No.

In the Supreme Court of the United States

ST. DAVID'S HEALTHCARE PARTNERSHIP, L.P., L.L.P.,
PETITIONER,

v.

MELISSA HICKSON, INDIVIDUALLY AND AS THE INDEPENDENT ADMINISTRATOR OF THE ESTATE OF MICHAEL HICKSON, DECEASED, AND AS NEXT FRIEND OF M.H., M.H., AND M.H. (ALL MINORS); MARQUES HICKSON

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Under Section 504 of the Rehabilitation Act, an "otherwise qualified individual with a disability" may not "be subjected to discrimination under any program or activity receiving Federal financial assistance" "solely by reason of her or his disability." 29 U.S.C. § 794(a). Section 1557 of the Affordable Care Act prohibits discrimination on the same ground by any health program receiving federal financial assistance. 42 U.S.C. § 18116(a).

The question presented is:

Whether claims challenging a healthcare provider's decisions about how to treat conditions related to a patient's disability are cognizable under Section 504 of the Rehabilitation Act and Section 1557 of the Affordable Care Act.

PARTIES TO THE PROCEEDING AND RULE 29.6 DISCLOSURE STATEMENT

1. Petitioner St. David's Healthcare Partnership, L.P., L.L.P. was a defendant in the district court and an appellee in the court of appeals. Respondents Melissa Hickson, individually and as the independent administrator of the Estate of Michael Hickson, deceased, and as next friend of M.H., M.H., and M.H. (all minors), and Marques Hickson were the plaintiffs in the district court and the appellants in the court of appeals. Dr. Devry Anderson, Hospital Internists of Texas, Carlye Mabry Cantu, and Viet Vo were also defendants in the district court and appellees in the court of appeals.

2. Petitioner St. David's Healthcare Partnership, L.P., L.L.P. is a Texas limited partnership and has no parent corporation. Its partnership interests are held by indirect subsidiaries of HCA Healthcare, Inc., St. David's Foundation, and Georgetown Health Foundation. HCA Healthcare, Inc. is publicly traded on the New York Stock Exchange (symbol "HCA"), and no publicly held company owns 10% or more of its stock. St. David's Foundation and Georgetown Health Foundation are non-profit entities with no parent corporations.

RELATED PROCEEDINGS

United States District Court (W.D. Tex.):

Hickson v. *St. David's Healthcare Partnership, L.P., L.L.P. et al.*,
No. 1:21-cv-514 (Sept. 6, 2022)
(order dismissing disability-discrimination claims)

Hickson v. *St. David's Healthcare Partnership, L.P., L.L.P. et al.*,
No. 1:21-cv-514 (Oct. 23, 2024)
(order granting summary judgment)

United States Court of Appeals (5th Cir.):

Hickson v. *St. David's Healthcare Partnership, L.P., L.L.P. et al.*,
No. 24-50956 (Feb. 25, 2026)

TABLE OF CONTENTS

Page

Introduction 1
Opinions below 4
Jurisdiction 4
Statutory provisions involved 5
Statement of the case 5
A. Legal background 5
B. Factual background 7
C. Procedural background 8
Reasons for granting the petition 11
I. The decision below deepens an acknowledged circuit conflict 12
II. The decision below is wrong. 17
III. The question presented is important, and this case is an excellent vehicle for resolving it. 24
Conclusion 28
Appendix A — Court of appeals opinion (Feb. 25, 2026) 1a
Appendix B — District court order adopting report and recommendation (Sept. 6, 2022) 19a
Appendix C — Report and recommendation (Aug. 8, 2022) 23a
Appendix D — District court order granting motion for summary judgment (Oct. 23, 2024) 44a
Appendix E — Court of appeals order denying rehearing (June 25, 2026) 50a
Appendix F — Statutory provisions involved 52a

TABLE OF AUTHORITIES

Cases: Page(s)

Alexander v. *Choate*,
469 U.S. 287 (1985) 5, 21

American Academy of Pediatrics v. *Heckler*,
561 F. Supp. 395 (D.D.C. 1983) 21

Bond v. *United States*,
572 U.S. 844 (2014) 21

Bowen v. *American Hospital Ass'n*,
476 U.S. 610 (1986) 21

Burger v. *Bloomberg*,
418 F.3d 882 (8th Cir. 2005) 13, 16

Dinkins v. *Correctional Medical Services*,
743 F.3d 633 (8th Cir. 2014) 12, 13, 16, 27

Doe v. *BlueCross BlueShield of Tennessee, Inc.*,
926 F.3d 235 (6th Cir. 2019) 7, 17

FCC v. *NextWave Personal Communications Inc.*,
537 U.S. 293 (2003) 18

Fitzgerald v. *Corrections Corp. of America*,
403 F.3d 1134 (10th Cir. 2005) 14, 27

Gonzales v. *Oregon*,
546 U.S. 243 (2006) 21

Gross v. *FBL Financial Services, Inc.*,
557 U.S. 167 (2009) 19

Cases—Continued: Page(s)

Grzan v. *Charter Hospital of Northwest Indiana*, 104 F.3d 116 (7th Cir. 1997) 14, 16, 24

Gunn v. *McCoy*, 554 S.W.3d 645 (Tex. 2018) 25, 26

Henson v. *Santander Consumer USA Inc.*, 582 U.S. 79 (2017) 20

Johnson by Johnson v. *Thompson*, 971 F.2d 1487 (10th Cir. 1992) 14, 16, 18, 19

Lesley v. *Hee Man Chie*, 250 F.3d 47 (1st Cir. 2001) 15

McGugan v. *Aldana-Bernier*, 752 F.3d 224 (2d Cir. 2014) 14, 16, 24

Olmstead v. *L.C. ex rel. Zimring*, 527 U.S. 581 (1999) 24

Pegram v. *Herdrich*, 530 U.S. 211 (2000) 21, 24

Samaha v. *Rau*, 977 So. 2d 880 (La. 2008) 25

Schiavo ex rel. Schindler v. *Schiavo*, 403 F.3d 1289 (11th Cir. 2005) 13, 16

Southeastern Community College v. *Davis*, 442 U.S. 397 (1979) 18, 20

Thomas v. *Lewis*, 289 So. 3d 734 (Miss. 2019) 25

United States v. *University Hospital, State University of New York at Stony Brook*, 729 F.2d 144 (2d Cir. 1984) 13, 14, 16, 19, 20, 21, 22

