated in mandatory terms" and thus creates a private right of action under § 1983); *Planned Parenthood Ariz., Inc.* v. *Betlach*, 727 F.3d 960, 965–72 (9th Cir. 2013) ("we hold that § 1396a(a)(23) may be enforced through individual § 1983 lawsuits").

Yet even while reaching the same conclusion, the Sixth, Seventh, and Ninth Circuits could not agree on the reason why. The Sixth Circuit believes that *O'Bannon* actually supports the holding that § 1396a(a)(23) creates enforceable, substantive rights. *Harris*, 442 F.3d at 462 (quoting *O'Bannon*, 447 U.S. at 785, for the proposition that § 1396a(a)(23) "gives recipients the right to choose among a range of qualified providers[ ] without government interference."). The Seventh Circuit, like the Fifth, believed *O'Bannon* was irrelevant. *Planned Parenthood of Indiana*, 699 F.3d at 977 (drawing the same procedural versus substantive distinction the Fifth Circuit drew here). And the Ninth Circuit did not discuss *O'Bannon* at all. So even among circuits that *agree* that § 1396a(a)(23) provides a private right of action, there is conflict as to why that conclusion is correct.

II. The question presented is a recurring issue of national importance.

The numerous conflicting circuit decisions, the dissenting and concurring opinions within those decisions, and the Fifth Circuit's 7-7 *en banc* opinion show that the issue presented is recurring and creating unnecessary litigation. The Court should grant the petition and resolve that conflict now.

First, the deep division among the circuits is far from academic; it involves an "issue of great importance" with considerable repercussions. App. 230a (Elrod, J., dissenting). As observed by the Eighth Circuit and explained in more detail below, the circuit majority's approach lays waste to the administrative and judicial-review processes Congress required states to establish for providers who disagree with state administrator decisions, rendering those processes (and Congress' directive to have them) entirely superfluous.

Second, the circuit-majority approach requires states—who already are struggling to fund Medicaid programs—to assume the costs and administrative burdens of defending hundreds of disqualification decisions in federal court, with corresponding exposure to attorney fees pursuant to 42 U.S.C. § 1988. Louisiana alone took 182 such actions in fiscal year 2017, and 175 through March 31, 2018, of fiscal year 2018. At a cost of tens or even hundreds of thousands of dollars per federal case (excluding statutory attorney fees, which double the financial exposure), the initial financial exposure amounts to many millions of dollars in state funds. That is a troubling result in an environment where thousands of unique providers may be terminated from Medicaid nation-

wide in a given year. U.S. Dep't of Health & Human Servs. Office of Inspector General, *Providers Terminated From One State Medicaid Program Continued Participating In Other States*, 17, Table B-1, (Aug. 2015), available a*t* https://goo.gl/SqbjPY. With a clear circuit majority placing its imprimatur on beneficiary § 1983 suits with the possibility of attorney fees, challenging provider exclusions will quickly become a cottage industry.

Third, it is highly unlikely that subsequent circuit decisions or *en banc* proceedings will resolve the conflict or provide useful additional analysis. The Fifth Circuit in this very case had the opportunity to stake out a clear position on one side of the split or the other. But instead of granting *en banc* review, the court divided evenly, 7-7.

Fourth, further delay in resolving the question presented harms states, because this is not the legislative bargain they struck. As demonstrated in the Eighth Circuit and here, this is the new normal. "Disqualified providers can now circumvent state law . . . so long as there are patients to join a lawsuit filed in federal court." App. 235a (Elrod, J., dissenting). And while this case involved the disqualification of a politically controversial provider, the ruling applies to *any* provider. With the possibility of a statutory award of attorney fees under § 1988, providers will be highly incentivized to go to federal court (indeed, they have no incentive whatsoever to go through the state process) and now have a clear path to do so. States have an important interest in protecting their own sovereignty and stopping a judicially-created right of action that will divert precious state resources from other critical services.

Fifth, the ruling below eliminates the plan flexibility that Congress built into the Medicaid Act. When a federal court exercises the power—based on nothing more than an individual citizen suit—to enjoin the state and compel it to contract with Medicaid providers that the state has determined should be disqualified from all state Medicaid funding, the state loses the ability to work with CMS on crafting a plan acceptable to both the state and the agency. That flexibility is precisely what Congress envisioned when it gave states wide latitude to establish qualification criteria and required the states to create a deprivation-of-funding remedy.

Sixth, delay harms the federal government. If individual plaintiffs can obtain an injunction to compel a state to act, then the Secretary has been deprived of the discretion to waive Medicaid plan requirements. That judicial curbing of federal authority, too, is contrary to the scheme Congress enacted.

