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.

On Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

BRIEF FOR RESPONDENTS

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QUESTION PRESENTED

Planned Parenthood affiliates provide essential medical care to low-income individuals through state Medicaid programs. South Carolina terminated the Medicaid provider agreement of a Planned Parenthood affiliate without cause. The affiliate and one of its patients sued under 42 U.S.C. 1983. The patient invoked the Medicaid Act's free-choice-of provider provision, which states that "any individual eligible for medical assistance" "may obtain such assistance from any institution" that is "qualified to perform the service or services required" and "undertakes to provide him such services." 42 U.S.C. 1396a(a)(23)(A).

Three times, the court of appeals has held that the free-choice-of-provider provision unambiguously confers a right that is privately enforceable under Section 1983. In its most recent decision, the court of appeals so held after faithfully applying this Court's recent decision in *Health & Hospital Corp. of Marion County* v. *Talevski*, 599 U.S. 166 (2023).

The question presented is:

Whether the Medicaid Act's free-choice-of-provider provision, 42 U.S.C. 1396a(a)(23)(A), confers a right enforceable under 42 U.S.C. 1983.

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BRIEF FOR RESPONDENTS

INTRODUCTION

Julie Edwards is insured through Medicaid. Like many Medicaid patients, she has had trouble finding a doctor who would treat her. After two doctors turned her away, she obtained care at Planned Parenthood South Atlantic (PPSAT). But then South Carolina decided to terminate PPSAT's participation in the State's Medicaid program, even though it acknowledged that PPSAT is a medically qualified provider.

The Medicaid Act does not allow that. It gives an individual covered by Medicaid the right to obtain care from any qualified and willing provider. 42 U.S.C. 1396a(a)(23)(A). The record establishes that PPSAT is a qualified and willing provider. So, as both courts below found and as petitioner no longer contests, South Carolina violated Ms. Edwards' right to obtain care from the provider of her choice. The only

question before this Court is whether Ms. Edwards can do anything about it – in particular, whether she can sue under 42 U.S.C. 1983 to vindicate this right.

The answer is yes. In *Health & Hospital Corp. of Marion County* v. *Talevski*, 599 U.S. 166, 183, 186 (2023), this Court explained that a statutory provision is enforceable under Section 1983 if it unambiguously confers an individual right on the plaintiff and there is no comprehensive federal enforcement scheme that is incompatible with individual enforcement under Section 1983.

The statute here readily meets that test. It protects a deeply personal right that is fundamental to individual dignity and autonomy – the right to choose one's doctor. Congress incorporated that right into Medicaid more than 50 years ago, using unambiguous terms: A State that participates in Medicaid "must" ensure that "any individual" insured through Medicaid "may obtain" care from any qualified and willing provider. 42 U.S.C. 1396a(a)(23)(A).

That is precisely the type of individual-focused, rights-creating language necessary to confer an individual right. It is materially similar to the provisions in *Talevski* that confer individual rights on nursing-home residents. Indeed, as Judge Wilkinson wrote for the Fourth Circuit, if this language "does not suffice to provide a right of action, then it is hard to conceive of any text" that would. Pet. App. 35a. The unambiguous statutory text resolves this case because petitioner makes no argument that an alternative, incompatible federal enforcement scheme shows an intent to preclude enforcement under Section 1983.

Resisting that conclusion, petitioner makes a variety of arguments that this Court and Congress already have rejected. Petitioner notes that the free-

choice-of-provider provision does not use the word "right," but this Court has repeatedly rejected a magic-words requirement. Petitioner argues that a state plan requirement cannot be privately enforceable, but Congress expressly rejected that argument in 42 U.S.C. 1320a-2. And petitioner's substantial-compliance argument is flatly inconsistent with *Talevski*, because the statute there also allowed federal funding to continue in cases of substantial compliance, yet the Court found that it unambiguously conferred privately enforceable rights on nursing-home residents. Finally, petitioner renews the argument that the State has an unfettered right to deem a provider unqualified for any reason it wishes, but this Court declined to grant certiorari on that question.

This Court should affirm.

STATUTORY PROVISIONS INVOLVED

Relevant statutory provisions are reproduced in the appendix to this brief. App., *infra*, 1a-6a.

STATEMENT

A. Legal Background

1. Medicaid is the national health insurance program for persons of limited financial means. Pet. App. 5a. It provides federal funding for medical care for children; families living in poverty; people who are elderly, blind, or disabled; and pregnant women. See 42 U.S.C. 1396d(a). Medicaid is an important component of the national healthcare system; over 72 million people currently are enrolled in Medicaid. See Ctrs. for Medicare & Medicaid Servs., *October 2024 Medicaid & CHIP Enrollment Data Highlights* (Jan. 15, 2025), https://perma.cc/3L9U-ZBFY.

Medicaid is a cooperative federal-state program. Pet. App. 5a. It "offers the States a bargain: Congress

provides federal funds in exchange for the States' agreement to spend them in accordance with congressionally imposed conditions." *Armstrong* v. *Exceptional Child Ctr., Inc.*, 575 U.S. 320, 323 (2015). States prepare plans and submit them for federal approval. 42 U.S.C. 1396-1. Within broad federal guidelines, a State decides who is eligible for Medicaid, which services are covered, and how much it will reimburse providers for those services. Pet. App. 84a-85a; see 42 U.S.C. 1396a(a)(10)(A)(ii), (a)(17).

The Medicaid Act authorizes the federal government to withhold federal funding to a State that "fail[s] to comply substantially" with federal requirements. 42 U.S.C. 1396c; see 42 C.F.R. 430.12(c). That remedy is rarely invoked because of the severe and immediate harm it would cause to beneficiaries. See Kaiser Family Found., *Focus on Health Reform: A Guide to the Supreme Court's Decision on the ACA's Medicaid Expansion* 1 (Aug. 2012), https://perma.cc/SZ54-XPE4.

2. One important requirement in the Medicaid Act is the free-choice-of-provider requirement. It states that a State's Medicaid plan "must" provide that "any individual eligible for medical assistance * * * may obtain such assistance" from any provider who is "qualified to perform the service or services required" and "who undertakes to provide him such services." 42 U.S.C. 1396a(a)(23)(A).

Congress recognized that medical decisions are intensely personal and that the doctor-patient relationship is an important one. Pet. App. 33a. It enacted the free-choice-of-provider provision to ensure that Medicaid patients, like everyone else, can choose their own doctor. *Id.* at 41a; H. Rep. No. 544, 90th Cong., 1st Sess. 122 (1967). Congress specifically enacted this provision in response to some States' efforts to

restrict Medicaid patients' choice of provider. Pet. App. 43a.

