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February 18, 2016

Michael E. Gans, Clerk of Court
U.S. Court of Appeals for the Eighth Circuit
Thomas F. Eagleton Courthouse
111 South 10th Street
Room 24.329
St. Louis, MO 63102

Re: *Planned Parenthood Arkansas & Eastern Oklahoma et al. v. Selig,* No. 15-3271

Dear Mr. Clerk:

I write to bring to the Court's attention a new development pursuant to Federal Rule of Appellate Procedure 28(j). The United States filed an *amicus* brief in a similar action pending before the U.S. Court of Appeals for the Fifth Circuit. *See* Brief for the United States, *Planned Parenthood Gulf Coast v. Gee*, No. 15-30987 (5th Cir. Feb. 17, 2016) (Doc. 00513384431). The brief supports Appellees' arguments in this case.

That action was brought by a Planned Parenthood affiliate and three Medicaid beneficiary plaintiffs challenging Louisiana's effort to terminate the affiliate from the Medicaid program. As here, Plaintiffs contend the Medicaid Act's Free Choice of Provider requirement, 42 U.S.C. § 1396a(a)(23), creates individual rights enforceable through 42 U.S.C. § 1983, which were violated by the termination of their chosen provider.

In its *amicus* brief, the United States agrees that the Free Choice of Provider requirement confers an individual right enforceable through § 1983, and that *Armstrong v. Exceptional Child Ctr. Inc.*, 135 S. Ct. 1378 (2015), does not alter this analysis. Br. of United States at 7-9.

The United States further agrees that the Free Choice of Provider Requirement prevents states from excluding providers for reasons unrelated to fitness to provide medical services or to properly bill for those services. *Id*. at 9-12. It clarifies that this standard applies regardless of whether the exclusion is imposed through an across-the-board rule or through the termination of individual provider agreements under a standard unrelated to the provider's fitness to perform Medicaid services, *id*. at 13, and that the Free Choice of Provider requirement would be a nullity if states "could use individualized proceedings to exclude providers for no reason or for an invalid reason, or without any supporting evidence," *id*. at 16. The United States further states

that affiliation with a sanctioned entity is not, by itself, sufficient basis to exclude a provider. *Id.* at 6. Finally, it also notes that Arkansas terminated PPH without making "any actual determination regarding the actual fitness of PPH to perform services." *Id.* at 16 n.7.

Please do not hesitate to contact me with any questions.

Sincerely,

Jennifer Sandman
Counsel for Plaintiffs-Appellees

No. 15-30987

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

PLANNED PARENTHOOD GULFCOAST, INCORPORATED;
JANE DOE #1; JANE DOE #2; and JANE DOE #3,

Plaintiffs-Appellees,

v.

REBEKAH GEE, Secretary, Louisiana Department of Health and Hospitals,

Defendant-Appellant.

On Appeal from the United States District Court
for the Middle District of Louisiana (No. 3:15-cv-00565)

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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STATEMENT OF INTEREST

The United States respectfully submits this amicus brief pursuant to Rule 29(a) of the Federal Rules of Appellate Procedure. The United States has a strong interest in the proper operation of the Medicaid program—which provides health care coverage to more than seventy million low-income persons who otherwise would likely be unable to afford health care services—and in ensuring that states administer their federally subsidized Medicaid programs in a manner that is consistent with the Medicaid statute.

This appeal concerns 42 U.S.C. § 1396a(a)(23), which gives Medicaid beneficiaries the right to obtain services from any qualified and willing provider of their choosing. The same provision, known as the "free choice of providers requirement," was at issue in *Planned Parenthood of Indiana, Inc. v. Commissioner of the Indiana State Department of Health*, 699 F.3d 962 (7th Cir. 2012), *cert. denied*, 133 S. Ct. 2736 (2013), and *Planned Parenthood Arizona, Inc. v. Betlach*, 727 F.3d 960 (9th Cir. 2013), *cert. denied*, 134 S. Ct. 1283 (2014), where the United States participated as amicus. In those cases, the Seventh and Ninth Circuits concluded that Indiana and Arizona violated the free choice of providers requirement by enacting laws that had the effect of excluding local Planned Parenthood organizations from their respective Medicaid programs for grounds unrelated to their fitness to perform needed services.

