

No. 23-1275

In the Supreme Court of the United States

ROBERT M. KERR, DIRECTOR, SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
PETITIONER

v.

PLANNED PARENTHOOD SOUTH ATLANTIC, ET AL.,
RESPONDENTS

*ON 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 councils² 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

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 this brief.

² Alabama Policy Institute, Alaska Family Council, Center for Arizona Policy, Family Council (Arkansas), California Family Council, Family Institute of Connecticut, Delaware Family Policy Council, Florida Family Voice, Frontline Policy Council (Georgia), Hawaii Family Forum, Idaho Family Policy Center, Indiana Family Institute, The Family Leader (Iowa), Kansas Family Voice, The Family Foundation (Kentucky), Louisiana Family Forum, Christian Civic League of Maine, Maryland Family Institute, Massachusetts Family Institute, Michigan Family Forum, Minnesota Family Council, Montana Family Foundation, Nebraska Family Alliance, Cornerstone Action (New Hampshire), New Jersey Family Policy Center, New Mexico Family Action Movement, New York Families Foundation, North Carolina Family Policy Council, North Dakota Family Alliance, Center for Christian Virtue (Ohio), Oklahoma Council of Public Affairs, Rhode Island Family Institute, Palmetto Family Council (South Carolina), Pennsylvania Family Institute, South Dakota Family Voice, Family Action Council of Tennessee, Inc., Texas Values, The Family Foundation (Virginia), Family Policy Institute of Washington, Wisconsin Family Action, and Wyoming Family Alliance.

disqualify Medicaid providers that do not reflect the healthcare priorities of the individual states.

SUMMARY OF THE ARGUMENT

Proper administration of the cooperative federal-state Medicaid program affects the wellbeing of families and is an issue of great national importance. Liability under 42 U.S.C. 1396a(a)(23) 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.

Moreover, allowing private litigants to enforce the any-qualified-provider provision of 42 U.S.C. 1396a(a)(23) 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 disqualifies a provider from providing Medicaid services undermines this uniformity.

Medicaid's any-qualified-provider provision guarantees that Medicaid beneficiaries are entitled to visit any qualified provider within their state. 42 U.S.C. 1396a(a)(23). 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).

Therefore, Respondents are limited to the remedies created by Congress. See *Health & Hosp. Corp. v. Talevski*, 143 S. Ct. 1444, 1457 (2023) (citing *Gonzaga Univ. v. Doe*, 536 U.S. 273, 283 (2002)) (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. This inconsistent application of this Court's precedents in the courts of appeals has wrought confusion, not just with reference to Medicaid, but across the board with regard to private rights of action. In applying the test articulated in *Gonzaga*, the Court in *Talevski* clarified the process by which courts determine when a provision unambiguously creates rights which are privately enforceable under Section 1983. While *Talevski* is instructive in this matter, it does not resolve the issue now before the Court nor does it resolve the circuit split caused by different interpretations of the any-qualified-provider provision, which is the central focus of this case. The existence of an implied private right of action would permit Medicaid providers and beneficiaries to pursue Section 1983 actions in federal court in parallel with challenging disqualification in state court—with great potential for inconsistent results.

This case serves as a useful vehicle to resolve the confusion among the courts of appeals in this matter as well to the larger issue of when courts ought to read private rights of action into a statutory scheme. *Amici* urge this Court to grant the petition to resolve this

important question of federal law and of great national significance.

ARGUMENT

The Medicaid program's joint federal-state partnership funds many different programs and serves many needs. It is imperative that it run as efficiently as possible so as to maximize the benefit to those who need it. To allow private rights of action to challenge states' administrative decisions would drain the program of resources, harming its beneficiaries and impairing the program.

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

Implying a private right of action under 42 U.S.C. 1396a(a)(23) 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, 64, 68-69 (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 Medicaid program, which is jointly financed by the federal government and states, was created in 1965. 42 C.F.R. 430.0. Its purpose is to provide “primary and acute medical services, as well as long-term services and supports (LTSS), to a diverse low-

income population, including children, pregnant women, adults, individuals with disabilities, and people aged 65 and older.”³

As of Fiscal Year 2021, Medicaid delivered services to an estimated 85 million people at a total cost to the federal and state governments of \$748 billion. *Id.* at 2. Significantly, in 2021, Medicaid provided health coverage for 39% of all children in the United States and provided health coverage for 59% of all nonelderly individuals with income below 100% of the federal poverty level. *Ibid.*