Statutes: Page(s)

28 U.S.C. § 1254 4
28 U.S.C. § 1331 9
28 U.S.C. § 1343 9
28 U.S.C. § 1367 9
29 U.S.C. § 794 ..... 2, 6, 17, 18, 22
42 U.S.C. § 2000d 5
42 U.S.C. § 18116 ..... 2, 7, 17
La. Rev. Stat. Ann. § 40:1231.2 26
La. Rev. Stat. Ann. § 40:1231.8 25
Miss. Code Ann. § 11-1-60 26
Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1557, 124 Stat. 260 (2010) 7
Rehabilitation Act of 1973, Pub. L. No. 93-112, § 504, 87 Stat. 394 6
Tex. Civ. Prac. & Rem. Code § 74.301 ..... 25, 26
Tex. Civ. Prac. & Rem. Code § 74.351 ..... 25, 26

Other Authorities:

117 Cong. Rec. 45,974 (1971) 5
118 Cong. Rec. 525 (1972) 5
CDC Data Shows Over 70 Million U.S. Adults Reported Having a Disability, Ctrs. for Disease Control & Prevention (July 16, 2024) 26
Fact Sheet: Medicare and Medicaid Constitute Majority of Hospital Payments, Am. Hosp. Ass'n (Mar. 16, 2026) 27

Other Authorities—Continued: Page(s)

Fast Facts on U.S. Hospitals, 2026, Am. Hosp. Ass'n (Feb. 2026) 27

H.R. 12154, 92d Cong. § 1 (1971) 5

Laura M. Maruschak et al., U.S. Dep't of Just., Bureau of Just. Stat., NCJ 252642, *Disabilities Reported by Prisoners: Survey of Prison Inmates, 2016* (2021) 27

Margo Schlanger, *Inmate Litigation*, 116 Harv. L. Rev. 1555 (2003) 27

Medicare Payment Advisory Comm'n, *Report to the Congress: Medicare Payment Policy* (2026) 27

S. 3044, 92d Cong. § 1 (1972) 5, 6

S. Rep. No. 93-1297 (1974), *reprinted in* 1974 U.S.C.C.A.N. 6373 6

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INTRODUCTION

Every day in this country, doctors make difficult decisions about how to care for patients with disabilities. When a patient or the patient's loved ones disagree with those treatment decisions, there is a well-established path for legal redress: state medical-malpractice law.

Federal courts have resisted attempts to federalize malpractice law. In the more than half century since the enactment of the Rehabilitation Act, the dominant view among federal courts has rejected disability-discrimination law as an alternative path for challenging medical treatment of conditions arising from a patient's disability. In the decision below, the Fifth Circuit departed from that view and became the first court of appeals to

conclude that a plaintiff had stated a disability-discrimination claim challenging treatment decisions relating to a patient's disability. That decision disregarded the statutory text and entrenched a three-way division among the courts of appeals. Its expansive approach carries profound consequences for healthcare providers and federal courts. This Court's review is warranted.

This case arises from tragic circumstances. Michael Hickson suffered a spinal-cord injury that left him unable to walk and contributed to a host of chronic medical issues, including reduced function of his diaphragm, immune suppression, recurring infections, and repeated hospitalizations. During his final hospitalization, Hickson developed pneumonia, sepsis, and respiratory failure. His doctors concluded that further aggressive treatment was unlikely to alter the outcome and, with his guardian's consent, moved him to hospice care. It was a medical judgment—a sad one, and perhaps even a debatable one, but a treatment decision that doctors face every day.

The Fifth Circuit held that plaintiffs could challenge that treatment decision under the Rehabilitation Act and the Affordable Care Act. Those federal laws protect an "otherwise qualified individual with a disability" from discrimination "solely by reason of" the disability. 29 U.S.C. § 794(a); see 42 U.S.C. § 18116(a). The Fifth Circuit seized on an alleged comment by Hickson's doctor about his inability to walk and talk—conditions stemming from the same spinal-cord injury that caused the medical issues for which he was hospitalized—and held that a disability-discrimination claim may proceed whenever medical treatment is allegedly based "'solely,' in the pejorative sense," on the patient's disability. App., *infra*, 10a.

In reaching that conclusion, the court of appeals acknowledged it was breaking from other circuits. Unlike the Fifth Circuit, the Eighth and Eleventh Circuits categorically reject disability-discrimination claims predicated on medical treatment, on the ground that such claims challenge the substance of medical judgment rather than discrimination in access to care. Meanwhile, the Second, Seventh, and Tenth Circuits permit such claims only to challenge discrimination based on a disability *unrelated* to the condition being treated. In those circuits, then, a blind patient could pursue a Rehabilitation Act claim for a refusal to treat the flu but not for treatment decisions relating to impaired vision. By dispensing with that guardrail, the Fifth Circuit joined (and even outstripped) the First Circuit in reading disability-discrimination statutes to permit claims even when the treatment decision concerned conditions arising from the disability.

The Fifth Circuit's stance is irreconcilable with the text, context, and purpose of the Rehabilitation Act and ACA. A patient is not "otherwise qualified" for medical treatment for a condition related to a disability; without the disability, the patient would not be seeking the challenged treatment. Assessing a dispute about how a disability was treated under the framework of discrimination would elide key textual differences between the disability-discrimination laws and Title VI. And doing so ignores what every federal disability-discrimination law recognizes: The nature of disabilities will sometimes require benign consideration of the disability in deciding eligibility for services.