Recently, a number of states including Louisiana, Arkansas and Alabama have sought to terminate local Planned Parenthood providers from their Medicaid programs. In each case, the district court concluded that the plaintiff Medicaid beneficiaries are likely to succeed on their claim that the termination violates the free choice of providers requirement.[1] In this amicus brief, we set out the legal principles that are generally applicable to such claims, and defer to the parties to address the particular facts, circumstances and procedural posture of this case.[2]

STATEMENT

The Medicaid program, established under Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.*, is a cooperative program through which the federal government provides financial assistance to states so that they may furnish medical care to needy individuals. "The Federal Government shares the costs of Medicaid with States that elect to participate in the program." *Atkins v. Rivera*, 477 U.S. 154, 156-57 (1986). "In return, participating States are to comply with

[1] *See* ROA.886-965 (district court opinion); *Planned Parenthood Arkansas & Eastern Oklahoma v. Selig*, No. 4:15-cv-00566 (E.D. Ark. Oct. 2, 2015), *appeal pending*, No. 15-3271 (8th Cir.); *Planned Parenthood Southeast, Inc. v. Bentley*, __ F. Supp. 3d __, 2015 WL 6517875 (M.D. Ala. 2013). Alabama did not appeal the preliminary injunction, and a permanent injunction was entered on the parties' joint motion. *See Planned Parenthood Southeast, Inc. v. Bentley*, No. 2:15-cv-00620 (M.D. Ala.), Dkt. No. 70.

[2] We likewise defer to the parties to address issues such as ripeness, exhaustion, and irreparable harm.

requirements imposed by the Act and by the Secretary of Health and Human Services." *Id*. at 157.

To be eligible for federal funds, a participating state must develop a plan for medical assistance that demonstrates compliance with the requirements of the Medicaid statute and regulations. *See* 42 U.S.C. § 1396a. If the Department of Health and Human Services (HHS) approves the state plan, the federal government reimburses the state for a percentage of qualified Medicaid expenses. The federal contribution rate varies depending on a state's per capita income, but federal funds pay at least 50% of the cost of providing medical assistance to Medicaid beneficiaries. *See id*. § 1396d(b). For family planning services, the federal government pays 90% of the cost of the services, whereas a state pays only 10% of the cost. *See id*. § 1396b(a)(5).[3]

Although state participation in the Medicaid program is voluntary, once a state elects to join the program, it must comply with federal requirements. The requirement at issue here is 42 U.S.C. § 1396a(a)(23), which gives Medicaid beneficiaries "the right to choose among a range of qualified providers, without government interference." *O'Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773,

[3] This case does not involve abortion services. *See* ROA.891. Moreover, the federal Hyde Amendment prohibits the use of Medicaid funding for abortions except where the pregnancy results from rape or incest or the life of the pregnant woman is at stake. *See Harris v. McRae*, 448 U.S. 297, 302 (1980).

785 (1980) (emphasis omitted). Subparagraph (B) of this provision establishes additional protections for recipients of family planning services (which, as noted above, are reimbursed at an enhanced federal rate). Even in the context of managed care, where a state otherwise may place certain limits on a Medicaid beneficiary's free choice of providers, a state may not limit a beneficiary's free choice of providers of family planning services. *See* 42 U.S.C. § 1396a(a)(23)(B) (cross-referencing § 1396d(a)(4)(C)).

Longstanding HHS regulations allow a state to establish "reasonable standards relating to the qualifications of providers." 42 C.F.R. § 431.51(c)(2). Consistent with Section 1396a(a)(23)'s free choice of providers requirement, however, such standards must relate to a provider's fitness to perform the medical services the patient requires—*i.e.*, its capability to perform the required services in a professionally competent, safe, legal, and ethical matter—or to bill appropriately for those services. *See Planned Parenthood of Indiana, Inc. v. Commissioner of the Indiana State Department of Health*, 699 F.3d 962, 978 (7th Cir. 2012); *Planned Parenthood Arizona, Inc. v. Betlach*, 727 F.3d 960, 975 (9th Cir. 2013); 42 C.F.R. § 455.101.

The Medicaid statute also provides that in addition to any other authority, a state may exclude from Medicaid any "individual or entity" "for any reason for which the Secretary could exclude the individual or entity" from the Medicare

program under 42 U.S.C. §§ 1320a-7, 1320a-7a, or 42 U.S.C. 1395cc(b)(2). *See* 42 U.S.C. § 1396a(p)(1), (3). These provisions require or permit the Secretary to exclude a provider for specific reasons enumerated in the statute, after an administrative hearing.

