No. 21-1431

In the Supreme Court of the United States

ROBERT M. KERR, in his official capacity as DIRECTOR, SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

PLANNED PARENTHOOD SOUTH ATLANTIC, et al., RESPONDENTS

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF OF *AMICI CURIAE* FAMILY POLICY ALLIANCE AND STATE FAMILY POLICY COUNCILS IN SUPPORT OF PETITIONER

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INTEREST OF AMICI CURIAE[1]

Amici curiae Family Policy Alliance and state family policy councils[2] joining in this brief are organizations that collectively educate and advocate at the state level for policies and legislation supporting healthy marriages and strong families. As organizations that are focused on state policies that serve families, they support a state's ability to disqualify Medicaid providers that do not reflect the healthcare priorities of the individual states.

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[1] No party's counsel authored any part of this brief. No person other than *amici* and their counsel contributed any money intended to fund the preparation or submission of this brief. Counsel for all parties received timely notice of the intent to file and have consented in writing to the filing of this brief.

[2] Alaska Family Council, Center for Arizona Policy, California Family Council, Delaware Family Policy Council, Florida Family Policy Council, Frontline Policy Council (Georgia), Hawaii Family Forum, Indiana Family Institute, The Family Leader (Iowa), The Family Foundation (Kentucky), Louisiana Family Forum, Christian Civic League of Maine, Massachusetts Family Institute, Michigan Family Forum, Minnesota Family Council, Nebraska Family Alliance, Cornerstone Action of New Hampshire, Family Policy Alliance of New Jersey, Family Policy Alliance of New Mexico, New Yorkers for Constitutional Freedoms, North Carolina Family Policy Council, North Dakota Family Alliance, Center for Christian Virtue (Ohio), Palmetto Family Council (South Carolina), Pennsylvania Family Institute, Family Policy Alliance of Rhode Island, Family Heritage Alliance (South Dakota), Texas Values, The Family Foundation (Virginia), Family Policy Institute of Washington, Wisconsin Family Action, and Family Policy Alliance of Wyoming.

INTRODUCTION

Medicaid's any-qualified-provider provision guarantees that a Medicaid beneficiary is entitled to visit any qualified provider within their state. 42 U.S.C. 1396a(a)(23). If a state fails to follow the requirements of section 1396a(a)(23), Congress has authorized the Secretary of the Department of Health and Human Services to withhold federal funding. Additionally, when a provider is terminated from the Medicaid program—and is no longer deemed "qualified"—federal regulations require that the state provide an appeal process to the disqualified provider. 42 U.S.C. 1396a(a)(4); 42 C.F.R. 1002.213.

Rather than pursue the available remedies, Respondents, a patient and her preferred provider, sought to pursue their claims in federal court, asserting a private right of action pursuant to section 1396a(a)(23). However, Congress has not evinced an "unambiguous intent" to create a private right of action under section 1396a(a)(23), and therefore Respondents are limited to the remedies created by Congress. See *Gonzaga Univ. v. Doe*, 536 U.S. 273, 280 (2002) (stating that in the absence of unambiguous intent, private rights of action do not arise under spending provisions).

Several courts of appeals have addressed the question of whether section 1396a(a)(23) provides an implied right of action and have reached conflicting conclusions. *Compare Planned Parenthood of Greater Tex. Family Planning & Prevention Health Servs., Inc. v. Kauffman*, 981 F.3d 347, 360 (5th Cir. 2020) (finding that section 1396a(a)(23) does *not* contain an

implied private right of action); *Does v. Gillespie*, 867 F.3d 1034 (8th Cir. 2017) (same), with *Planned Parenthood S. Atl. v. Baker*, 941 F.3d 687, 700 (4th Cir. 2019) (finding that § 1396a(a)(23) contains an implied private right of action); *Planned Parenthood v. Andersen*, 882 F.3d 1205 (10th Cir. 2018) (same); *Planned Parenthood v. Betlach*, 727 F.3d 960 (9th Cir. 2013) (same); *Planned Parenthood v. Comm'r of the Ind. State Dep't of Health*, 699 F.3d 962 (7th Cir. 2012) (same); and *Harris v. Olszewski*, 442 F.3d 456 (6th Cir. 2006) (same).

Proper administration of the cooperative federal-state Medicaid program affects the wellbeing of families and is an issue of great national importance. Moreover, this case serves as a useful vehicle to resolve the confusion among the courts of appeal as to the larger issue of when courts ought to read private rights of action into a statutory scheme.