This Court's intervention is needed. The courts of appeals are in deep conflict over where medical judgment ends and disability discrimination begins. And the

stakes are high. The decision below not only allows plaintiffs to circumvent state-law limitations on medical-malpractice claims by restating them as federal disability discrimination but also invites federal courts to second-guess sensitive clinical judgments. Disagreements about medical-treatment decisions, especially those involving end-of-life care, are profoundly difficult, and the law provides time-tested channels for addressing the soundness of those treatments. Federal disability-discrimination law is not one of them. The Court should grant the petition.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-18a) is reported at 168 F.4th 282. The order of the district court dismissing plaintiffs' discrimination claims (App., *infra*, 19a-22a), the report and recommendation of the magistrate judge that the district court adopted (App., *infra*, 23a-43a), and the order of the district court granting the defendants' motion for summary judgment (App., *infra*, 44a-49a) are not published in the Federal Supplement or electronic reporters.

JURISDICTION

The judgment of the court of appeals was entered on February 25, 2026. Petitions for rehearing were denied on June 25, 2026 (App., *infra*, 50a-51a). On September 8, 2026, Justice Alito extended the time within which to file a petition for a writ of certiorari to and including October 23, 2026. This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

Relevant provisions are reproduced in the appendix. App., *infra*, 52a-56a.

STATEMENT OF THE CASE

A. Legal background

When Congress took up the problem of disability discrimination in the early 1970s, its concern was exclusion from the basic institutions of public life. Congress "focus[ed] on several substantive areas—employment, education, and the elimination of physical barriers to access—in which it considered the societal and personal costs of refusals to provide meaningful access to the handicapped to be particularly high." *Alexander* v. *Choate*, 469 U.S. 287, 306-307 (1985). At the time, roughly a million children with disabilities were excluded from schools, adults with disabilities were consigned to institutions for confinement without treatment, architectural and transportation barriers kept the disabled out of public buildings, and employers would not hire them. 117 Cong. Rec. 45,974 (1971) (statement of Rep. Vanik); 118 Cong. Rec. 525 (1972) (statement of Sen. Humphrey).

Congress's first attempts to remedy that "shameful oversight[ ]," 117 Cong. Rec. 45,974, came in 1971 and 1972. Members of Congress proposed amending Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of "race, color, or national origin" by any program or activity receiving federal funding, 42 U.S.C. § 2000d, by adding "physical or mental handicap" to that list of protected grounds. H.R. 12154, 92d Cong. § 1 (1971); S. 3044, 92d Cong. § 1 (1972).

From the beginning of this effort to combat disability discrimination, legislators recognized a crucial difference between disability and race. Unlike race, a disability can sometimes bear directly on whether a person qualifies for a particular service or what that service should consist of. So in crafting the amendment to Title VI, legislators proposed preserving the ability of those receiving federal funding to consider disability when it implicated a "bona fide qualification." S. 3044 § 1. Structured that way, the amendment would have prohibited disability-based discrimination but also allowed those receiving federal funding to consider an individual's disability in limited circumstances.

Although the attempt to add disability to Title VI failed, in 1973 Congress enacted a separate law patterned after its prohibitions: Section 504 of the Rehabilitation Act. Pub. L. No. 93-112, § 504, 87 Stat. 394; see also S. Rep. No. 93-1297, 37-40 (1974), *reprinted in* 1974 U.S.C.C.A.N. 6373, 6388-6390. While the Rehabilitation Act was patterned on Title VI, Congress did not flatly prohibit exclusion based on a disability as it did for the protected characteristics in Title VI. Instead, Section 504 of the Rehabilitation Act provides that "[n]o otherwise qualified individual with a disability * * * shall, solely by reason of her or his disability, * * * be subjected to discrimination under any program or activity receiving Federal financial assistance." 29 U.S.C. § 794(a).

Against that backdrop, Congress in 2010 enacted a disability-discrimination prohibition specific to health programs as part of the Affordable Care Act. Section 1557 of the ACA incorporates the Section 504 standard: "[A]n individual shall not, on the ground prohibited under * * * section 504 of the Rehabilitation Act of 1973

(29 U.S.C. 794), be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity" receiving federal funding. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1557, 124 Stat. 260 (codified at 42 U.S.C. § 18116(a)). For that reason, courts construe the two provisions together. See *Doe* v. *BlueCross BlueShield of Tennessee, Inc.*, 926 F.3d 235, 239 (6th Cir. 2019) (Sutton, J.).

B. Factual background

Michael Hickson suffered a cardiac arrest in 2017. C.A. ROA 23. The episode injured his brain, and the extensive CPR that first responders administered to save his life damaged his spinal cord. C.A. ROA 23. As a result of his spinal-cord injury, Hickson was unable to walk and suffered from short-term memory loss, vision loss, slow speech, and chronic immune suppression that made him "more susceptible to infections." C.A. ROA 23.

Hickson's spinal-cord injury repeatedly landed him in the hospital. In the three years after his injury, Hickson had "multiple hospitalizations for recurring urinary tract infections, sepsis and pneumonia," which, according to plaintiffs, "occur with great frequency to persons with the disabilities that Mr. Hickson had." C.A. ROA 23. One such hospitalization occurred at St. David's in March 2020, when Hickson was treated for "double pneumonia and sepsis." C.A. ROA 24.

In June 2020, Hickson was hospitalized again, this time for pneumonia, urinary tract infection, sepsis, and suspected COVID-19. C.A. ROA 24. He was brought to St. David's emergency department and placed in the intensive care unit, where he was treated with antibiotics and oxygen. C.A. ROA 24-25. During the next three

days, Hickson suffered "intermittent desaturations of oxygen," which required a BiPAP machine, "lung aspiration," and "acute – respiratory failure." C.A. ROA 26, 28. He stopped feeding through his tube, experienced "high fevers," and "required periodic moderate assistance to clear secretions." C.A. ROA 26. His physician assessed that he was in "multi-organ system failure." C.A. ROA 28.

Three days after Hickson was admitted, and after receiving consent from his court-appointed guardian, his physicians made the difficult decision to move him to do-not-resuscitate status and place him in hospice care. C.A. ROA 19, 27-28. In the treatment-decision form provided to his guardian, one of Hickson's physicians listed his conditions as "chronic – anoxic encephalopathy," "acute – respiratory failure, pneumonia, SARS2 corona virus," and the available treatments as "mechanical ventilator with intubation, BiPAP, vasopressors, fluids." C.A. ROA 28. The physician described Hickson's prognosis as "poor" and "[l]ikely death" "regardless of interventions." C.A. ROA 28. Further treatment, he explained, "is difficult and likely won't change outcome," which he described as "futile." C.A. ROA 28. The doctor recommended "comfort/hospice" given Hickson's "baseline functions" and "recoverability." C.A. ROA 28. A few days after being moved to hospice, Hickson passed away. C.A. ROA 30.