For example, an individual or entity must be excluded under Section 1320a-7 if convicted of specified criminal offenses, such as a felony related to health care fraud; a felony related to the unlawful manufacture or distribution of a controlled substance; or a criminal offense related to the delivery of services under a federal or state health care program or the neglect or abuse of patients. *See id*. § 1320a-7(a). An individual or entity may also be excluded under that section if convicted of other specified offenses, such as a misdemeanor related to health care fraud; an offense related to the obstruction of an investigation or audit relating to offenses for which exclusion is permitted; or an offense related to obstruction of an investigation or audit relating to the use of funds received from a federal health care program. *See id*. § 1320a-7(b). The Secretary may exclude any individual or entity whose license to provide health care has been revoked or suspended by any state licensing authority for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity. 42 U.S.C. § 1320a-7(b)(4). In addition, the Secretary may exclude any individual or entity that the Secretary determines has submitted substantially excessive bills

under Medicare or a state health care program without good cause, or has furnished items or services substantially in excess of the needs of patients or of a quality which fails to meet professionally recognized standards of health care. *See id*. § 1320a-7(b)(6).[4]

Reasons for termination of a Medicare provider agreement pursuant to 42 U.S.C. § 1395cc(b)(2) are also enumerated in the statute and, like the reasons for exclusion under Section 1320a-7, relate to the provider's compliance with program standards and financial integrity.

These provisions of the Social Security Act do not treat affiliated entities as a single entity. Instead, the provisions separately address the treatment of individuals and entities that are associated with sanctioned or excluded providers. Section 1320a-7(b)(8) allows the Secretary to exclude "[e]ntities controlled by a sanctioned individual" from federal health care programs, and Section 1320a-7(b)(15) allows the Secretary to exclude "[i]ndividuals controlling a sanctioned entity." Thus, a provider's affiliation with a sanctioned individual or entity is not, by itself, a sufficient basis to exclude the provider from a health care program under these provisions.

[4] Additional grounds for exclusion are set forth in Section 1320a-7 and in 42 U.S.C. § 1320a-7a, which also provides additional remedies.

ARGUMENT

I. The Free Choice Of Providers Requirement Confers An Individual Right That Medicaid Beneficiaries May Enforce In A Section 1983 Action.

The free choice of providers requirement, 42 U.S.C. § 1396a(a)(23), confers an individual right that Medicaid beneficiaries may enforce in an action under 42 U.S.C. § 1983. For the reasons stated by the three courts of appeals that addressed the issue, the free choice of providers requirement meets the standard established by *Gonzaga University v. Doe*, 536 U.S. 273 (2002), for determining that a provision of Spending Clause legislation may be enforced in a Section 1983 action. *See Planned Parenthood of Indiana, Inc. v. Commissioner of the Indiana State Department of Health*, 699 F.3d 962, 972-77 (7th Cir. 2012); *Planned Parenthood Arizona, Inc. v. Betlach*, 727 F.3d 960, 965-68 (9th Cir. 2013); *Harris v. Olszewski*, 442 F.3d 456, 460-65 (6th Cir. 2006).

First, "the free-choice-of-provider statute unambiguously gives Medicaid-eligible patients an individual right," that is, "the right to receive care from the qualified provider of their choice." *Planned Parenthood of Indiana*, 699 F.3d at 974. "Second, the right is administrable and falls comfortably within the judiciary's core interpretive competence." *Ibid.* "[T]he term 'qualified' as used in § 1396a(a)(23) unambiguously refers to the provider's fitness to render the medical services required." *Id*. at 980. Third, "§ 1396a(a)(23) is plainly couched in

mandatory terms." *Id*. at 974. "It says that all states 'must provide' in their Medicaid plans that beneficiaries may obtain medical care from any provider qualified to perform the service." *Ibid*. Finally, "the Medicaid Act does not 'explicitly or implicitly foreclose the private enforcement of this statute through § 1983 actions.'" *Id*. at 975 (quoting *Harris*, 442 F.3d at 462). "That the Federal Government may withhold federal funds to non-complying States is not inconsistent with private enforcement." *Harris*, 442 F.3d at 463. Indeed, this Court has held that another provision of the Medicaid statute, 42 U.S.C. § 1396a(a)(10), is enforceable under Section 1983. *See S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 602-07 (5th Cir. 2004); *see also Center for Special Needs Trust Admin., Inc. v. Olson*, 676 F.3d 688, 699-700 (8th Cir. 2012) (concluding that 42 U.S.C. § 1396p(d)(4)(C) is enforceable under Section 1983).