State Medicaid programs are responsible for establishing and maintaining health standards for providers of services and are required to provide quality-of-care information to consumers. 42 U.S.C. 1396a(a)(9)(A)(D). States also, through their program integrity initiatives, have the responsibility for ensuring that entities receiving Medicaid funds establish written policies to detect and prevent fraud, waste, and abuse and provide whistleblower protection. 42 U.S.C. 1396a(a)(68)(B)(C). Likewise, states are required to establish procedures for the reporting of alleged instances of fraud, waste, and abuse and must compile data relating thereto. 42 U.S.C. 1396a(a)(64). These responsibilities are designed to ensure that Medicaid monies are spent in a way to maximize the benefit to enrollees. To effectively fulfill these responsibilities, states need the flexibility to evaluate which providers will best

³ *Medicaid: An Overview*, Congressional Research Service, R43357 at 1 (February 2023).
<https://crsreports.congress.gov/product/pdf/R/R43357>

serve their beneficiaries and meet the goals of the state's program. Allowing beneficiaries or providers to pursue private enforcement actions whenever a Medicaid provider enrollment is denied or is terminated will result in enormous exposure to the costs of litigation, including attorneys' fees under 42 U.S.C. 1988. This will divert limited funds from medical care and support services, 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 either decline Medicaid provider enrollment or terminate provider status.

Preventing Medicaid monies from being paid to providers who do not best serve, or even pose a threat to Medicaid and its beneficiaries, protects beneficiaries and ensures program integrity. A study that examined fees paid to terminated providers between January 2019 and May 2019 revealed that nearly 1,000 or 11 percent of all terminated providers were inappropriately enrolled in state Medicaid programs and were associated with \$50.3 million in post-termination Medicaid payments.⁴ "Some of these providers were terminated for criminal convictions, licensure issues, and provider misconduct, representing a risk to beneficiaries' safety and their quality of care." *Id.* at 16. The report concluded that states need to do more to ensure that terminated providers are prohibited from receiving Medicaid

⁴ "States Could Do More to Prevent Terminated Providers From Serving Medicaid Beneficiaries," U.S. Dep't Health & Human Servs. OEI-03-19-00070 at 7, 16 (2020). Full report can be found at oig.hhs.gov/oei/reports/oei-03-19-00070.asp.

monies. *Id.* at 17-18. To effectively pursue this goal, 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.

To this end, this Court is urged to 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 resources from the individuals and families who are in need of these services.

II. Allowing a private right of action to challenge states' provider enrollment decision-making would impair the Medicaid program.

Medicaid was created as a federal-state partnership, with significant discretion left to the states, including the decision whether to participate at all. States have the responsibility for administering the Medicaid program and the flexibility to design most elements within broad guidelines. 42 U.S.C. 1396a(a)(4); 42 C.F.R. 430.0 and 431.40(a).⁵ “Indeed, state flexibility has been viewed by the federal government as an essential tool in Medicaid program administration—states have driven payment and service delivery reforms that balance Medicaid’s multifaceted goals of improving access, ensuring quality care, and containing costs.”⁶

⁵ See also *Medicaid: An Overview*, Congressional Research Service, R43357 at 1 (2023).

<https://crsreports.congress.gov/product/pdf/R/R43357>

⁶ Brietta Clark, *Medicaid Access & State Flexibility: Negotiating Federalism*, 17 HOUS. J. HEALTH L. & POL’Y 241, at 243-244

Under Medicaid’s federal-state partnership, states are responsible for setting reasonable standards for the qualification of their Medicaid providers. 42 C.F.R. 431.51(c) and 455.452. Before enrolling a provider, states must require the provider to complete a provider agreement with the state. 42 C.F.R. 431.107(b). Participation is contractual and requires compliance with specific directives relating to record-keeping, disclosure of specified information and other duties. *Ibid.* As part of the provider enrollment process, states must also conduct a risk-based screening assessment which evaluates the provider’s compliance with state and federal regulations, licensure verifications, and additional enrollment criteria. 42 C.F.R. 455.450.