C. Procedural background

1. Plaintiffs—Hickson's estate and several family members—sued St. David's and Hickson's physicians. C.A. ROA 20-22. Plaintiffs allege that Hickson had a 70% chance of survival, that he was not in multi-organ system failure, and that his death was not the result of

the severe complications arising from his spinal-cord injury. C.A. ROA 27-28, 34.

Instead, plaintiffs assert that Hickson "was a casualty of deadly discriminatory ableist views held by [his] physicians that determined his life was not worth living and not worth treating." C.A. ROA 20. Seizing on alleged comments by his providers about his diminished "quality of life" resulting from his spinal-cord injury, plaintiffs allege that Hickson's doctors discriminated against him "[b]ased on his underlying disabilities that precluded him from walking and talking." C.A. ROA 34.

Based on these allegations, plaintiffs asserted state-law claims against Hickson's doctors and St. David's. Chief among those claims were medical-malpractice claims against Hickson's physicians and the hospital. C.A. ROA 37-46, 52-55. Plaintiffs also brought two federal disability-discrimination claims—one under the Rehabilitation Act and the other under the ACA—against St. David's alone. C.A. ROA 32-37.[1]

2. The district court dismissed the Rehabilitation Act and ACA claims at the pleading stage. Adopting the magistrate judge's report and recommendation, it held that those claims "ultimately relate to medical-treatment decisions" and therefore are not actionable under the disability-discrimination statutes. App., *infra*, 20a; see also App., *infra*, 30a (report and recommendation).

The district court allowed several of plaintiffs' state-law medical-malpractice claims to proceed to discovery. But under Texas law, a malpractice plaintiff must prove the standard of care, breach, and causation through ex-

[1] The district court had jurisdiction under 28 U.S.C. §§ 1331, 1343(a)(3)-(4), and 1367.

pert testimony. App., *infra*, 46a. Because plaintiffs neither designated a medical expert nor responded to the defendants' motion for summary judgment, the court entered summary judgment for defendants. App., *infra*, 45a-47a.

Plaintiffs appealed. They did not contest the district court's dismissal of their medical-malpractice claims. Instead, they primarily pressed their federal disability-discrimination claims.

3. The Fifth Circuit vacated the district court's dismissal of the federal claims. It agreed with plaintiffs that "disability laws do not categorically preclude disability-discrimination claims related to medical-treatment decisions." App., *infra*, 7a. In rejecting that categorical rule, the Fifth Circuit noted that it did "not accept statements" by the Eighth and Eleventh Circuits "that medical treatment decisions, or the withholding of medical care, never qualify as disability discrimination." App., *infra*, 10a-11a & n.5.

In place of that categorical prohibition, the Fifth Circuit permitted claims alleging disability discrimination based on medical treatment as long as a plaintiff alleges that the treatment was based solely "in the pejorative sense" on the disability. App., *infra*, 10a. The Fifth Circuit did not limit its allowance of disability-discrimination claims, as other circuits have, to those challenging treatment for conditions unrelated to the patient's disability. Applying its uniquely permissive rule, the Fifth Circuit concluded that plaintiffs' Rehabilitation Act and ACA claims should not have been dismissed. App., *infra*, 2a, 18a.

St. David's petitioned for panel rehearing and rehearing en banc, which the Fifth Circuit denied on June 25, 2026. App., *infra*, 50a-51a.

REASONS FOR GRANTING THE PETITION

The Fifth Circuit's decision deepens an acknowledged circuit conflict on an issue of great importance. In holding that disability-discrimination claims can be based on decisions about how to treat conditions *related to the disability itself*, the Fifth Circuit adopted a uniquely broad reading of Section 504. It openly broke from the Eighth and Eleventh Circuits, which entirely foreclose disability-discrimination claims based on medical-treatment decisions. The Fifth Circuit also departed from the approach of the Second, Seventh, and Tenth Circuits, which permit disability-discrimination claims based on medical-treatment decisions only when the condition being treated is unrelated to the disability. In dispensing with that limitation, the Fifth Circuit joined, and even outstripped, the First Circuit.

The Fifth Circuit's expansive approach is untenable given the text, context, and purpose of the Rehabilitation Act and ACA. Those statutes protect an "otherwise qualified individual with a disability" from exclusion from federal programs "solely by reason of" the disability. Disability-discrimination claims challenging the medical treatment of conditions related to the disability do not fit that text. A patient cannot be "otherwise qualified" for medical treatment related to a disability apart from that disability; there is no suitable comparator. Congress added those requirements, which have no counterpart in Title VI, because a disability can bear directly on eligibility for a service. And it wrote the statute to end exclusion from programs when a person's qualifications can be measured apart from the disability, not to superintend medical-treatment decisions the States have always governed.

The consequences of the question presented are significant. The Fifth Circuit's approach threatens to undercut the safeguards States have constructed for medical-malpractice claims and open the federal courts to medical-malpractice claims garbed as discrimination claims. Patients, doctors, and the judicial system will all be worse off. This Court should grant the petition.

I. THE DECISION BELOW DEEPENS AN ACKNOWLEDGED CIRCUIT CONFLICT.

As the Fifth Circuit acknowledged, its decision broke from the approach of other circuits addressing disability-discrimination claims challenging medical-treatment decisions. The courts of appeals are now divided into three camps on the question presented. The Eighth and Eleventh Circuits categorically bar disability-discrimination claims based on medical-treatment decisions. The Second, Seventh, and Tenth Circuits allow plaintiffs to challenge some medical-treatment decisions, but only when those decisions discriminate against patients based on a disability unrelated to the conditions being treated. And in the decision below, the Fifth Circuit departed from both of those approaches, aligning with the First Circuit in holding that medical-treatment decisions can support disability-discrimination claims even if—as in this case—the disability is related to the conditions being treated.