Contrary to Louisiana's suggestion, these decisions were not overruled by the Supreme Court's decision in *Armstrong v. Exceptional Child Center, Inc.*, 135 S. Ct. 1378 (2015). *Armstrong* was not a Section 1983 case, and it did not purport to alter the framework established by *Gonzaga University* for determining whether a provision of Spending Clause legislation may be enforced in a Section 1983 action. Moreover, the Court found the particular provision of the Medicaid statute that was at issue in *Armstrong*—42 U.S.C. § 1396a(a)(30)(A)—to be "judicially unadministrable." *Id*. at 1385. The Court explained that it was "difficult to

imagine a requirement broader and less specific than § 30(A)'s mandate that state plans provide for payments that are 'consistent with efficiency, economy, and quality of care,' all the while 'safeguard[ing] against unnecessary utilization of ... care and services.'" *Ibid*.; *see also id*. at 1388 (Breyer, J., concurring) ("Reading § 30(A) underscores the complexity and nonjudicial nature of the rate-setting task.").

"By contrast, the statutory term here, 'qualified,' is tethered to an objective benchmark: 'qualified *to perform the service or services required.*'" *Planned Parenthood Arizona*, 727 F.3d at 967-68 (quoting 42 U.S.C. § 1396a(a)(23)(A)) (court's emphasis). "This standard is not subjective or amorphous, and requires no balancing." *Id*. at 968.

II. A State Does Not Have Unfettered Discretion To Disqualify Medicaid Providers.

Under the Medicaid statute, a beneficiary may obtain medical assistance from any entity or person who is "qualified to perform the service or services required" and "who undertakes to provide him such services." 42 U.S.C. 1396a(a)(23)(A). This free choice of providers requirement gives Medicaid beneficiaries "the right to choose among a range of qualified providers, without government interference." *O'Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773, 785 (1980) (emphasis omitted).

Long standing HHS regulations provide that a state may set "reasonable standards relating to the qualifications of providers." 42 C.F.R. § 431.51(c)(2). For example, states have primary responsibility for licensing health care practitioners within their jurisdictions. Consistent with the free choice of providers requirement, however, a state does not have unfettered discretion to determine provider qualifications. The Seventh Circuit concluded that, "[r]ead in context, the term 'qualified' as used in § 1396a(a)(23) unambiguously relates to a provider's fitness to perform the medical services the patient requires." *Planned Parenthood of Indiana*, 699 F.3d at 978. It reasoned that "[t]o be 'qualified' in the relevant sense is to be capable of performing the needed medical services in a professionally competent, safe, legal, and ethical manner." *Ibid*. The Ninth Circuit adopted the same reasoning. *See Planned Parenthood Arizona*, 727 F.3d at 969 ("We agree with the Seventh Circuit that '[r]ead in context, the term "qualified" as used in § 1396a(a)(23) unambiguously relates to a provider's ... capab[ility] of performing the needed medical services in a professionally competent, safe, legal, and ethical manner.'") (quoting *Planned Parenthood of Indiana*, 699 F.3d at 978). And as the Seventh and Ninth Circuits held, when a state adopts a legal standard that required termination of a provider on grounds unrelated to its fitness to perform services that Medicaid beneficiaries require, individual beneficiaries are denied their right under Section 1396a(a)(23) and may bring suit to enforce that

right under Section 1983. *Id.* at 972; *see Planned Parenthood of Indiana*, 699 F.3d at 980.

As noted above, the Medicaid statute also authorizes a state to exclude an individual or entity from Medicaid for any reason for which the Secretary could exclude the individual or entity from the Medicare program. 42 U.S.C. § 1396a(p)(1), (3) (cross-referencing 42 U.S.C. § 1320a-7). As discussed above, these enumerated grounds for exclusion include, for example, a conviction of specified criminal offenses, or a determination that the provider furnished items or services of a quality that failed to meet professionally recognized standards of health care. These grounds for termination are not exhaustive, and there is no dispute that a state has primary responsibility for licensing the medical practitioners that operate within its jurisdiction. *See Planned Parenthood of Indiana*, 699 F.3d at 980. Indeed, Section 1320a-7 expressly acknowledges that states have such licensing authority; it provides that that the Secretary may exclude from Medicare any individual or entity "whose license to provide health care has been revoked or suspended by any State licensing authority . . . for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity." 42 U.S.C. § 1320a-7(b)(4)(A).