Congress then provided extra protections for the right to choose one's provider in the family-planning context. It provided that, even when a State uses a managed-care system, the State cannot "restrict the choice of the qualified person from whom the individual may receive" family-planning services. 42 U.S.C. 1396a(a)(23)(B); see 42 U.S.C. 1396n(b) (State may not "restrict the choice of the individual in receiving [family-planning] services").

B. Factual Background

1. South Carolina's citizens have an immense need for Medicaid services. One-fifth of all residents are insured through Medicaid, including about one-third of the State's rural residents. See Kaiser Family Found., *Health Care in South Carolina* (Oct. 2024), https://perma.cc/JCK7-5H6F (Kaiser, *Health Care*); FamiliesUSA, *Cutting Medicaid Would Hurt Rural America* (Mar. 23, 2017), https://perma.cc/HDJ6-M84Q. The State's population has a higher-than-average rate of key health problems, such as obesity, diabetes, and cardiovascular disease. Kaiser, *Health Care*.

Medicaid beneficiaries often face significant barriers to obtaining care, particularly in South Carolina. Twenty-five percent of state residents live in medically underserved areas, meaning areas designated by the U.S. Department of Health and Human Services as having too few healthcare providers to adequately serve the population. Univ. of S.C. Inst. for Families in Soc'y, *S.C. Legislative Safety-Net Proviso Report* 4, 17 (2022), https://perma.cc/TU8T-BVC4. All but 6 of South Carolina's 46 counties have a shortage of primary care providers. See Rural Health Info. Hub,

Health Professional Shortage Areas: Primary Care, by County, October 2024 – South Carolina (Oct. 2024), https://perma.cc/7ZLP-V45S.

For a person insured through Medicaid, finding a qualified and willing provider can be difficult. Except in emergencies, no medical provider is required to treat Medicaid patients. See 42 U.S.C. 1396a(a)(23)(A). Many healthcare providers do not treat Medicaid patients. See Diane Alexander & Molly Schnell, *The Impacts of Physician Payments on Patient Access, Use, and Health*, 3 Am. Econ J. 142, 146 (2024). And many healthcare providers that do treat Medicaid patients are so overwhelmed that they are not accepting new patients. See Medicaid & CHIP Payment & Access Comm'n, *Physician Acceptance of New Medicaid Patients: Findings from the National Electronic Health Records Survey* 3-4 (June 2021), https://perma.cc/7GZE-62LM.

2. For four decades, respondent PPSAT and its predecessors have provided compassionate, high-quality care to South Carolina residents, including those with low incomes or disabilities. Pet. App. 7a, 58a. PPSAT operates two health centers in the State, one in Charleston and one in Columbia. *Id*. at 6a. Both are in medically underserved communities. J.A. 2. They serve hundreds of Medicaid patients each year. Pet. App. 7a, 87a.

PPSAT's health centers provide essential medical care through Medicaid. They offer a wide range of services, including physical exams; cancer screenings; contraception; pregnancy testing and counseling; and screenings for conditions such as diabetes, depression, anemia, high cholesterol, thyroid disorders, and high blood pressure. Pet. App. 6a, 69a; J.A. 19-20; see PPSAT, *About This Health Center* (2025), https://perma.cc/JP6P-2RNH. The health centers also

provide abortion services outside of Medicaid to the limited extent allowed under South Carolina law. Pet. App. 6a-7a.[1]

Patients insured through Medicaid choose PPSAT for many reasons. PPSAT provides non-judgmental, high-quality medical care. See Pet. App. 6a-7a. It also has designed its services to help low-income patients overcome barriers to accessing care. *Id.* at 7a. For example, PPSAT offers extended hours and flexible scheduling; same-day appointments and short wait times; comprehensive contraceptive care in a single appointment; and interpreter services. *Ibid.*

Throughout this litigation, petitioner has "agree[d]" that PPSAT "is perfectly competent" to provide healthcare. Pet. App. 41a. Nonetheless, petitioner's brief cites new, extra-record materials to attempt to impugn the care offered by PPSAT. That effort is both inappropriate and wrong. Petitioner is wrong to say (Br. 9-10) that PPSAT offers only limited pregnancy-related services and treats only a small number of conditions; PPSAT offers prenatal and postpartum services, and its board-certified physicians and other healthcare professionals treat most of the conditions that petitioner lists. See PPSAT, *About This Health Center* (2025), https://perma.cc/JP6P-2RNH. Petitioner mentions (Br. 8) a state investigation of PPSAT, but fails to note that it was resolved with a minor fine. See S.C. Bd. of Health & Envt'l Control, *Administrative Orders and Consent Orders*

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[1] Medicaid does not cover abortion except in cases of rape, incest, or a threat to the patient's life, Pet. App. 6a-7a; see Further Consolidated Appropriations Act, 2024, Pub. L. No. 118-47, §§ 506-507, 138 Stat. 703, and state law separately prohibits PPSAT from using any state funds for abortion, S.C. Code Ann. § 44-41-90(C).

Issued by Health Regulation 3 (Dec. 10, 2015), https://perma.cc/4X3J-6D8A. And petitioner's suggestion (Br. 10) that a Medicaid patient should have to receive care at the State's favored provider (Waverly Women's Health Center) ignores Congress's command that States cannot dictate a person's choice of doctor. 42 U.S.C. 1396a(a)(23)(A).

3. Respondent Julie Edwards is insured through Medicaid. Pet. App. 7a. She suffers from diabetes. *Id.* at 44a. Because complications from diabetes would make it dangerous for her to carry a pregnancy to term, she sought access to safe and effective birth control. *Ibid.*; see J.A. 30-31. After having difficulty finding a doctor who would treat her, she obtained care at PPSAT. Pet. App. 7a, 44a. PPSAT doctors provided her with her desired birth control and also informed her that her blood pressure was elevated, so she could obtain follow-up care. *Ibid.*; see J.A. 32.

Ms. Edwards was impressed with the quality of PPSAT's services. J.A. 32-33. She appreciated that PPSAT provided judgment-free, respectful care and made it easy to schedule appointments. *Ibid.* She intends to obtain her future gynecological and reproductive healthcare there. Pet. App. 7a; see J.A. 33, 64.

4. In July 2018, South Carolina's Department of Health and Human Services (DHHS) terminated PPSAT's participation in the state Medicaid program. Pet. App. 8a, 70a. It did so based on two executive orders, where the Governor withdrew funding from any organization that provides abortion. *Id.* at 8a, 88a; see *id.* at 149a-153a, 157a-160a.