SUMMARY OF THE ARGUMENT

The Medicaid any-qualified-provider provision found in 42 U.S.C. 1396a(a)(23) does not allow individuals to maintain a private right of action challenging a state's determination that a provider is no longer qualified to provide Medicaid services. For laws enacted pursuant to the Spending Clause, this Court has made clear that Congress must speak with unambiguous intent to confer individual rights enforceable under 42 U.S.C. 1983. *Gonzaga Univ. v. Doe*, 536 U.S. 237, 280 (2002). Nevertheless, the application of this Court's precedents in the courts of appeal has wrought confusion, not just with reference

to Medicaid, but across the board with regards to private rights of action.

Moreover, allowing private litigants to enforce the any-qualified-provider provision would frustrate the purposes and intent of the Medicaid statute, which explicitly creates an administrative enforcement regime. Medicaid is a federal-state cooperative program that must be run according to uniform standards, remedies, and enforcement mechanisms to promote the intent of Congress. Permitting private litigants to sue every time a state terminates a provider's ability to administer Medicaid services undermines this uniformity—especially when the circuit conflict results in differing remedies depending on the circuit where the beneficiary is located.

The existence of an implied private right of action would permit Medicaid providers to pursue section 1983 actions in federal court in parallel with challenging disqualification in state court—with great potential for inconsistent results. Moreover, liability under section 1983 will siphon state resources away from those intended to be helped—low-income patients and their families. Congress surely did not intend such a perverse result.

For these reasons, Respondents and those similarly situated cannot be permitted to file federal actions regarding the any-qualified-provider provision. *Amici* urge that this Court grant the petition to resolve this important question of federal law and of great national significance.

ARGUMENT

In determining whether a private right of action exists, this Court places primary emphasis on congressional intent. See *Alexander v. Sandoval*, 532 U.S. 275, 286 (2001) ("The judicial task is to interpret the statute Congress has passed to determine whether it displays an intent to create not just a private right but also a private remedy. Statutory intent on this latter point is determinative.") (internal citations omitted). This Court has already spoken to the exact statutory issue in question, the any-qualified-provider provision of section 1396a(a)(23), and determined that patients do not have a right—as applied in the context of nursing facilities—"to continued residence in the home of one's choice" but only "the right to choose among a range of qualified providers." *O'Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773, 785 (1980). Likewise, the provision does not "confer a right in a recipient to continue to receive benefits for care in a home that has been decertified." *Id.* In the absence of any right to a decertified provider, the analysis should end since there can be no private remedy in the absence of a private right. See *Sandoval, supra.* If that were not clear enough, this Court has already held that "the Medicaid Act implicitly precludes private enforcement of" another provision of the same subsection, section 1396a(a)(30). See *Armstrong v. Exceptional Child Ctr., Inc.*, 575 U.S. 320, 328 (2015).

Respondents' difficulties do not end there. When legislation is enacted pursuant to Congress' spending power—such as Medicaid—this Court has clarified that "the typical remedy for state noncompliance with

federally imposed conditions is not a private cause of action for noncompliance but rather action by the Federal Government to terminate funds to the State." *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 28 (1981). This Court has also "made clear that unless Congress 'speak[s] with a clear voice,' and manifests an 'unambiguous' intent to confer individual rights, federal funding provisions provide no basis for private enforcement by § 1983." *Gonzaga*, 536 U.S. at 280 (citing *Pennhurst*, 451 U.S. at 17, 28 & n.21). It is evident that Congress has not communicated an intent—let alone an unambiguous one—to create an implied private right of action pursuant to section 1396a(a)(23), and that Congress' intent would be substantially frustrated by such a finding.

I. Medicaid's existing remedies, which are intended to produce uniformity and efficiency, foreclose a private right of action.

This Court has noted that when a statute explicitly provides remedies or penalties, or specifically directs enforcement of its protections to parties such as government officials or agencies, this suggests that Congress' omission of a private remedy was intentional. See *Gonzaga*, 536 U.S. at 287; *Sandoval*, 532 U.S. at 288; *Touche Ross & Co. v. Redington*, 442 U.S. 560, 568– 71 (1979); *Cort v. Ash*, 422 U.S. 66, 79–80 (1975); *Nat'l R.R. Passenger Corp. v. Nat'l Ass'n of R.R. Passengers*, 414 U.S. 453 (1974). Congressional intent not to provide a private right of action can be evident where Congress has created "a comprehensive enforcement scheme that is incompatible with individual enforcement under §

1983." *Blessing v. Freestone*, 520 U.S. 329, 341 (1997). Allowing a private right of action pursuant to section 1396a(a)(23) would frustrate the intent of Congress to provide the existing uniform process of remedies.