Seventh, delay harms individual litigants. If the Fifth, Sixth, Seventh, Ninth, and Tenth Circuits are correct, then Medicaid beneficiaries in the Eighth Circuit are being wrongfully denied their right to file individual claims when a state disqualifies their preferred provider. Conversely, if the Eighth Circuit is correct, then states in the five other circuits are being subjected to private rights of action in federal court without congressional authorization. Either way, the justice system is producing widely divergent results for similarly situated defendants—sometimes involving the exact some provider.

In sum, this case is an ideal vehicle to resolve the question presented. Certiorari is warranted.

III. The Fifth Circuit's decision is incorrect.

A. The decision below conflicts with *Gonzaga* and *Armstrong*.

The panel majority's decision is irreconcilable with *Gonzaga* and *Armstrong*. *Gonzaga* properly focused on express right- or duty-creating language in discerning whether Congress intended to confer a private right of action, language which is noticeably absent in § 1396a(a)(23). And the *Armstrong* plurality held that there was no private right of action in a Medicaid statute "phrased as a directive to the federal agency charged with approving state Medicaid plan," *id.*, which is the situation here.

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 *Gonzaga* explained, an individual claiming the right to a private cause of action must therefore show "an unambiguously conferred *right* to support a cause of action." 536 U.S. at 283. That the statute confers an individual *benefit* is not enough. *Id.*

Gonzaga contrasted the language of the Family Educational Rights and Privacy Act—which the Court said did not create a private right of action—with Title VI of the Civil Rights Act of 1964 and Title IX of the Education Amendments of 1972, which do create such a right. Title VI states that "No person . . . shall . . . be subjected to discrimination" based on race, color or national origin. *Id.* at 384 n.3 (quoting 42 U.S.C. § 2000d). Title IX similarly states "No person . . . shall, on the basis of sex, . . . be subjected

to discrimination" under a federally-funded education program. *Id.* (quoting 20 U.S.C. § 1681(a)). Section 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). And although this provision is in a mandatory context (what state plans must provide), it merely established the criteria for federal reimbursement and HHS approval of a state plan.

This structure is the exact opposite of one using unambiguous language to confer a right that could support a private cause of action. As the Seventh Circuit said in analyzing an analogous provision, 42 U.S.C. § 1396a(a)(19), such language "cannot be interpreted to create a private right of action, given the Supreme Court's hostility, most recently and emphatically expressed in *Gonzaga* . . ., to implying such rights in spending statutes." *Bruggeman* v. *Blagojevich*, 324 F.3d 906, 911 (7th Cir. 2003). To the contrary, the Medicaid Act's overall structure and its defunding provision, 42 U.S.C. § 1396c, is strong evidence Congress did not intend a private right of action under § 1983. *Gonzaga*, 536 U.S. at 289–90.

That evidence is even stronger given that Congress also granted the Secretary power to waive § 1396a's requirements altogether. 42 U.S.C. § 1396n(b). That power demonstrates that § 1396a is not mandatory. And to create an individual right, a federal statutory provision "must be couched in mandatory, rather than precatory terms." *Blessing* v. *Freestone*, 520 U.S. 329, 341 (1997). It is not possible

to say that an individual Medicaid beneficiary has a "right" to sue if the Secretary has the discretionary power to waive that "right." *Gonzaga* should control.

As for *Armstrong*, a plurality of this Court held that there was no private right of action in a Medicaid statute "phrased as a directive to the federal agency charged with approving state Medicaid plans." 135 S. Ct. at 1387. The "express provision of one method of enforcing a substantive rule suggests that Congress intended to preclude others." *Id.* at 1385 (quotation omitted). The same is true here with respect to § 1396a(a)(23).

First, the statute 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. "[P]hrased as a directive to a federal agency," the Act is "two steps removed from the interests of the patients who seek services." *Gillespie*, 867 F.3d at 1041. This statutory structure is similar to the one at issue in *Armstrong*.

Second, the Act and its implementing regulations require a state plan to provide a state administrative and judicial review process for Medicaid providers that the state disqualifies. The governing regulations require states to give Medicaid providers "the opportunity to submit documents and written argument against the exclusion." 42 C.F.R. § 1002.213. In addition, the regulations require states to grant providers "any additional appeals rights that would otherwise be available under procedures established by the State." *Id.*

These regulations are part of a scheme that anticipates *states* will be in the business of disqualifying providers and reviewing those decisions under federally-approved procedures. See 42 U.S.C. § 1320a-7(b)(5) (allowing the federal government to disqualify providers who are excluded by a state). And they not only evidence a distinct lack of need for private rights of action by individual Medicaid beneficiaries, they do not even contemplate beneficiary participation in the appeals process.

Here, PPGC had a right to administratively challenge its termination. La. Rev. Stat. Ann. § 46:437.4; La. Admin. Code tit. 50, §§ 4161, 4211, 4213. At the conclusion of those proceedings, PPCG could have pursued a state-court appeal. PPGC "may also have a § 1983 claim based on rights under provisions of the Medicaid statutes and regulations (other than § 1396a(a)(23) and regulations promulgated under it) to challenge the State's termination of its provider agreement." App. 77a (Owen, J. dissenting). No private right of action is necessary.