Individual Medicaid beneficiaries do not participate in any part of the contractual or enrollment process through which the state-enrolled provider relationship is established, nor do they have any say in the ratesetting for services provided. Moreover, this Court has made it clear that even enrolled providers, as parties to the state-provider agreement, do not have a right of private enforcement to challenge the ratesetting process. *Armstrong v. Exceptional Child Ctr., Inc.*, 575 U.S. 320, 332 (2015). In *Armstrong*, the Court noted that the ratesetting process requires states “to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers” to assure the provision of “care and services” equivalent

(2017). https://www.law.uh.edu/hjhelp/volumes/Vol_17/V17%20-%20Clark-FinalPDF.pdf

to that “available to the general population in the geographic area.” *Id.* at 323 (citing 42 U.S.C. 1396a(a)(30)(A)). In making this determination, a myriad of factors must be considered by the state, such as “the actual cost of providing quality services, including personnel and total operating expenses; changes in public expectations with respect to delivery of services; inflation; [and] a comparison of rates paid in neighboring States for comparable services[.]” *Armstrong*, 575 U.S. at 334 (Breyer, J., concurring). These considerations, which are unique in every state, “underscore[] the complexity and nonjudicial nature of the ratesetting task.” *Ibid.*

Ratesetting, with all its complexity, represents just one facet of the states’ administrative oversight process. States are the administrators of the Medicaid program precisely because they are in the best position to make administrative decisions. States must evaluate which providers will best meet the needs of the state’s Medicaid program, considering such factors as the scope and focus of a provider’s practice and the availability of other more or less qualified providers in a geographical location. Moreover, states are accountable for their decision-making process and compliance with federal standards under their approved Medicaid-state plan. 42 U.S.C. 1396a. See also 42 C.F.R. 430.32 (Program reviews), 430.33 (Audits), and 430.35 (Withholding of payment for failure to comply with Federal requirements). To afford providers and individual beneficiaries the right to legally challenge a state’s provider enrollment process and outcomes would disrupt the federal-state cooperation by making states accountable for decisions that may run

contrary to their own decision-making process. The impact would be that articulated by Justice Breyer in *Armstrong*—“increased litigation, inconsistent results, and disorderly administration of highly complex federal programs that demand public consultation, administrative guidance, and coherence for their success.” *Armstrong*, 575 U.S. at 335 (Breyer, J., concurring). “More fundamentally, however, the modern jurisprudence permitting intended beneficiaries to sue does not generally apply to contracts between a private party and the government.” *Id.* at 332 (citing *Astra USA, Inc. v. Santa Clara County*, 563 U.S. 110, 117-118 (2011)).

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

In determining whether a private right of action exists, this Court places primary emphasis on congressional intent. This Court has “made clear that unless Congress ‘speaks 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 Univ. v. Doe*, 536 U.S. 273, 280 (2002) (citing *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17, 28 & n.21(1981)).

This Court in *Health & Hosp. Corp. v. Talevski*, 143 S. Ct. 1444 (2023), clarified that this intent, for purposes of 42 U.S.C. 1983, must manifest itself in “rights-creating, individual-centric language with an unmistakable focus on the benefitted class.” *Id.* at 1457 (quoting *Gonzaga*, 536 U.S. at 284, 287). In

applying the *Gonzaga* test, the Court held in *Talevski* that the Federal Nursing Home Reform Act's (FNHRA) unnecessary restraint and predischarge notice provisions unambiguously conferred rights upon the residents of nursing facilities, noting that such rights were explicitly identified as "rights" within a statute relating to residents' rights. *Talevski*, 143 U.S. at 1457-1458. Moreover, such rights, and particularly the violation of those rights, were personal and had direct impact on an individual's health, medical needs, safety and welfare—considerations which were delineated within the applicable provisions of the FNHRA. See *id.* at 1458.

Conversely, respondents in this matter have not been deprived of healthcare or any right in a way that has personally impacted the health and well-being of individual beneficiaries. Rather, they seek to use the any-qualified-provider provision of the Medicaid Act to challenge a state's determination of which healthcare providers are best qualified to participate in the state's Medicaid plan. They propose that Section 1396a(a)(23) should be interpreted to create an individual right of beneficiaries to choose for themselves which healthcare providers are qualified to provide Medicaid-funded services to them, regardless of a state's administrative process for choosing or disqualifying such providers.