A. The Eighth and Eleventh Circuits disallow disability-discrimination claims based on decisions about medical treatment.

The Eighth Circuit has concluded that "medical treatment decisions" "cannot form the basis of a claim" under the Rehabilitation Act. *Dinkins* v. *Correctional Medical Services*, 743 F.3d 633, 634 (8th Cir. 2014). The

court accordingly held that a prison's failure to accurately diagnose and treat an inmate's anemia could not give rise to liability under the statute. See *ibid.*; see also *Burger* v. *Bloomberg*, 418 F.3d 882, 883 (8th Cir. 2005) ("[A] lawsuit under the Rehab Act * * * cannot be based on medical treatment decisions.").

The Eleventh Circuit has reached the same conclusion. In rejecting a claim against a hospice provider for failing to provide a patient with a feeding tube, the court observed that the patient was not "otherwise qualified" under the statute "because she would not have had any need for a feeding tube to deliver nutrition and hydration but for her medical condition." *Schiavo ex rel. Schindler* v. *Schiavo*, 403 F.3d 1289, 1294 (11th Cir. 2005) (citation omitted). Section 504, the court explained, "was never intended to apply to decisions involving the termination of life support or medical treatment." *Ibid.*

B. The Second, Seventh, and Tenth Circuits permit plaintiffs to challenge some medical-treatment decisions as disability discrimination. But, applying the statute's "otherwise qualified" language, they allow such claims only if the claims allege discrimination against patients based on a disability unrelated to the conditions being treated.

The Second Circuit has concluded that "section 504 prohibits discrimination against a handicapped individual only where the individual's handicap is unrelated to, and thus improper to consideration of, the services in question." *United States* v. *University Hospital, State University of New York at Stony Brook*, 729 F.2d 144, 156 (2d Cir. 1984). It therefore held that Section 504 did not govern a doctor's decision about how to treat an infant's birth defects when those defects brought her to the hospital in the first place. *Id.* at 156-158. The court

explained that "one would not ordinarily think of a newborn infant suffering from multiple birth defects as being 'otherwise qualified' to have corrective surgery performed." *Id.* at 156. "If congress intended section 504 to apply in this manner, it chose strange language indeed." *Ibid.*; see *McGugan* v. *Aldana-Bernier*, 752 F.3d 224, 232 (2d Cir. 2014) (a doctor's refusal to "prescribe a particular treatment" based on "an appraisal of the patient's medical condition" is "not discrimination in violation of the statute, even if the doctor's medical analysis is flawed").

The Seventh Circuit is in accord. It rejected a Section 504 claim by a psychiatric patient against her hospital alleging that the psychiatric treatment she received was "poor" and "defective." *Grzan* v. *Charter Hospital of Northwest Indiana*, 104 F.3d 116, 120-121 (7th Cir. 1997). "Had she not suffered from the psychiatric condition," the court reasoned, "she would not have qualified for" the program "and would not have been treated, negligently or otherwise." *Id.* at 121. The court declined the patient's invitation to convert Section 504 into a "federal malpractice tort remedy." *Id.* at 123.

The Tenth Circuit has come out the same way. It rejected a Section 504 claim based on the treatment of a birth defect because "if such a person were not so handicapped, he or she would not need the medical treatment and thus would not 'otherwise qualify' for the treatment." *Johnson by Johnson* v. *Thompson*, 971 F.2d 1487, 1493 (10th Cir. 1992); see *Fitzgerald* v. *Corrections Corp. of America*, 403 F.3d 1134, 1144 (10th Cir. 2005) (no claim under the Rehabilitation Act when the "disability in this case was the reason why" an inmate "was seeking medical treatment").

C. The First and Fifth Circuits depart from both these camps.

The First Circuit has concluded that Section 504 sometimes permits disability-discrimination claims based on medical treatments—contrary to the view of the Eighth and Eleventh Circuits. *Lesley* v. *Hee Man Chie*, 250 F.3d 47, 55 (1st Cir. 2001). But it has also rejected the views of the Second, Seventh, and Tenth Circuits by concluding that such a claim can be based on treatment for conditions related to the disability if the treatment decision is "unreasonable in a way that reveals it to be discriminatory." *Ibid.* (emphasis omitted). "For example," a medical-treatment decision may be "so unreasonable * * * as to imply that it was pretext for some discriminatory motive, such as animus, fear, or 'apathetic attitudes.'" *Ibid.* Although the First Circuit ultimately did not allow the claim to proceed—concluding that the challenged decision was "simply a reasoned medical judgment with which the patient disagreed"—it nonetheless opened the door to a broader set of claims. *Id.* at 58.

In the decision below, the Fifth Circuit walked through that door. It adopted a similar test—and one even more expansive than the First Circuit's—for disability-discrimination claims.[2] It expressly rejected the approach of the Eighth and Eleventh Circuits, stating that it did "not accept" these decisions holding "that

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[2] The First Circuit permits such a claim "[o]nly where the physician's judgment is entirely without any reasonable medical basis." *Lesley*, 250 F.3d at 57. Although the Fifth Circuit recited that standard in passing, App., *infra*, 9a, it never considered whether the decision to move Hickson to hospice was "entirely without any reasonable medical basis."

medical treatment decisions, or the withholding of medical care, never qualify as disability discrimination." App., *infra*, 10a-11a & n.5 (citing *Dinkins*, 743 F.3d at 634; *Burger*, 418 F.3d at 883; *Schiavo*, 403 F.3d at 1294). Instead, the Fifth Circuit concluded that "disability discrimination *can* arise from the medical treatment of disabled persons." App., *infra*, 8a (emphasis added).

The Fifth Circuit also departed from the position of the Second, Seventh, and Tenth Circuits. Although the Fifth Circuit invoked decisions from some of those circuits in rejecting a categorical ban on Rehabilitation Act claims challenging medical-treatment decisions, App., *infra*, 9a-10a, it broke from them by permitting such claims even when they challenge the treatment of the disability that brought the patient to the hospital. Because those circuits hold that a patient is not "otherwise qualified" for medical treatment of disability-related conditions absent the disability, they would not permit disability-discrimination claims such as plaintiffs' claim that Hickson's doctors should have recommended different and continuing treatment for Hickson's medical complications and illnesses related to his spinal-cord disability. See *Stony Brook*, 729 F.2d at 156; *McGugan*, 752 F.3d at 232; *Grzan*, 104 F.3d at 120-121; *Johnson*, 971 F.2d at 1493-1494. In contrast, the Fifth Circuit held that such claims are cognizable "when allegations show that the treatment was based 'solely,' in the pejorative sense, on the individual's disability." App., *infra*, 10a.