Congress expressly created a remedy for the enforcement of section 1396a(a)(23) through 42 U.S.C. 1396c. That section permits the Secretary of Health and Human Services to withhold payment of federal funds where "there is failure to comply substantially with any" provision of section 1396a, including the any-qualified-provider provision. 42 U.S.C. 1396c(2). As this Court detailed in *Armstrong*, "the sole remedy Congress provided for a State's failure to comply with Medicaid's requirements—for the State's 'breach' of the Spending Clause contract—is the withholding of Medicaid funds by the Secretary of Health and Human Services." 575 U.S. at 328 (holding that Medicaid beneficiaries cannot bring a private right of action to challenge the reimbursement rate standard contained in section 1396a(a)(30)). Indeed, "the 'express provision of one method of enforcing a substantive rule suggests that Congress intended to preclude others.'" *Id.* (citing *Sandoval*, 532 U.S. at 290).

Congress further authorized the HHS Secretary to promulgate regulations pertaining to the methods of administration of a state Medicaid plan "as are found by the Secretary to be necessary for the proper and efficient operation of the plan." 42 U.S.C. 1396a(a)(4). Pursuant to these regulations, states are required to give providers a right to appeal when they are terminated from the Medicaid program. *See* 42 C.F.R. 1002.213 ("the State agency must give the individual

or entity the opportunity to submit documents and written argument against the exclusion. The individual or entity must also be given any additional appeals rights that would otherwise be available under procedures established by the State.").

As the Eighth Circuit has noted, "[b]ecause 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." *Does v. Gillespie*, 867 F.3d 1034, 1041 (8th Cir. 2017). To imply a private right of action would frustrate the intent of Congress, which already created a uniform administrative remedy to challenge states' disqualification of Medicaid providers, and could lead to "parallel litigation and inconsistent results." *Id.* at 1042.

Respondents' decision to bypass the process set up by Congress by filing a federal lawsuit undermines the congressional intent and purpose of providing a uniform and efficient scheme of remedies. Allowing states to use their local expertise to manage, in a streamlined way, which providers qualify to administer Medicaid funds is undercut by judicial intervention in a state's decision-making processes.

The fact that Congress has provided a comprehensive scheme for the enforcement of the requirements contained in section 1396a precludes an intent to create an implied private right of action.

II. Medicaid beneficiaries do not have a right to question a state's determination that a provider is unqualified.

In analyzing section 1396a(a)(23), this Court has additionally stated that, "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." *O'Bannon*, 447 U.S. at 786 (finding that section 1396a(a)(23) gives recipients the right to choose among a range of *qualified* providers only). This conclusion alone quells Respondents' argument that individual Medicaid beneficiaries are granted the rights to have any given provider "qualified," presumably even if that provider does not seek to be "qualified" itself. See *Planned Parenthood of Greater Tex. Family Planning and Prevention Health Servs., Inc. v. Kauffman*, 981 F.3d 347, 358 (5th Cir. 2020).

Section 1396a provides that "any individual eligible for medical assistance . . . may obtain such assistance from any [provider] *qualified* to perform the services or services required." 42 U.S.C. 1396a(a)(23) (emphasis added); *O'Bannon*, 447 U.S. at 785. According to the plain reading of the statute, the Medicaid patient may incur a benefit only from a "qualified" provider, and it is up to the particular state to determine which provider is "qualified" to perform the services. *See* 42 U.S.C. 1396a(p)(1). If a state determines that a provider is not qualified, there can be no available benefit to the Medicaid patient. Indeed, a "Medicaid patient may choose among qualified and willing providers but has no

right to insist that a particular provider is 'qualified' when the State has determined otherwise." *Kauffman*, 981 F.3d at 358.

III. The Medicaid statute is undermined by the patchwork of remedies produced by a court-imposed system of differing enforcement mechanisms.

Disagreement among the courts of appeals has disrupted the cooperative federal-state Medicaid program, producing parallel proceedings and affording different rights wholly dependent on the circuit of the Medicaid beneficiary. This undermines the interests in federalism contained in the Medicaid statute, which allows states to determine which providers are qualified.