B. The decision below conflicts with this Court's decision in *O'Bannon*, too.

This Court in *O'Bannon* 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. 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 here.

The plaintiffs in *O'Bannon* were nursing-home residents; the nursing home's Medicaid provider agreement was revoked. The home and several individual residents sued, alleging they were entitled to an evidentiary hearing because the revocation deprived them of a property right arising from 42 U.S.C. § 1396a(a)(23). This Court rejected that claim. While § 1396a(a)(23) gives beneficiaries "the right to choose among a range of qualified providers," the provision "does not confer a right on a recipient to continue to receive benefits for care in a home that has been decertified." *Id.* at 784. The "right to choose among a range of qualified providers" is fundamentally different than the right to choose—*or challenge*—which providers are included in that range.

The panel majority's attempts below to distinguish *O'Bannon* do not withstand scrutiny. For example, the majority says that *O'Bannon* stemmed "from a deprivation of due process rights," whereas this case "assert[s] the violation of a substantive right." App. 24a. But "there is no right to due process unless there is a substantive right that may be vindicated if adequate process is accorded." App. 58a (Owen, J., dissenting). Indeed, this Court in *O'Bannon* expressly rejected the argument that § 1396a(a)(23) created a "property right" in favor of beneficiaries to "remain in the home of their choice." *Id.* at 59a (quoting *O'Bannon*, 448 at 874). The panel majority "is plainly mistaken in characterizing the *O'Bannon* decision as dealing only with 'due process,' but not substantive, rights under 42 U.S.C. § 1396a(a)(23)." *Id.* at 59a–60a.

O'Bannon likewise "did not turn on whether the State revoked the nursing home's authorization to continue functioning as a nursing home," as the panel majority suggested. App. 50a. *O'Bannon* was decided on the specific question whether § 1396a(a)(23) "gave Medicaid beneficiaries 'a right to continued residence in the home of one's choice.'" App. 71a–76a (Owen, J., dissenting).

Nor did *O'Bannon* turn on the fact that the decertification decision there involved the provider's authority to service the general public, rather than merely Medicaid beneficiaries. App. 26a. In any event, the Department's notice of intent to terminate PPGC's provider agreements here *did* "assert acts or omissions that would come within prohibitions in the federal statutory and regulatory scheme." App. 64a (Owens, J., dissenting).

O'Bannon also cannot be distinguished on the ground that the individual plaintiffs here are not "challenging the merits of" the Department's decision to terminate PPGC Medicaid provider agreements. App. 26a. Several of the grounds the Department provided for termination do, in fact, pertain to qualifications to continue as a Medicaid provider. App. 64a (Owen, J., dissenting). What's more, the panel majority then says that the individual plaintiffs are likely to prevail on their merits contention that PPGC is a qualified provider. This is "circular" reasoning that allowed the beneficiaries "to do precisely what *O'Bannon* said they have no statutory right to do": "challenge the merits of whether a provider is a qualified Medicaid provider." *Id.* This conflict counsels strongly in favor of this Court's review.

C. The Fifth Circuit's decision renders state administrative remedies superfluous and allows Medicaid providers to litigate their claims by proxy.

Louisiana law—consistent with federal Medicaid law—provides that there will be no interruption of services as a result of disqualification until after all administrative and state-court judicial remedies are exhausted. La. Admin. Code §§ 50:4169, 4211. To avoid a ripeness challenge, PPGC made the calculated decision to renounce these rights.

That strategic choice creates an anomaly. The individual plaintiffs say Louisiana caused the plaintiffs to lose their access to PPGC's services. But that is not accurate. The provider-of-choice provision assumes a willing provider, that is, a provider "who undertakes to perform" covered services as the statute requires. But "in instances in which a provider does not challenge the termination of its Medicaid agreement, it cannot be said to be undertaking to provide Medicaid services to its patients." App. 78a (Owens, J., dissenting). By forfeiting its administrative state-court judicial remedies, PPGC chose not to be a willing provider.

What's more, this is not an isolated occurrence. The fact pattern here—where PPGC deliberately abandoned its state remedies—is identical to what transpired in the Eighth Circuit's *Gillespie* case. And with the roadmap for § 1983 actions now in place, the stage is set for thousands of future cases where Medicaid beneficiaries are used as proxies for providers who are dissatisfied with a state's exclusion decision.

Congress created a comprehensive statutory scheme requiring state remedies in state plans, plans which must be approved and overseen by the Secretary of HHS, with corresponding mechanisms for states to challenge the decisions of the Secretary. Nothing in this comprehensive structure suggests Congress intended a loophole whereby providers may forfeit their rights and—with the help of private-litigant beneficiaries serving as proxies for the provider—evade the very review scheme Congress expressly required. This absurd and costly interpretation of the Medicaid Act warrants this Court's immediate review.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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