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The bottom line is that the courts of appeals are divided three ways over whether and when medical-treatment decisions give rise to disability-discrimination claims under the Rehabilitation Act and the ACA.

Two courts hold that such decisions are categorically out of bounds. Three allow discrimination claims only when medical-treatment decisions are unrelated to the patient's disability. And two allow discrimination claims even when those claims are related to treatment necessitated by the patient's disability. Plaintiffs' claims against St. David's turn on treatment decisions that required Hickson's doctors to consider his underlying disability in assessing his prognosis. See pp. 22-23, *infra*. The result is that the complaint here would be tossed out in at least five circuits but proceeded below. This Court's review is necessary to resolve this acknowledged, deep, and entrenched conflict.

II. THE DECISION BELOW IS WRONG.

The Fifth Circuit's expansive approach is untenable. The text, context, and purpose of the Rehabilitation Act and ACA confirm that they authorize a disability-discrimination claim only when the disability is unrelated to the conditions being treated. The Fifth Circuit's decision authorizing claims challenging how Hickson's doctors treated his disabilities cannot be reconciled with the statutes.

A. The text of the Rehabilitation Act and ACA permits disability-discrimination claims based on medical treatment only when the discrimination is unrelated to the conditions necessitating the treatment.

1. Section 504 of the Rehabilitation Act—which the ACA incorporates—protects an "otherwise qualified individual with a disability" from discrimination "solely by reason of" the disability. 29 U.S.C. § 794(a); see 42 U.S.C. § 18116(a); *BlueCross BlueShield of Tennessee*, 926 F.3d at 239. For discrimination to give rise to liability under the Rehabilitation Act and the ACA, therefore,

(1) a person must be an "otherwise qualified individual with a disability," and (2) the discrimination must be "solely by reason of her or his disability." 29 U.S.C. § 794(a). Put differently, the statute requires the ability to isolate discrimination—not the mere existence of the disability—as the distinguishing factor for a plaintiff's treatment.

Start with "otherwise qualified." The "plain meaning" of an "otherwise qualified" person is "one who is able to meet all of a program's requirements in spite of his handicap." *Southeastern Community College* v. *Davis*, 442 U.S. 397, 406 (1979). That means an "otherwise qualified" person is one who is eligible for a program notwithstanding his disability.

In the medical-treatment context, an individual is "otherwise qualified" only if he would qualify for the same treatment absent the disability. In other words, Section 504 protects a disabled person who meets the same eligibility requirements for medical treatment as a person without that disability. See *Davis*, 442 U.S. at 410 (Section 504 governs "the evenhanded treatment of qualified handicapped persons," not "affirmative efforts to overcome the disabilities caused by handicaps").

Now consider "solely by reason of." That phrase means that "the discrimination must result from the handicap and from the handicap *alone*." *Johnson*, 971 F.2d at 1493 (emphasis added); see *FCC* v. *NextWave Personal Communications Inc.*, 537 U.S. 293, 301 (2003) (interpreting "solely because" to mean that the specified ground "must alone be the proximate cause" of the challenged act). In Section 504, that phrase modifies the text that follows. The statute provides that no one shall, solely by reason of disability, "be subjected to discrimination." 29 U.S.C. § 794(a). Read together, the language

asks whether a difference in treatment can be attributed to the disability and nothing else, because decisions resting on any other consideration are not actionable. See *Gross* v. *FBL Financial Services, Inc.*, 557 U.S. 167, 176-177 (2009) (phrase "by reason of" requires at least but-for causation).

Putting those two requirements together sharply limits when a medical-treatment decision can constitute disability discrimination. Section 504 applies *only* when a person would qualify for the treatment apart from the disability and is denied that treatment solely because of the disability. When the disability is what makes the treatment necessary, the person is not "otherwise qualified" for the treatment without that disability. See *Stony Brook*, 729 F.2d at 156. And when the disability is related to the condition being treated, it is impossible to isolate a difference in treatment that is "solely by reason of" discrimination, because a physician must necessarily treat a patient with that condition differently than a patient without it. As the Second Circuit put it, "[w]here the handicapping condition is related to the condition(s) to be treated, it will rarely, if ever, be possible to say with certainty that a particular decision was 'discriminatory.'" *Id.* at 157; see *Johnson*, 971 F.2d at 1494.

To make matters concrete, the statute would permit a disability-discrimination claim if, for example, a doctor refused to treat a blind patient for the flu out of a bias against the blind. The patient would be "otherwise qualified" for the flu treatment regardless of impaired vision, and the refusal to treat the flu would be "solely by reason of" that disability. But the statute would not permit a disability-discrimination suit if a doctor refused to perform experimental eye surgery on the same patient. The

patient would not be "otherwise qualified" for the surgery absent his lack of vision, and the treatment decision cannot be chalked up solely to discrimination.

2. Statutory context confirms the point. The "otherwise qualified" and "solely by reason of" requirements have no counterpart in Title VI, on which Section 504 was modeled. That "difference[ ] in language * * * convey[s] [a] difference[ ] in meaning." *Henson* v. *Santander Consumer USA Inc.*, 582 U.S. 79, 86 (2017). Congress added those requirements to Section 504 to set a higher bar for disability-discrimination claims than for claims of discrimination based on race or national origin. See pp. 5-6, *supra*.