Here, however, the state licensing authority did not revoke PPGC's license (or that of its professionals) to practice medicine, and there is no contention that

PPGC is unfit to perform the services it provides to Medicaid beneficiaries—services such as gynecological exams, cervical pap smears, breast exams, and contraceptive counseling. The State's termination letter of September 15, 2015, relied on grounds that would be legally insufficient to exclude a provider under Section 1320a-7 and that letter, standing alone, does not establish that the State has made a proper determination to exclude PPGC for cause or otherwise properly determined that PPGC is unqualified to perform the required services within the meaning of 42 U.S.C. § 1396a(a)(23) and 42 C.F.R. § 431.51(c)(2). For example, whereas Section 1320a-7 authorizes the exclusion of a provider that has been *convicted* of health care fraud, the Louisiana termination letter relied on *allegations* of health care fraud in a pending case and on a settlement of a False Claims Act case brought by a relator in which PPGC expressly disclaimed liability. *See* ROA.953-55 (district court opinion).[5]

[5] When a state initiates an exclusion on grounds set forth in 42 U.S.C. § 1320a-7, HHS regulations provide that it must give the entity written notice of its intent, the basis for the proposed exclusion, and the potential effect of an exclusion. 42 C.F.R. § 1002.212 (incorporating 42 C.F.R. § 1001.2001). Before imposing an exclusion, the state agency must give the individual or entity the opportunity to submit documents and written argument against the exclusion. 42 C.F.R. § 1002.213. If the state agency determines that an exclusion is warranted, it must provide notice of its decision in a specified form, and the exclusion takes effect 20 days from the date of the notice. 42 C.F.R. § 1002.2001 (incorporated by 42 C.F.R. § 1002.212). The excluded entity also must be afforded any additional appeals rights that would otherwise be available under procedures established by the State. 42 C.F.R. § 1002.213. Here, the State maintains that it provides an

Continued on next page.

The Seventh and Ninth Circuits correctly rejected the argument that a state's adoption of grounds for excluding a provider from the state Medicaid program must be treated as a conclusive determination that the provider is not "qualified" within the meaning of Section 1396a(a)(23). As the Seventh Circuit explained, a state cannot circumvent the free choice of providers requirement "by simply labeling any exclusionary rule as a 'qualification.'" *Planned Parenthood of Indiana*, 699 F.3d at 978. "This would open a significant loophole for restricting patient choice, contradicting the broad access to medical care that § 1396a(a)(23) is meant to preserve." *Ibid.*; *see also Planned Parenthood Arizona*, 727 F.3d at 970 (rejecting "Arizona's position that states can preclude Medicaid beneficiaries from choosing otherwise appropriate service providers by defining certain classes of providers as 'unqualified,' for § 1396a(a)(23) purposes, 'for any reason supplied by State law'"). That concern applies whether the exclusion is imposed through an across-the-board rule or through the termination of individual provider agreements under a standard that is unrelated to the fitness of the provider to perform needed Medicaid services. Indeed, the state-law exclusions in the Seventh and Ninth

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opportunity for an informal and then a formal hearing to a provider that is subject to termination.

Circuit cases would have been implemented through the termination of individual provider agreements.[6]

The Seventh Circuit was likewise correct in rejecting the argument that *O'Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773 (1980), makes each state the conclusive arbiter of a provider's qualifications. As the Seventh Circuit explained, the Supreme Court's decision in *O'Bannon* did not involve the basis for a substantive challenge to a provider's disqualification. *See Planned Parenthood of Indiana*, 699 F.3d at 977. Instead, *O'Bannon* addressed a procedural due process claim. *See ibid.*

In *O'Bannon*, the U.S. Department of Health, Education and Welfare (HEW), the predecessor to HHS, notified a nursing home that it no longer met the statutory and regulatory standards for skilled nursing facilities and that, consequently, its Medicare provider agreement would not be renewed. 447 U.S. 775-76. The HEW notification explained that a skilled nursing facility is required to be in compliance with eighteen specified conditions, and that a survey performed by the Pennsylvania Department of Health found that the facility did not comply with seven identified conditions. *See id.* at 776 n.3. Shortly after HEW