DHHS did not find that PPSAT is unqualified to provide care. Pet. App. 87a. Instead, it terminated PPSAT's participation in Medicaid "solely because [PPSAT] performed abortions outside of the Medicaid

program." *Ibid.* As a result, PPSAT's health centers immediately had to begin turning away Medicaid patients. *Id.* at 88a.

C. Procedural History

1. Respondents sued under 42 U.S.C. 1983 to challenge the State's termination decision. Pet. App. 8a. Ms. Edwards alleged that the termination violated her free-choice-of-provider right under the Medicaid Act. *Ibid.* Separately, PPSAT alleged that the termination violated its Fourteenth Amendment rights; that claim was not litigated and is not before this Court. *Id.* at 8a n.1. Respondents sought preliminary injunctive relief, so that Ms. Edwards and other patients could continue to receive care from PPSAT. *Id.* at 8a.

PPSAT also filed a state administrative challenge to the termination decision. J.A. 59. It did not pursue that challenge because South Carolina told the district court that doing so would be "futile," J.A. 56, since "there is no relief that [the state hearing officer] could grant given the directive of the Governor" to exclude PPSAT from the State's Medicaid program, J.A. 53.

The district court entered a preliminary injunction. Pet. App. 146a. It first held that the Medicaid Act's free-choice-of-provider requirement is enforceable under Section 1983 because the statute "unambiguously confers a right" on Medicaid patients to "obtain assistance from any qualified and willing provider." *Id.* at 134a. The court then concluded that petitioner likely violated this requirement by terminating PPSAT's Medicaid participation without cause. *Id.* at 138a-141a. The court found it "undisputed" that PPSAT is "professionally competent" to provide medical care. *Id.* at 138a-139a. It also rejected petitioner's

argument that including PPSAT in Medicaid would indirectly subsidize abortion outside of Medicaid, explaining that "PPSAT is reimbursed through the Medicaid program on a fee-for-service basis for covered services," and "Medicaid reimbursement rates in South Carolina do not even fully cover the cost of the Medicaid services PPSAT provides." *Id.* at 139a-140a.

The court of appeals affirmed. Pet. App. 80a-125a. It agreed that "the free-choice-of-provider provision unambiguously gives Medicaid-eligible patients an individual right" enforceable under Section 1983. *Id.* at 96a (internal quotation marks omitted). It also held that Ms. Edwards was likely to succeed on the merits, because the free-choice-of-provider provision forbids a State from excluding a qualified provider, and South Carolina admitted that "PPSAT is professionally qualified." *Id.* at 107a.

This Court denied certiorari. *Baker* v. *Planned Parenthood S. Atl.*, 141 S. Ct. 550 (2020) (No. 19-1186).

2. The district court granted summary judgment to respondents and entered a permanent injunction. Pet. App. 66a-79a. It reaffirmed that the Medicaid Act's free-choice-of-provider provision is enforceable under Section 1983 and determined that petitioner violated that provision by terminating PPSAT's Medicaid participation without cause. *Id.* at 74a.

The court of appeals affirmed. Pet. App. 38a-64a. It explained that the free-choice-of-provider provision is enforceable under Section 1983 because it "unmistakably evinces Congress's intention to confer on Medicaid beneficiaries a right to the free choice of their provider." *Id.* at 57a-62a. The court noted that petitioner no longer contested the merits: Petitioner "d[id] not challenge the district court's determination

(and our own previous conclusion) that South Carolina violated" the free-choice-of-provider provision "by terminating Planned Parenthood's Medicaid provider agreement." *Id.* at 51a & n.1.

3. Petitioner filed a petition for a writ of certiorari. While that petition was pending, this Court decided *Health & Hospital Corp. of Marion County* v. *Talevski*, 599 U.S. 166, 174 (2023), holding that a nursing-home resident can sue under Section 1983 to enforce two provisions in the Federal Nursing Home Reform Act, 42 U.S.C. 1396r(c)(1)(A)(ii) and 1396r(c)(2)(A).

The Court then granted the petition in this case, vacated the judgment, and remanded for further consideration in light of *Talevski*. *Kerr* v. *Planned Parenthood S. Atl.*, 143 S. Ct. 2633 (2023) (No. 21-1431).

4. The court of appeals affirmed. Pet. App. 1a-36a. "[W]ith the benefit of *Talevski*'s guidance," the court again held that the free-choice-of-provider provision confers a right enforceable under Section 1983. *Id.* at 12a-13a.

The court of appeals first explained that the provision unambiguously confers an individual right on Medicaid patients. Pet. App. 24a-26a. "Like the text at issue in *Talevski*," the provision here "speak[s] 'in terms of the person benefited,' and ha[s] an 'unmistakable focus on the benefited class.'" *Id.* at 25a (quoting *Talevski*, 599 U.S. at 186). It uses rights-creating language to "guarantee[] them a choice" of any qualified medical provider "free from state interference." *Ibid.* The court then explained that the Medicaid Act does not provide a comprehensive enforcement scheme that forecloses private enforcement. *Id.* at 32a-33a. The court had previously so held, and

petitioner had "not ask[ed] [the court] to revisit this question [i]n this appeal." *Id*. at 33a.

Finally, the court of appeals reaffirmed that petitioner violated Ms. Edwards' free-choice-of-provider right. Pet. App. 33a-34a. The court found no justification for the termination, emphasizing that petitioner "has not contested" "during the long path of this litigation" that PPSAT "is professionally qualified to provide the care that the plaintiff seeks." *Id*. at 33a.

SUMMARY OF ARGUMENT

Medicaid's free-choice-of-provider provision, 42 U.S.C. 1396a(a)(23)(A), creates a right that is privately enforceable under Section 1983.

A. In *Health & Hospital Corp. of Marion County* v. *Talevski*, 599 U.S. 166, 183 (2023), the Court reaffirmed its "established method for ascertaining" whether a statute sets out a right enforceable under Section 1983. First, the Court analyzes the text of the provision at issue to decide whether "Congress has 'unambiguously conferred' 'individual rights upon a class of beneficiaries' to which the plaintiff belongs." *Ibid.* (quoting *Gonzaga Univ.* v. *Doe*, 536 U.S. 273, 283, 285-286 (2002)). Second, the Court determines if Congress elsewhere indicated an intent to preclude Section 1983 enforcement, either by forbidding use of Section 1983 or by creating a comprehensive enforcement scheme that is "incompatible" with private enforcement. *Id.* at 186.

B. The free-choice-of-provider provision unambiguously confers an individual right on Medicaid patients that is enforceable under Section 1983. This provision, which has been a part of Medicaid for over 50 years, protects an important individual right – the freedom to choose one's own healthcare provider.