That choice makes sense because disability, unlike race, can bear directly on eligibility for programs or services. For example, a nursing program might choose to exclude prospective students with hearing impairments and require its students to understand speech without lip reading. See *Davis*, 442 U.S. at 407-410. Because patient safety in a surgical setting depends on clear communication between patient and nurse, an applicant with a hearing impairment would not be "otherwise qualified" for the nursing program, so the exclusion would not give rise to a disability-discrimination claim. *Ibid.*

Medical services are another prime example. "[W]here medical treatment is at issue, it is typically the handicap itself that gives rise to, or at least contributes to, the need for services." *Stony Brook*, 729 F.2d at 156. Evaluating a dispute about how doctors treated a disability under the rubric of disability discrimination would erase the distinction between Section 504 and Title VI and transform a statute designed to prevent discriminatory exclusion from services into a vehicle for second-guessing the substantive medical treatment of disability.

The "background principle that Congress does not normally intrude upon the police power of the States" bolsters that reading of Section 504. *Bond* v. *United States*, 572 U.S. 844, 863 (2014). That federalism principle favors interpreting statutes not to encroach on the States' traditional authority over the "regulation of health and safety"—including medical practice. *Gonzales* v. *Oregon*, 546 U.S. 243, 271-274 (2006). This Court has therefore declined to read ERISA to authorize "federal fiduciary breach claims" that would "federalize malpractice litigation." *Pegram* v. *Herdrich*, 530 U.S. 211, 236 (2000). It has likewise avoided "federal superintendence of treatment decisions traditionally entrusted to state governance," in the context of medical treatment for children. *Bowen* v. *American Hospital Ass'n*, 476 U.S. 610, 643 (1986). The same for Section 504: It should not be extended to allow federal disability-discrimination claims to supplement or displace state tort law governing medical malpractice.

3. Section 504's purpose only underscores that it is not aimed at regulating medical-treatment decisions except in limited circumstances. "[N]o congressional committee or member of the House or Senate ever even suggested that section 504 would * * * establish standards for preserving a particular quality of life." *Stony Brook*, 729 F.2d at 158 (quoting *American Academy of Pediatrics* v. *Heckler*, 561 F. Supp. 395, 401 (D.D.C. 1983)). That is because the problem Congress set out to address in Section 504 was exclusion from "relatively static programs" like "education, employment, and transportation systems," in which a person's qualifications for admission can be measured against a standard that exists independent of his disability. *Id.* at 156 (citations omitted); see pp. 5-6, *supra*; *Choate*, 469 U.S. at 297 (describing

"elimination of architectural barriers" as "one of the central aims of the Act"). Medical treatment offers no such independent benchmark, because the disability is often the very reason treatment is needed. The medical disability often must be considered by the patient's doctor in deciding the proper course of treatment. As a result, the "otherwise qualified" requirement "cannot be applied in the comparatively fluid context of medical treatment decisions without distorting its plain meaning." *Stony Brook*, 729 F.2d at 156.

B. Under the proper test, plaintiffs' claims—which seek to hold St. David's liable for how its doctors treated conditions resulting from Hickson's spinal-cord disability—cannot proceed.

The gravamen of plaintiffs' complaint is that Hickson's doctors mistreated conditions resulting from his spinal-cord injury. By plaintiffs' own account, that injury suppressed Hickson's immune system and produced the recurring infections that repeatedly placed him in the hospital—including during his tragic final hospitalization. C.A. ROA 23-24. Hickson was a candidate for treatment during that hospitalization only because of acute complications arising from the same spinal-cord injury that plaintiffs say impermissibly influenced the physicians' judgment. C.A. ROA 19, 23-24, 28.

Had the court of appeals applied the correct statutory test, it would have rejected plaintiffs' disability-discrimination claims. Hickson was not "otherwise qualified" for his treatment apart from his disability because he was being treated for conditions resulting from that disability. 29 U.S.C. § 794(a). So plaintiffs' Rehabilitation Act and ACA claims should have been nonstarters.

C. In reaching the opposite conclusion, the court of appeals disregarded the statutes' plain meaning. It ignored the requirement that an individual must be "otherwise qualified" for a benefit notwithstanding his disability, except when quoting Section 504 in a footnote. App., *infra*, 9a n.3. The court also failed to recognize that Hickson's disability was related to the conditions his doctors were treating—even though, by the court's own account, his spinal-cord injury "left him susceptible to" the very infections for which he was hospitalized. App., *infra*, 3a.

As a result of those errors, the court allowed plaintiffs to proceed on claims that depend entirely on conditions that Hickson's disability produced. The court accepted plaintiffs' theory that St. David's "stopped treating" Hickson because of "his inability to walk or talk," App., *infra*, 8a, and held that such a claim is cognizable whenever treatment was allegedly based "solely," in the pejorative sense, on the disability, App., *infra*, 10a. But the treatment at issue was for illnesses that Hickson's spinal-cord injury caused, and the physicians could not assess his prognosis without taking that injury into account. Under the Fifth Circuit's test, that medical judgment about how to treat a disability becomes actionable discrimination the moment a plaintiff alleges that the physician took a pejorative view of the disability—here that required nothing more than the observation that an inability to walk and talk reduces quality of life. That erroneous conclusion flouts the statutes' command that disability discrimination can occur only when an individual is "otherwise qualified" absent the disability.

III. THE QUESTION PRESENTED IS IMPORTANT, AND THIS CASE IS AN EXCELLENT VEHICLE FOR RESOLVING IT.

A. This Court's intervention is warranted because the question presented raises serious federalism and practical concerns. The Fifth Circuit's decision authorizes a substantial federal incursion into core state prerogatives over healthcare. It provides an avenue for plaintiffs to recast their medical-malpractice claims as disability discrimination and circumvent the guardrails that States have imposed on malpractice claims. And it opens the federal courts to a cascade of malpractice litigation against healthcare providers that receive federal funding.

The Rehabilitation Act and ACA prohibit discrimination, not medical malpractice. The regulation of medical malpractice is reserved for the States. See *Pegram*, 530 U.S. at 235-236. That is why, as this Court explained in the context of the Americans with Disabilities Act, nothing in that statute imposes "a 'standard of care' for whatever medical services" providers render. *Olmstead* v. *L.C. ex rel. Zimring*, 527 U.S. 581, 603 n.14 (1999). The same is true of the Rehabilitation Act and ACA. See *Grzan*, 104 F.3d at 123.

