No. 23-1275

IN THE
# Supreme Court of the United States

EUNICE MEDINA, INTERIM DIRECTOR, SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

PLANNED PARENTHOOD SOUTH ATLANTIC, ET AL., RESPONDENTS

*ON 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.

[2] Alabama Policy Institute, Alaska Family Council, Center for Arizona Policy, California Family Council, Family Institute of Connecticut, Delaware Family Policy Council, Florida Family Voice, Hawaii Family Forum, 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, 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, Palmetto Family Council (South Carolina), Pennsylvania Family Council, Rhode Island Family Institute, South Dakota Family Voice, Texas Values, The Family Foundation (Virginia), Family Policy Institute of Washington, Wisconsin Family Action, and Wyoming Family Alliance.

## 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. 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.

Nor did Congress intend or suggest the allowance of a private right of action to challenge states' provider enrollment decision-making. This is clear because such rights would run contrary to, and completely undermine, the foundational structure that supports the entire Medicaid program. This foundational structure uniquely defines Medicaid as a federal-state cooperative and jointly financed program that requires each state to administer its own version of the program. Within broad federal guidelines, states have primary responsibility for determining the type and scope of coverage of their Medicaid plans. The program recognizes the different needs of the individual states by affording states significant flexibility in the administrative implementation of their plans. Indeed, state knowledge and expertise are essential to the success of the program.

Medicaid's any-qualified-provider provision guarantees that Medicaid beneficiaries are entitled to obtain services from 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 pursuant to Section 1396a(a)(23). Therefore, respondents are limited to the remedies created by Congress. See *Health & Hosp. Corp.* v. *Talevski*, 599 U.S. 166, 183 (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).

The inconsistent application of this Court's precedents in the courts of appeals on this issue 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 did not resolve the issue of whether Medicaid's any-qualified-provider provision contains a private right of action.

Congress, in establishing the Medicaid program, made no mention of allowing a private right of action under the any-qualified-provider provision, and certainly did not indicate unambiguous intent to do so. To the contrary, Congress designed the Medicaid program with an explicit administrative scheme that promotes uniformity and efficiency within the program. Permitting private litigants to sue every time a state disqualifies a provider from providing Medicaid services would seriously undermine this

uniformity. Moreover, 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 and confusion within the Medicaid program.

For these reasons, *Amici* urge the Court to reverse the decision of the Fourth Circuit.

## 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 pursuant to 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 and administered by the states, was created in 1965. See 42 U.S.C. 1396a(a) and 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. See 42 U.S.C. 1396a(a)(9)(A) and (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

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

whistleblower protection. See 42 U.S.C. 1396a(a)(68)(B) and (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. See 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 serve their beneficiaries and meet the goals of the state's program. Allowing beneficiaries or providers to pursue private enforcement actions whenever 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 plans 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 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 foundational structure of the entire 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

[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 5, 7, 16 (2020). Full report can be found at oig.hhs.gov/oei/reports/oei-03-19-00070.asp.

most elements within broad guidelines. Specifically, states are responsible for deciding "eligible groups, types and range of services, payment levels for services, and administrative and operating procedures." 42 C.F.R. 430; see 42 U.S.C. 1396a(a)(4) and (5) and 42 C.F.R. 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]

Under Medicaid's federal-state partnership, states are responsible for setting reasonable standards for the qualification of their Medicaid providers. See 42 C.F.R. 431.51(c)(2) and 455.452. Before enrolling a provider, states must require the provider to complete a provider agreement with the state. See 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. See 42 C.F.R. 455.450.

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[5] *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 (2017). https://www.law.uh.edu/hjhlp/volumes/Vol_17/V17%20-%20Clark-FinalPDF.pdf

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 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. See 42 U.S.C. 1396a; 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 creation of such rights would completely undercut the benefits of federalism inherent in Medicaid, which has always acknowledged that states have a superior ability to understand state needs and priorities. Medicaid's foundational structure, which relies on the states using local expertise and knowledge to determine which providers will best serve their Medicaid recipients, has been essential to the federal-state cooperative relationship and has served the Medicaid program well.

**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 & Hospital Corporation* v. *Talevski*, 599 U.S. 166 (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 183 (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*, 599 U.S. at 184-185. 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 185.

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); 42 C.F.R. 455.450 and 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, 293 (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). "More fundamentally, however, the modern jurisprudence permitting intended beneficiaries to sue does not generally apply to contracts between a private party and the government." *Armstrong*, 575 U.S. at 332 (citing *Astra USA, Inc.* v. *Santa Clara County*, 563 U.S. 110, 117-118 (2011)).

**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*, 599 U.S. at 187 (emphasis in original) (quoting *Fitzgerald* v. *Barnstable Sch. Comm.,* 555 U.S 246, 252 (2009)) (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,* 599 U.S. at 186.

This Court has long recognized that federal spending clause legislation has the potential to create Section 1983-enforcable 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*, 599 U.S. at 183 (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); see 42 C.F.R. 430.1. Pursuant to these regulations, states are required to give providers a right to appeal when they are excluded 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.

Moreover, the expansion and availability of differing remedies and mechanisms of enforcement would be a nightmare in a federally supervised program such as Medicaid. By creating an

administrative quagmire for the states, the elimination of nationwide procedural uniformity in enforcement would strain the resources of the states and would increase the complexity of an already complex program. 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).

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 and uniform scheme for the enforcement of the requirements contained in Section 1396a precludes an intent to create an implied private right of action.

## CONCLUSION

The ability of states to model their individual Medicaid programs according to their unique needs and health priorities is essential to the continued success of the federal-state Medicaid partnership. Granting individual beneficiaries the right to sue states for their provider enrollment decisions would

have far-reaching consequences that are incompatible with Congress' intent to promote uniformity and efficiency within the program. For these reasons, *Amici* urge the Court to reverse the decision of the Fourth Circuit.

Respectfully submitted,

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