That right "could not be more personal, nor more precious." Pet. App. 33a.

The language Congress chose reflects that. The provision is phrased in terms of individual Medicaid patients ("any individual eligible for medical assistance") and it uses mandatory, rights-creating language (the State plan "must" "provide" that each Medicaid beneficiary "may obtain" care from any qualified and willing provider). 42 U.S.C. 1396a(a)(23)(A). This is not merely conferral of a benefit on Medicaid patients, but recognition of an intensely personal right. This language is quite similar to the nursing-home provisions at issue in *Talevski*, which are privately enforceable, and unlike the provision about disclosure of educational records in *Gonzaga*, which spoke only of institutional policy and practice and said nothing about individual rights. Most courts of appeals have held that the free-choice-of-provider provision is privately enforceable, and for nearly 20 years, the federal government agreed.

C. Petitioner's principal argument is that the provision here is not privately enforceable because it does not use certain words, such as "right" or "no person shall." This Court has repeatedly held that Congress is not required to use magic words to make its intent clear. In two of the three instances where this Court held that a Spending Clause statute creates a privately enforceable right, the statute did not use the word "right" at all. Here, the words Congress chose – the state plan "must" provide that "any individual eligible for medical assistance" under Medicaid "may obtain" care from his or her chosen provider – establish a right to receive that care.

Petitioner alternatively argues that Congress must say that "no person shall" be denied a certain right in order to unambiguously confer that right. But

several statutes that this Court has found create privately enforceable rights do not use that phrasing, and (contrary to petitioner's suggestion) the Bill of Rights does not uniformly use that phrasing either. There are many ways to create a right, and it is up to Congress to decide what language to use.

Petitioner argues that the free-choice-of-provider provision is "two steps removed" from beneficiaries because it speaks only to the federal government. That is flat wrong; the text refers directly to the rights-holder (the individual Medicaid recipient) and the actor that could threaten those rights (the State). The same was true of the provisions in *Talevski*, which the Court found confer privately enforceable rights.

D. The free-choice-of-provider provision's context and history confirm that Congress intended to permit individual enforcement. This is not a run-of-the-mill state plan requirement; it is Congress's recognition of an important, inherently personal right. It is included in both Medicare and Medicaid. Congress added it to Medicaid after States attempted to restrict Medicaid patients' choice of providers, and Congress has repeatedly protected the right in the context here (family planning).

Petitioner focuses on the provision's inclusion in a list of state plan requirements. But that is the natural place for Congress to set out this right, because it is a condition on federal funding. Further, in 42 U.S.C. 1320a-2, Congress expressly rejected the argument that a state plan requirement cannot confer a right enforceable under Section 1983.

Petitioner argues that the free-choice-of-provider provision does not create an individual right because Congress allowed funding to continue in cases of substantial compliance. But whether Congress created a

right is distinct from how Congress intended for the right to be enforced. The argument also incorrectly assumes that Congress intended to tolerate individual violations instead of allowing beneficiaries to sue under Section 1983. And the argument cannot be reconciled with *Talevski*, because the provisions there also allow funding to continue in cases of substantial compliance, yet the Court held that they confer privately enforceable rights. Finally, the experience in the federal courts has disproved petitioner's assertion that allowing private enforcement of the free-choice-of-provider provision will open the litigation floodgates.

E. Because the free-choice-of-provider provision unambiguously confers an individual right, it is presumptively enforceable under Section 1983. Petitioner does not try to overcome that presumption by demonstrating that the Medicaid Act contains a comprehensive enforcement scheme that is incompatible with Section 1983 enforcement.

Instead, petitioner argues that alternative enforcement mechanisms show that Congress did not intend to create a right in the first instance. But those are two separate questions, as *Talevski* explained. Anyway, the possibility of other enforcement does not show Congress's intent to preclude Section 1983 enforcement here. The federal government can withhold funds, but only in certain circumstances, and that remedy does not vindicate individual rights. A Medicaid recipient can bring a state administrative proceeding, but only to challenge a claim denial, not to challenge a provider's exclusion. A provider can challenge its Medicaid exclusion in a state proceeding, but that does not vindicate the individual's right. And here, the State conceded that any state administrative proceeding would be futile. The limited nature of these alternative remedies confirms that Congress

expected Section 1983 enforcement for individual violations.

F. There is no question that PPSAT is a qualified and willing provider and that petitioner violated Ms. Edwards' free-choice-of-provider right by terminating PPSAT's participation in the state Medicaid program.

Petitioner argues that the State has unfettered discretion to disqualify a provider for any reason it wishes. But the Court declined to grant certiorari on that question, and so the question is not before the Court. Further, the court of appeals' merits holding is plainly correct. The statute asks whether the provider is "qualified to perform the service or services required," 42 U.S.C. 1396a(a)(23)(A), which means professionally qualified to provide medical services, Pet. App. 107a. Petitioner's argument that "qualified" means whatever the State says it means would make the free-choice-of-provider right meaningless.

South Carolina violated Ms. Edwards' free-choice-of-provider right. Congress intended for her to seek redress through Section 1983. This Court should affirm.

ARGUMENT

THE FREE-CHOICE-OF-PROVIDER PROVISION UNAMBIGUOUSLY CONFERS AN INDIVIDUAL RIGHT ENFORCEABLE UNDER SECTION 1983

A. A Provision Is Enforceable Under Section 1983 When Congress Unambiguously Confers An Individual Right And Does Not Otherwise Preclude Individual Enforcement

1. Section 1983 authorizes individuals to sue state officials for violating their federal rights. It provides that any person within the jurisdiction of the United States may bring a civil action against any person

who, "under color of" state law, "depriv[ed]" the individual "of any rights, privileges, or immunities secured by the Constitution and laws" of the United States. 42 U.S.C. 1983. The term "laws" encompasses all federal laws, *Maine* v. *Thiboutot*, 448 U.S. 1, 4-8 (1980), including those Congress enacted using its Spending Clause authority, *Health & Hosp. Corp. of Marion Cnty.* v. *Talevski*, 599 U.S. 166, 172, 180 (2023).

Section 1983 "does not provide an avenue for relief every time a state actor violates a federal law." *City of Rancho Palos Verdes* v. *Abrams*, 544 U.S. 113, 119 (2005). Instead, to sue under Section 1983, a person "must assert the violation of a federal *right*, not merely a violation of federal *law*." *Blessing* v. *Freestone*, 520 U.S. 329, 340 (1997).

2. Over several decades, this Court has "crafted a test for determining whether a particular federal law actually secures rights for § 1983 purposes." *Talevski*, 599 U.S. at 175. That test has two steps.