But the Fifth Circuit's decision gives plaintiffs "an almost unfettered ability to re-frame claims of medical malpractice into federal claims of discrimination," "federaliz[ing] many (if not most) claims for medical malpractice." *McGugan*, 752 F.3d at 234. To do so, plaintiffs need only allege that they have received a different service solely because they are disabled—even when the disability bears on treatment decisions. For example, a

wheelchair-bound patient with a hip fracture may require transfer to a more advanced hospital. A patient with lupus may be advised by her dermatologist to avoid laser treatment because her condition makes her unusually sensitive. Or a patient with diabetes may wait longer while her physician consults a specialist about potential comorbidities. If the patient in any of those scenarios suffers an adverse result, she may accurately claim to have been treated differently because of her disability—but consideration of that disability is critical to the proper exercise of medical judgment. The Fifth Circuit's decision twists that exercise of medical judgment into potentially unlawful disability discrimination.

By inviting plaintiffs to artfully plead medical-malpractice claims as disability discrimination, the Fifth Circuit's decision also allows an end run around many attempts by States to limit medical costs by erecting safeguards in malpractice laws. For example, some States impose threshold barriers before a malpractice suit may proceed. Texas, for instance, requires a malpractice plaintiff to serve an expert report within 120 days of the defendant's answer or face dismissal. Tex. Civ. Prac. & Rem. Code § 74.351(a), (b). Louisiana requires review by a medical panel before the claim may proceed. La. Rev. Stat. Ann. § 40:1231.8(B)(1)(a)(i). Each State in the Fifth Circuit also imposes evidentiary and damages rules for malpractice claims, like requiring that a plaintiff prove the standard of care and breach through expert testimony. *Gunn* v. *McCoy*, 554 S.W.3d 645, 658 (Tex. 2018); *Samaha* v. *Rau*, 977 So. 2d 880, 884 (La. 2008); *Thomas* v. *Lewis*, 289 So. 3d 734, 739 (Miss. 2019). Each caps a plaintiff's recovery. Tex. Civ. Prac. & Rem. Code § 74.301(a) ($250,000 in noneconomic damages); La. Rev. Stat. Ann. § 40:1231.2(B)(1) ($500,000,

exclusive of future medical care); Miss. Code Ann. § 11-1-60(2)(a) ($500,000 in noneconomic damages).

A plaintiff who recasts medical-malpractice claims under the Rehabilitation Act or ACA avoids those tort-law limits. As a result, in Texas, Louisiana, and Mississippi, any plaintiff now can bypass the safeguards in medical-malpractice laws and reach discovery merely by alleging that their doctor had a "pejorative" view of the disability the doctor was treating.

This case is the poster child for that problem. Plaintiffs alleged that the same conduct—Hickson's physicians' recommendation of hospice care and do-not-resuscitate status—constituted both malpractice under Texas law and discrimination under Section 504 and the ACA. C.A. ROA 32-46. Plaintiffs' malpractice claims failed at summary judgment because they never designated an expert as required by Texas medical-malpractice law. *Gunn*, 554 S.W.3d at 658; Tex. Civ. Prac. & Rem. Code § 74.351(a), (b); App., *infra*, 46a-48a. But if the Fifth Circuit's decision stands, plaintiffs may still pursue their malpractice-disguised-as-discrimination claims on remand. They can push effectively the same malpractice theory, even though they were unable to sustain their actual malpractice claims with the expert testimony Texas law demands. And any ultimate recovery could far exceed the caps Texas imposes on malpractice claims. Tex. Civ. Prac. & Rem. Code § 74.301(a).

This will not be a one-off occurrence. More than one in four American adults reports a disability.[3] Nearly all

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[3] *CDC Data Shows Over 70 Million U.S. Adults Reported Having a Disability*, Ctrs. for Disease Control & Prevention (July 16, 2024), tinyurl.com/5dh296nb.

of the Nation's 6,100 hospitals accept Medicare and Medicaid, and they process around 35.7 million admissions each year.[4] Medicare alone pays for hospice care for more than 1.8 million patients a year, each admitted on a physician's judgment about prognosis of the kind at issue here.[5] The pool of potential plaintiffs and defendants is massive.

And that is before accounting for another set of lawsuits that already predominates in the federal courts—prisoner suits. "Medical care is consistently one of the most prominent topics in inmate litigation." Margo Schlanger, *Inmate Litigation*, 116 Harv. L. Rev. 1555, 1676 n.390 (2003). The Fifth Circuit's decision offers disabled prisoners held in facilities receiving federal funding a new path for such suits—under a much easier pleading standard than a constitutional "deliberate indifference" claim. Roughly a third or more of prisoners in the federal and state systems report a disability.[6] Indeed, some of the decisions at the center of the circuit conflict rejected prisoner suits challenging medical treatment. See *Fitzgerald*, 403 F.3d at 1136; *Dinkins*, 743 F.3d at 634. The outcome of these cases will now

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[4] *Fast Facts on U.S. Hospitals, 2026*, Am. Hosp. Ass'n (Feb. 2026), tinyurl.com/3d4v9fk8; *Fact Sheet: Medicare and Medicaid Constitute Majority of Hospital Payments*, Am. Hosp. Ass'n (Mar. 16, 2026), tinyurl.com/33vh5vks.

[5] Medicare Payment Advisory Comm'n, *Report to the Congress: Medicare Payment Policy* 297 (2026), tinyurl.com/yzcaddxc (more than 1.8 million Medicare beneficiaries received hospice care in 2024).

[6] Laura M. Maruschak et al., U.S. Dep't of Just., Bureau of Just. Stat., NCJ 252642, *Disabilities Reported by Prisoners: Survey of Prison Inmates, 2016*, at 1 (2021), tinyurl.com/y47hnxz8 (40% of state prisoners and 29% of federal prisoners reported a disability).

depend on geography. A prisoner's claim that could survive a motion to dismiss in Houston could not in New York. That disuniformity cries out for correction.

B. This case is the ideal vehicle to address whether the Rehabilitation Act and ACA authorize disability-discrimination claims based on the treatment of the underlying disability. The question presented is a clean issue of law, and no jurisdictional or prudential defects would impede this Court's review.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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