[6] *See Planned Parenthood of Indiana*, 699 F.3d at 970 (Indiana law required the cancelation of contracts); *Planned Parenthood Arizona*, 727 F.3d at 965 (Arizona informed the local Planned Parenthood organization that it intended to "terminate [its] provider participation agreement").

terminated the nursing home from Medicare, the state agency terminated the home from Medicaid as required by federal regulations. *See id*. at 776 n.4. The plaintiff nursing home residents argued that they had a due process right to a pre-termination hearing on the issue of whether the home's Medicare and Medicaid provider agreements should be renewed. They relied in part on Section 1396a(a)(23), which, they urged, gave them a protected property interest in remaining in their nursing home. Rejecting that procedural due process claim, the Supreme Court explained that Section 1396a(a)(23) gives beneficiaries "the right to choose among a range of *qualified* providers, without government interference," but does not "confer a right on a recipient to enter an unqualified home and demand a hearing to certify it, nor does it confer a right on a recipient to continue to receive benefits for care in a home that has been decertified." *Id*. at 785.

Like the Seventh and Ninth Circuit cases, "[t]his is not a due-process case." *Planned Parenthood of Indiana*, 699 F.3d at 977. As in those cases, the beneficiaries here "are not suing for violation of their *procedural* rights; they are making a *substantive* claim" that the termination of PPGC violates Section 1396a(a)(23) by denying them the ability to obtain covered medical care from a qualified provider of their choosing. *Ibid*.

In a typical provider termination, such as the one underlying *O'Bannon*, beneficiaries will have no plausible claim that they have been denied their right to

choose a "qualified" provider. Indeed, beneficiaries will not prevail if a provider is terminated under valid standards and on the basis of supporting evidence.

But just as the free choice of providers requirement would be rendered a nullity if states were permitted to define "qualified" in any manner they chose, it would also be effectively nullified if states could use individualized proceedings to exclude providers for no reason or for an invalid reason, or without any supporting evidence. Here, the termination letters that prompted this lawsuit did not give *any* reason for Louisiana's decision to exclude PPGC from the Medicaid program. *See* ROA.895. And although the State substituted new termination letters while this lawsuit was pending, to the extent that that the newly offered reasons were, standing alone, insufficient on their face under federal law or lacked any supporting evidence, the beneficiaries adequately alleged a violation of their right under Section 1396a(a)(23) to obtain family planning services from any qualified and willing provider of their choosing.[7]

[7] Similarly, Arkansas first terminated the local Planned Parenthood organization (PPH) without giving any reason for the termination, and then, after the lawsuit was filed, substituted a second letter that failed to make any actual determination regarding the actual fitness of PPH to perform services. *See Planned Parenthood Arkansas & Eastern Oklahoma v. Selig*, No. 4:15-cv-566, Order at 8 (E.D. Ark. Oct. 2, 2015) (second termination letter stated that "there is evidence that [PPH] and/or its affiliates are acting in an unethical manner and engaging in what appears to be wrongful conduct"). *See also Planned Parenthood Southeast, Inc. v. Bentley*, __ F. Supp. 3d __, 2015 WL 6517875, at *3 (M.D. Ala.

Continued on next page.

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FEBRUARY 2016

2013) (Alabama's termination letter to PPSE did not provide any reason for the termination).

CERTIFICATE OF SERVICE

I hereby certify that on February 17, 2016, I electronically filed the foregoing brief by using the appellate CM/ECF system. The participants in the case are registered CM/ECF users and service will be accomplished by the appellate CM/ECF system.

/s/ Alisa B. Klein
ALISA B. KLEIN

CERTIFICATE OF COMPLIANCE

I hereby certify that this amicus brief complies with the requirements of Fed. R. App. P. 32(a)(5) and (6) because it has been prepared in 14-point Times New Roman, a proportionally spaced font. I further certify that this amicus brief complies with the type-volume limitation of Fed. R. App. P. 29(d) because it contains 3,788 words, excluding the parts of the brief exempted under Rule 32(a)(7)(B)(iii), according to the count of Microsoft Word.

/s/ Alisa B. Klein
ALISA B. KLEIN