First, the Court asks whether the statute at issue "'unambiguously confer[s]' 'individual rights upon a class of beneficiaries' to which the plaintiff belongs." *Talevski*, 599 U.S. at 183 (quoting *Gonzaga Univ.* v. *Doe*, 536 U.S. 273, 283, 285-286 (2002)). A provision does so when it is "'phrased in terms of the persons benefited,'" "contain[s] 'rights-creating,' individual-centric language," and has "'an unmistakable focus on the benefited class.'" *Ibid.* (quoting *Gonzaga*, 538 U.S. at 284, 287). A provision does not create individual rights when it has "an aggregate, not individual, focus," lacks "rights-creating language," and "serve[s] primarily to direct the [Federal Government's] distribution of public funds." *Id.* at 183-184 (quoting *Gonzaga*, 536 U.S. at 290). If a statute "unambiguously

secures" an individual right, then it is "presumptively enforceable" under Section 1983. *Id.* at 186.

Second, the Court asks whether Congress otherwise has precluded individual enforcement of the right under Section 1983. *Talevski*, 599 U.S. at 186-188. That occurs when Congress has "expressly forbid[den]" resort to Section 1983 or has created an alternative enforcement scheme that is so "incompatible with individual enforcement under § 1983" that it must be "the exclusive avenue" for asserting the right. *Id.* at 186-187 (internal quotation marks omitted). The mere presence of an alternative federal enforcement scheme is not enough; rather, that scheme must be "incompatible" with private enforcement. *Id.* at 188-189.

As the court of appeals recognized, courts are not "at liberty to imply private rights of action willy-nilly." Pet. App. 103a. That is especially true in the context of Spending Clause legislation, where the "typical remedy" for state noncompliance is terminating federal funds. *Gonzaga*, 536 U.S. at 280 (internal quotation marks omitted). But where Congress makes its intention to create an individual right "unmistakably clear," *id.* at 286, States have "clear notice" of their obligations, *Talevski*, 599 U.S. at 180 n.8. And courts are "bound to respect" Congress's judgment. Pet. App. 60a. Refusing to permit Section 1983 enforcement of a right Congress intended to create is just as much a separation-of-powers problem as permitting enforcement of a right Congress did not intend to create. *Id.* at 35a.

B. The Text Of The Free-Choice-Of-Provider Provision Unambiguously Confers An Individual Right On Medicaid Beneficiaries

1. The Medicaid Act's free-choice-of-provider provision requires States that participate in Medicaid to ensure that Medicaid patients can obtain care from any qualified and willing provider:

> A State plan for medical assistance must * * * provide that * * * any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required * * * who undertakes to provide him such services * * * .

42 U.S.C. 1396a(a)(23)(A).

This provision protects an important, uniquely personal right – the right of a person needing medical care to choose his or her provider. Congress recognized that this right is fundamental to patients' autonomy and dignity. *E.g.*, S. Rep. No. 744, 90th Cong., 1st Sess. 183 (1967). It has been a feature of the Medicaid Act since nearly the beginning. Pet. App. 43a; see Social Security Amendments Act of 1967, Pub. L. No. 90-248, § 227, 81 Stat. 903. And Congress reiterated the importance of this right in the family-planning context, providing that even in a managed-care system, a State cannot "restrict the choice of the qualified person from whom the individual may receive" family-planning services. 42 U.S.C. 1396a(a)(23)(B) (cross-reference to 42 U.S.C. 1396d(a)(4)(C)); see 42 U.S.C. 1396n(b).

2. The free-choice-of-provider provision unambiguously confers an individual right on Medicaid recipients.

To begin with, this provision expressly refers to individual Medicaid recipients to confer an individual, personal right. It ensures that "any *individual* eligible for medical assistance" can freely choose any healthcare provider "who undertakes to provide *him* such services." 42 U.S.C. 1396a(a)(23)(A) (emphases added). The repeated references to an individual Medicaid recipient show that the statutory language is "phrased in terms of the persons benefited," with an "individual" rather than "aggregate" focus. *Gonzaga*, 536 U.S. at 284, 287-288 (internal quotation marks omitted). "[B]y adopting as its benchmark whether 'the needs of any particular person have been satisfied,'" Congress "left no doubt that it intended to guarantee each Medicaid recipient's free choice of provider." Pet. App. 97a (quoting *Gonzaga*, 536 U.S. at 288).

Further, the provision uses mandatory, "explicit rights-creating terms." *Gonzaga*, 536 U.S. at 284. The right is set out in plain terms: "[A]ny individual * * * may obtain" medical services from "any" provider that is "qualified to perform the service or services" and that "undertakes to provide him such services." 42 U.S.C. 1396a(a)(23)(A). This language protects a very personal choice – the "ability to decide who treats us at our most vulnerable." Pet. App. 33a. And a State "must" provide this right in its state plan to participate in Medicaid. 42 U.S.C. 1396a(a)(23)(A). As this Court has recognized, this statutory language "gives recipients the right to choose among a range of qualified providers, without government interference." *O'Bannon* v. *Town Ct. Nursing Ctr.*, 447 U.S. 773, 785 (1980) (emphasis omitted).

The additional provisions addressing the free-choice-of-provider right in the family-planning context reinforce this conclusion. Immediately after

conferring the free-choice-of-provider right in Section 1396a(a)(23)(A), Congress addressed family-planning services in Section 1396a(a)(23)(B). It stated that, even if a State uses a managed-care system, it "shall not restrict the choice of the qualified person from whom the individual may receive [family-planning] services." 42 U.S.C. 1396a(a)(23)(B); see 42 U.S.C. 1396n(b) (State may not "restrict the choice of an individual" in receiving family-planning services). That is, in Section 1396a(a)(23)(B), Congress referred to the right in Section 1396a(a)(23)(A) as "the choice" of qualified provider. The references to individual "choice" make clear that Congress was conferring an individual right.

Congress's use of individual-focused, rights-creating language here is unsurprising. The ability to choose one's healthcare provider is so fundamental to patient dignity and autonomy that a person would ordinarily describe it as a "right." See Pet. App. 33a. "Doctors help patients make deeply personal decisions," and "candor is crucial." *National Inst. of Fam. & Life Advs.* v. *Becerra*, 585 U.S. 755, 771 (2018) (internal quotation marks omitted). Patients who are not comfortable with their healthcare providers will not share the information needed to obtain appropriate medical care. Doctors provide medical care to each individual based on that person's particular medical needs and history; they do not provide medical care in the aggregate. So of course this provision is written in individual, rights-creating terms.