This Court has already spoken to the exact statutory issue in question, the any-qualified-provider provision of 42 U.S.C. 1396a(a)(23), and determined that Medicaid recipients do not have a right—in the context of a nursing facility that has been decertified as a Medicaid provider—to

continued residence in the home of one's choice." *O'Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773, 785 (1980). Rather, they have "the right to choose among a range of *qualified* providers[.]" *Ibid* (emphasis in original) (citing 42 U.S.C. 1396a(a)(23)). According to the plain reading of the statute, a 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); 42 C.F.R. 455.452. If a state determines that a provider is not qualified and, as in the case of *O'Bannon*, decertifies that provider, 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." *Planned Parenthood of Greater Tex. Family Planning & Preventative Health Servs., Inc. v. Kauffman*, 981 F.3d 347, 358 (2020).

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 *Alexander v. Sandoval*, 532 U.S. 275 (2001). If that were not clear enough, this Court has already conducted an in-depth analysis of Congress' intent with regard to private enforcement of Section 1396a(a)(30) of the Medicaid Act and has ruled that "the Medicaid Act precludes private enforcement of [that subsection] in the courts." *Armstrong*, 575 U.S. at 329. This Court's decisions in *Armstrong* and *O'Bannon*, along with the Court's recent guidance in *Talevski* provide clear direction in this case and require a different result than that reached by the

Fourth Circuit. Congress has not communicated an intent—let alone an unambiguous one—to create an implied individual, private right of action pursuant to Section 1396a(a)(23).

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

In *Talevski*, this Court found that specific provisions of the FNHRA created rights which were presumptively enforceable under 42 U.S.C. 1983. However, even when such private rights are found, the analysis does not end there. The second part of the *Gonzaga* test requires a determination of “whether ‘Congress intended a statute’s remedial scheme to be *the exclusive avenue* through which a plaintiff may assert [his] claims.’” *Talevski*, 143 S. Ct. at 1459 (emphasis in original) (quoting *Fitzgerald v. Barnstable Sch. Comm.*, 555 U.S. 246, 252 (2009) (additional citations omitted)). Incompatibility between enforcement under 42 U.S.C. 1983 and the enforcement scheme enacted by Congress precludes a private right of action under Section 1983. See *Talevski*, 143 S. Ct. at 1459.

This Court has long recognized that federal spending clause legislation has the potential to create Section 1983-enforceable rights, but does not do so as a matter of course. “[T]he 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.” *Talevski*, 143 S. Ct. at 1457 (quoting *Gonzaga*, 536 U.S. at 280).

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 288-289; *Touche Ross & Co. v. Redington*, 442 U.S. 560, 568-571 (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, 458 (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. This Court has already held, in the Medicaid ratesetting context, that "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." *Armstrong*, 575 U.S. at 328 (citing 42 U.S.C. 1396c). Indeed, "the 'express provision of

one method of enforcing a substantive rule suggests that Congress intended to preclude others.” *Ibid.* (quoting *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); 42 C.F.R. 430.1. 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 has provided a uniform administrative remedy for challenging states’ disqualification of Medicaid providers, and is likely to 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 determine, in a streamlined way, which providers qualify to participate in the state's Medicaid program is undercut by judicial intervention in states' 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.

V. The circuit split is causing a patchwork of remedies produced by a court-imposed system of differing enforcement mechanisms.

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 *Kauffman*, 981 F.3d at 350 (finding that Section 1396a(a)(23) does *not* contain an implied private right of action); *Gillespie*, 867 F.3d at 1046 (same), with *Planned Parenthood S. Atl. v. Baker*, 941 F.3d 687, 700 (4th Cir. 2019) (finding that Section 1396a(a)(23) contains an implied private right of action); *Planned Parenthood of Kansas and Mid-Missouri v. Andersen*, 882 F.3d 1205, 1224 (10th Cir. 2018) (same); *Planned Parenthood Ariz., Inc. v. Betlach*, 727 F.3d 960, 963 (9th Cir. 2013) (same); *Planned Parenthood of Ind., Inc. v. Comm'r of the Ind. State Dep't of Health*, 699 F.3d 962, 968 (7th Cir. 2012) (same); and *Harris v. Olszewski*, 442 F.3d 456, 463 (6th Cir. 2006) (same).

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 Medicaid participation.

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 reason to 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 use their local expertise and knowledge to determine which providers will best serve their Medicaid recipients.

CONCLUSION

The question of whether Medicaid beneficiaries have a private right to demand a provider of choice is an “important and recurring” question. *Gee v. Planned Parenthood of Gulf Coast, Inc.*, 139 S. Ct. 408, 409 (2018) (Thomas, J., dissenting from denial of certiorari). 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. *Amici* urge the Court to grant certiorari on this issue of great national significance.

Respectfully submitted,

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