For instance, a beneficiary in Arkansas, pursuant to the Eighth Circuit's decision in *Gillespie*, must rely on a provider to challenge its disqualification through the statutorily-provided administrative appeal process. Yet, a Medicaid beneficiary in South Carolina can ignore the statutory appeal process altogether and file a suit in federal court. This can occur concurrently with the provider challenging the disqualification in administrative proceedings, frustrating the purpose of efficiency underlying the creation of administrative remedies and leading to inconsistent results even in the same state and regarding the same provider.

As the Eighth Circuit noted when it held that section 1396a(a)(23) does not contain an implied private right of action, "[t]he potential for parallel

litigation and inconsistent results gives [the court] further doubt that Congress in § 23(A) unambiguously created an enforceable federal right for patients." *Gillespie*, 867 F.3d at 1042. These differing remedies and mechanisms of enforcement are a nightmare in a federally supervised program, resulting in differing standards despite the intention of nationwide uniformity in procedures.

This problem is further complicated when a multi-state provider is located in both types of jurisdictions. In the substantially similar *Andersen v. Planned Parenthood of Kansas and Mid-Missouri,* 139 S. Ct. 638 (2018), Planned Parenthood of the St. Louis Region and Southwest Missouri ("PPSLR") "serves patients in both Missouri and Kansas. The Kansas patients, based on the Tenth Circuit's decision" finding a private right of action under section 1396a(a)(23), "have the right to challenge the termination of PPSLR as their Medicaid provider; meanwhile, PPSLR clients in Missouri, who are subject to the Eighth Circuit's decision in *Gillespie*, have no such right." See Petition for Writ of Certiorari at 24–25, *Andersen v. Planned Parenthood of Kansas and Mid-Missouri* (No. 17-1340) (internal citations omitted).

The prospect of parallel proceedings as well as the provision of differing rights and remedies depending on the circuit of the Medicaid beneficiary undermines the intent of the Medicaid statute. If uniform process is not maintained in programs such as Medicaid, it creates an administrative quagmire. Moreover, the lack of uniform process undercuts the benefits of federalism inherent in Medicaid, such as the superior

ability of states to implement state priorities and to be sufficiently local to determine which providers should be qualified.

IV. A private right of action would harm the intended beneficiaries—low-income families.

Implying a private right of action under section 1396a(a)(23)(A) will divert necessary funding from healthcare, adversely impacting Medicaid beneficiaries. The fact that a private right of action has the potential to cause harm to Medicaid beneficiaries counsels against the finding that one exists. See *Santa Clara Pueblo v. Martinez*, 436 U.S. 49 (1978) (holding that the Indian Civil Rights Act did not contain an implied private right of action, in part because such an action would frustrate the intent of Congress to allow Indian tribes to maintain their own sovereignty). The purpose of the Medicaid statute is to provide health insurance coverage to low-income Americans. Allowing private actions pursuant to section 1983 whenever a Medicaid provider is terminated will result in enormous exposure to attorneys' fees under section 1988, which will divert state resources and funding from healthcare, negatively impacting low-income families. States will be forced to engage in costly and lengthy federal litigation, using limited state resources to defend their decisions to terminate Medicaid providers.

In 2011 alone, over 2,500 unique providers were terminated from the Medicaid program by state

action.[3] Some providers that are terminated for cause in one state continue to participate in another state—including in South Carolina.[4] States need the flexibility to disqualify providers without being subject to civil rights claims, costing millions of dollars, that could be used to provide healthcare to low-income families.

As Petitioner has explained, the confusion in the courts of appeals is not limited to Medicaid cases but extends to cases involving the Adoption Assistance and Child Welfare Act, Article 36 in the Vienna Convention, and the Federal Nursing Home Reform Amendments. This Court must bring clarity to the field of private rights of action consistent with congressional intent. In doing so, states can avoid costly litigation that diverts much needed state resources.

CONCLUSION

The finding of a private right of action pursuant to Medicaid's any-qualified-provider provision undermines the congressional purpose of providing efficient, uniform administrative enforcement mechanisms, and undercuts states' abilities to serve Medicaid beneficiaries in a cost-effective way. The question of whether Medicaid beneficiaries have a private right to demand a provider of choice is an

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[3] See 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 at: https://oig.hhs.gov/oei/reports/oei-06-12-00030.pdf.

[4] See *id.* at 20, Table C-1.

"important and recurring" question. *Gee v. Planned Parenthood of Gulf Coast, Inc.*, 139 S. Ct. 408, 409 (2018) (Thomas, J., dissenting from cert denial). Clarity here will answer the larger question of private rights of action—a question that continues to produce inconsistent and puzzling results in the courts below. Since this is an issue of great national significance, cert should be granted.

Respectfully submitted,

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