3. The free-choice-of-provider provision is like the two provisions of the Federal Nursing Home Reform Act (FNHRA) that this Court found privately enforceable in *Talevski*. The first provision states that a federally funded nursing facility "must protect and promote the rights of each resident," including "[t]he

right to be free from" unnecessary "physical or chemical restraints." 42 U.S.C. 1396r(c)(1)(A)(ii). The second states that the nursing facility "must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility" unless certain preconditions are met, including "notify[ing] the resident" and the resident's family members. 42 U.S.C. 1396r(c)(2)(A)-(B). All Justices agreed that those provisions unambiguously confer individual rights. See 599 U.S. at 184-186 (majority opinion); *id.* at 230-231 (Alito, J., dissenting).

The free-choice-of-provider provision has the same key features as those FNHRA provisions. In both cases, the text "focus[es] on" the "rights bearers," *Talevski*, 599 U.S. at 185 – in FNHRA, "each resident" of the nursing-home facilities, 42 U.S.C 1396r(c)(1)(A), (c)(2), and here, "any individual eligible for medical assistance," 42 U.S.C. 1396a(a)(23)(A). Both use mandatory, rights-creating language. The FNHRA provisions give residents a "right to be free from" chemical restraints, 42 U.S.C. 1396r(c)(1)(A)(ii), and say that nursing homes "must" provide notice before a transfer or discharge, 42 U.S.C. 1396r(c)(2)(A). The free-choice-of-provider provision similarly instructs that state plans "must" provide that individual Medicaid beneficiaries "may obtain" care from their providers of choice. 42 U.S.C. 1396a(a)(23)(A). These are personal rights for individuals related to their medical care, rather than generalized requirements for nursing homes or state Medicaid plans.

Both the FNHRA provisions and the free-choice-of-provider provision are directed at the entities "that must respect and honor [the] statutory rights," *Talevski*, 599 U.S. at 185 – for FNHRA, "the Medicaid-participant nursing homes," *ibid.*, and here, the "State" that administers a Medicaid program, 42 U.S.C.

1396a(a)(23)(A). But the "necessary focus" of the provisions remains the individual beneficiaries. *Talevski*, 599 U.S. at 185. Just as the FNHRA provisions set out privately enforceable rights for nursing-home residents, the free-choice-of-provider provision sets out a privately enforceable right for Medicaid patients.

4. In contrast, the free-choice-of-provider provision is very different from the statute in *Gonzaga*, which does not confer privately enforceable rights.

Gonzaga involved a provision of the Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. 1232g, that prohibits nonconsensual disclosure of education records. 536 U.S. at 279. It states: "No funds shall be made available * * * to any educational agency or institution which has a policy or practice of permitting the release of education records * * * of students without the written consent of their parents." 20 U.S.C. 1232g(b)(1). That provision, unlike the free-choice-of-provider provision, is not phrased in terms of the putative rights bearers – there, the students and their parents. *Gonzaga*, 536 U.S. at 287. Nor is it directed to the entity that must respect the asserted right – the educational institution. Instead, it "speak[s] only to the Secretary of Education" who directs federal funds, and thus is "two steps removed from the interests of individual students and their parents." *Ibid.*

The FERPA provision also has an aggregate focus, rather than an individual one. It addresses "institutional policy and practice, not individual instances of disclosure," and thus is "not concerned with whether the needs of any particular person have been satisfied." *Gonzaga*, 536 U.S. at 288 (internal quotation marks omitted). The free-choice-of-provider provision, in contrast, is concerned with whether an

individual Medicaid beneficiary is able to "obtain" medical care from the particular provider "who undertakes to provide *him* such services." 42 U.S.C. 1396a(a)(23)(A) (emphasis added). The stark contrast between the FERPA provision and the free-choice-of-provider provision confirms that the provision here confers an individual right.[2]

5. The court of appeals faithfully applied this Court's precedents and correctly concluded that the free-choice-of-provider provision is privately enforceable under Section 1983. The majority of courts of appeals that have considered the question agreed.[3] So did the federal government, which administers the Medicaid program. In an unbroken line of briefs over nearly 20 years, the United States repeatedly stated that the free-choice-of-provider provision is privately enforceable under Section 1983.[4] It reaffirmed that

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[2] Petitioner also cites (Br. 31-32) *Universities Research Association* v. *Coutu*, 450 U.S. 754 (1981). The statute there required certain government contracts to "contain a provision stating the minimum wages to be paid various classes of laborers and mechanics." 40 U.S.C. 276a(a) (1980). That is very different from the statute here, because it lacks an individual focus and does not confer an individual right; it refers to workers as a class and does not guarantee any particular wage.

[3] See *Planned Parenthood of Kan. & Mid-Mo.* v. *Andersen*, 882 F.3d 1205, 1229 (10th Cir. 2018); *Planned Parenthood Ariz. Inc.* v. *Betlach*, 727 F.3d 960, 966-968 (9th Cir. 2013); *Planned Parenthood of Ind., Inc.* v. *Commissioner of Ind. State Dep't of Health*, 699 F.3d 962, 974-975 (7th Cir. 2012); *Harris* v. *Olszewski*, 442 F.3d 456, 461-462 (6th Cir. 2006); but see *Planned Parenthood of Greater Tex. Fam. Plan. & Preventative Health Servs., Inc.* v. *Kauffman*, 981 F.3d 347, 358 (5th Cir. 2020) (en banc); *Does* v. *Gillespie*, 867 F.3d 1034, 1046 (8th Cir. 2017).

[4] See U.S. Br. at 7-9, *Planned Parenthood of Gulf Coast* v. *Gee*, 876 F.3d 699 (5th Cir. 2017) (filed Feb. 17, 2016); U.S. Br. at 21-24, *Betlach*, *supra* (filed Feb. 15, 2013); U.S. Br. at 22-31,

position in *Talevski*: The free-choice-of-provider requirement "confers rights enforceable under Section 1983 because it uses the kind of individually focused terminology that unambiguously confers an individual entitlement under the law." U.S. Br. at 22 n.5, *Talevski*, *supra* (internal quotation marks and brackets omitted).

Now the federal government has made an abrupt about-face, with no real explanation. See, *e.g.*, *Encino Motorcars, LLC* v. *Navarro*, 579 U.S. 211, 222 (2016) (expressing skepticism of an unexplained change in position). The federal government had it right before: The free-choice-of-provider provision creates a privately enforceable right.

C. Petitioner's And The Federal Government's Textual Arguments Lack Merit

1. Petitioner's primary argument (Br. 20-27) is that the free-choice-of-provider provision does not create individual rights because it does not use the word "right" or the phrase "no person shall."

This Court has repeatedly held that Congress does not have to use any magic words to convey its intent. *E.g.*, *Henderson ex rel. Henderson* v. *Shinseki*, 562 U.S. 428, 436 (2011) (Congress "need not use magic words in order to speak clearly" that a rule is jurisdictional); *FAA* v. *Cooper*, 566 U.S. 284, 291 (2012) ("We have never required that Congress use magic words" to abrogate sovereign immunity). Even when a clear-statement rule applies, Congress is not required to use any particular wording. *MOAC Mall Holdings LLC v. Transform Holdco LLC*, 598 U.S. 288, 298 (2023). Rather, "the clarity of each statute must be

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Planned Parenthood of Ind., *supra* (filed Sept. 6, 2011); U.S. Br. at 22-30, *Harris*, *supra* (filed Nov. 23, 2005).

evaluated on its own terms." *Department of Agric. Rural Develop. Rural Hous. Serv.* v. *Kirtz*, 601 U.S. 42, 52 (2024) (internal quotation marks omitted). The reason is straightforward: to respect the separation of powers. It is Congress's job to write federal laws; federal courts have "neither the desire nor the power" to tell Congress which words it must use. Pet. App. 26a.

There is nothing magic about the word "right." In two of the three cases where this Court found that Spending Clause provisions created privately enforceable rights, the statutes did not use the word "right" at all. See *Wilder* v. *Virginia Hosp. Ass'n*, 496 U.S. 498, 513-515 (1990) (addressing 42 U.S.C. 1396a(a)(13)(A) (1982)); *Wright* v. *City of Roanoke Redevelopment & Hous. Auth.*, 479 U.S. 418, 429-432 (1987) (addressing 42 U.S.C. 1437a(a) (1982)).[5] Only one of the two provisions in *Talevski* used "right" in the operative text. 42 U.S.C. 1396r(c)(1)(A)(ii).

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[5] Although the *Gonzaga* Court rejected the suggestion in *Wilder* and *Wright* that something "short of an unambiguously conferred right" could be enforceable under Section 1983, it reaffirmed the holdings in both cases (that the provisions there were privately enforceable). 536 U.S. at 280-281, 283, 288 n.6; see *Armstrong*, 575 U.S. at 330 n.*. Petitioner attempts to limit those holdings (Br. 46, 50) to cases that involve "concrete monetary entitlement[s]." 536 U.S. at 288 n.6. But *Gonzaga* did not limit the holdings that way; the quoted language merely describes the type of rights at issue in those cases.

Petitioner urges the Court (Br. 50-52) to overrule *Wilder*, *Wright*, and *Blessing*. But the *Talevski* Court left their holdings intact, while reaffirming that "*Gonzaga* sets forth [the] established method for ascertaining unambiguous conferral" of individual rights. 599 U.S. at 183. Additionally, the statute in *Wilder* has been repealed, so there is no reason to disturb that holding. See *Long Term Care Pharmacy All.* v. *Ferguson*, 362 F.3d 50, 57 (1st Cir. 2004).

Here, instead of using the word "right," Congress said that a State "must" provide that an individual Medicaid recipient "may obtain" healthcare from his or her provider of choice. 42 U.S.C. 1396a(a)(23)(A). Petitioner argues (Br. 25) that "may obtain" is not sufficiently rights-creating. But the language Congress chose has the same effect as saying Medicaid patients have the "right" to choose their own medical providers. "Must" shows a mandatory obligation. *E.g.*, *Kingdomware Techs., Inc.* v. *United States*, 579 U.S. 162, 171-172 (2016). "Obtain" is a common way to describe receiving medical care. *E.g.*, *NFIB* v. *Sebelius*, 567 U.S. 519, 541 (2012). "May" recognizes that a patient is not required to obtain that care; the point is that if a patient needs care, he or she can choose any qualified and willing provider. *Black's Law Dictionary* (12th ed. 2024) ("may" is permissive).

If there were any doubt that "may obtain" confers a right, Congress dispelled it in the provisions about family-planning services. They confirm that the statute protects Medicaid patients' "choice" of provider. 42 U.S.C. 1396a(a)(23)(B); 42 U.S.C. 1396n(b); see pp. 20-21, *supra*. As petitioner admits (Br. 28), the word "choice" signifies a right.

Imagine that Congress wrote: "The Internal Revenue Service must provide that any individual may obtain a refund of overpaid taxes." Everyone would understand that provision to give taxpayers a right to get their overpaid taxes back from the government. The provision here is no different: It guarantees that Medicaid recipients can receive care from any qualified and willing provider. Notably, the federal government disagrees with petitioner about "may obtain"; it recognizes that that phrase "could be read as a free-standing guarantee." U.S. Br. 25.

2. Petitioner alternatively contends (Br. 26-27) that Congress must say that "no person shall" be denied a certain right in order to unambiguously confer that right.

This Court has never required Congress to use those magic words to confer a right. See pp. 25-26, *supra*. None of the statutes this Court has found to create rights enforceable through Section 1983 use that phrasing. See *Talevski*, 599 U.S. at 183-186 (42 U.S.C. 1396r(c)(1)(A)(ii), (c)(2)); *Wilder*, 496 U.S. at 513-515 (42 U.S.C. 1396a(a)(13)(A) (1982)); *Wright*, 479 U.S. at 429-432 (42 U.S.C. 1437a(a) (1982)). In *Gonzaga*, this Court noted "no person * * * shall" language in Title IX of the Education Amendment Acts of 1972, 20 U.S.C. 1681(a), and Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d, as an example of rights-creating language. 536 U.S. at 284 n.3. But the Court has never *required* that language.

Petitioner contends (Br. 26-27) that this special language is necessary because it is used to confer rights in the Bill of Rights. But the Bill of Rights uses a variety of phrasing to confer rights. Some provisions create rights by prohibiting government actors from violating those rights. *E.g.*, U.S. Const. Amend. I ("Congress shall make no law * * * abridging the freedom of speech."). Others refer to the rights-holders, using "no person shall." *E.g.*, U.S. Const. Amend. V ("No person shall be held to answer for a capital * * * crime, unless on a presentment or indictment."). And others do not refer to either the rights-holder or the government actor. *E.g.*, U.S. Const. Amend. VIII ("Excessive bail shall not be required.").

Congress can choose the language it uses to confer individual rights. It is not for federal courts to "strip Congress of its prerogative to use synonyms" or "limit

Congress to a thin thesaurus of [their] own design." Pet. App. 26a.

3. Petitioner argues (Br. 30-32) that because the free-choice-of-provider provision sets out a funding condition, it actually "speaks only to the Secretary of Health and Human Services," and so is "two steps removed" from Medicaid beneficiaries. But the provision does not mention the Secretary; it operates directly on the State (a "State plan" "must" provide a free-choice-of-provider right) and expressly confers a right on Medicaid beneficiaries ("any individual[s] eligible for medical assistance" "may obtain" care from a chosen provider). 42 U.S.C. 1396a(a)(23)(A). The statutory language is zero steps removed from both Medicaid beneficiaries and the actor that may violate their rights.

Petitioner's argument also is inconsistent with *Talevski*. Like the free-choice-of-provider provision, the FNHRA provisions set out federal funding conditions for state-run nursing homes. See 42 U.S.C. 1396r(h). But the Court did not conclude that those provisions speak only to the Secretary of Health and Human Services; instead the Court concluded they confer individual rights. 599 U.S. at 183.

D. The Free-Choice-Of-Provider Provision's Context And History Confirm That It Is Privately Enforceable

1. This is an important individual right that Congress specifically intended to protect

The free-choice-of-provider provision confers an important individual right – the right of a person needing medical care to choose his or her own doctor. That right is foundational to healthcare in this country, and it has been a feature of both Medicare and

Medicaid for over 50 years. It is designed to respect patients' dignity and autonomy and to ensure that people who need care actually receive it.

When Congress enacted Medicare and Medicaid in 1965, it included the free-choice-of-provider right in Medicare but not in Medicaid. See Social Security Amendments of 1965, Pub. L. No. 89-97, § 102(a), 79 Stat. 291. Some States and territories responded by restricting Medicaid patients' choice of provider and steering them toward or away from certain providers. For example, Puerto Rico allowed Medicaid patients to be treated only at designated government facilities, whereas Massachusetts excluded physicians at teaching hospitals. *President's Proposals for Revision in the Social Security System: Hearing on H.R. 5710 before the H. Comm. on Ways and Means*, 90th Cong. 2273, 2301 (1967) (House Hearings).

Congress enacted the free-choice-of-provider provision to prevent that second-class treatment. It did so in a separate section of the Social Security Amendments Act of 1967, titled "Free Choice By Individuals Eligible For Medical Assistance." Pub. L. No. 90-248, § 227, 81 Stat. 903 (capitalization altered). This was not some provision buried among a long list of routine state plan requirements; it was a targeted response to practices that Congress found particularly objectionable. See H. Rep. No. 544, 90th Cong., 1st Sess. 122 (1967). Congress modeled the Medicaid provision on the Medicare provision, using materially identical language. See p. 34, *infra*. These provisions have remained in Medicare and Medicaid, unchanged, for over 50 years.

The free-choice-of-provider provision is premised on a recognition that "the choice of one's doctor and other provider of health services is a right which should be enjoyed by all Americans." *Social Security*

Amendments of 1967: Hearings Before the S. Comm. on Finance, 90th Cong. 1600 (1967) (Senate Hearings) (statement of Sen. Metcalf). Congress wanted to give Medicaid patients the "freedom in their choice of medical institution or medical practitioner" that is "characteristic of our medical care system in this country." H. Rep. No. 544, 90th Cong., at 122. Congress therefore "required" States "to permit the individual to obtain his medical care from any institution, agency, or person, qualified to perform the service or services." *Ibid.*

Testimony from medical professionals explained why this freedom to choose is so important. It is part of the free-market healthcare system in the United States that encourages competition among providers, which improves the quality of medical care. House Hearings 1663 (statement of Dr. Charles L. Hudson, President, Am. Med. Ass'n). It promotes better health outcomes, because "[t]he patient who knows and trusts his doctor and talks freely with him has a better chance of getting well." *Id.* at 1637 (statement of Dr. Luis A. Izquierdo-Mora, President, P.R. Med. Ass'n). And it ensures that Medicaid beneficiaries are "integrate[d]" into "the community," *id.* at 541 (statement of Dr. Carl R. Ackerman, Chairman, Nat'l Ass'n of Blue Shield Plans), rather than treated like "second class" citizens, *id.* at 1663 (statement of Dr. Hudson).

The legislative record shows Congress's clear intention to confer an individual right. Members of Congress referred to the free-choice-of-provider right as a "*right* which should be enjoyed by all Americans." Senate Hearings 1600 (emphasis added) (statement of Sen. Metcalf). The House and Senate Committee Reports explain that the provision "require[s]" States participating in Medicaid to "provide" Medicaid beneficiaries "*freedom in their choice* of medical institution

or medical practitioner." S. Rep. No. 744, 90th Cong., at 183 (emphasis added); see H. Rep. No. 544, 90th Cong., at 122 (same). They emphasize that "[u]nder this provision, an *individual* is to have a *choice* from among qualified providers of service." H. Rep. No. 544, 90th Cong., at 122 (emphases added); see *id.* at 19 (provision ensures that "people covered under the [M]edicaid program would have *free choice* of qualified medical facilities and practitioners" (emphasis added)). The Conference Report likewise explains that the provision "assure[s] that any individual eligible for medical assistance will be *free* to obtain such assistance from the qualified [provider] of his *choice*." H. Rep. No. 1030, 90th Cong., 1st Sess. 64 (1967) (emphases added). The repeated references to patients' "right" to "free" "choice" confirms that Congress was recognizing an important right.

Congress has repeatedly acted to protect the free-choice-of-provider right in the particular context here, family planning. Beginning in 1981, Congress permitted States to use managed-care systems under Medicaid. See Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2175, 95 Stat. 809-811. Congress allowed States to seek waivers of most Medicaid requirements if "necessary" to implement those systems, so long as they "do[] not substantially impair access to services of adequate quality where medically necessary." *Ibid.* (enacting 42 U.S.C. 1396n(b)(1)).[6]

But Congress singled out family-planning services for special protection, ensuring that the free-choice-of-provider right is respected even in managed-care systems. In 1986, it added a provision stating that "[n]o

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[6] As the court of appeals noted, "[t]here is no contention that any waiver of the free-choice-of-provider provision took place here." Pet. App. 117a n.5.

waiver * * * may restrict the choice of the individual in receiving [family-planning] services," Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9508, 100 Stat. 210-211 (1986) (enacting 42 U.S.C. 1396n(b)). Then in 1987, it stated that an individual's enrollment in a managed-care program "shall not restrict the choice of the qualified person from whom the individual may receive [family-planning] services." Consolidated Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, § 4113(c)(1), 101 Stat. 1330-152 (enacting 42 U.S.C. 1396a(a)(23)(B)). This additional history confirms that Congress was protecting an individual right to choose one's doctor.

2. Inclusion as a state plan requirement does not undercut Section 1983 enforceability

Petitioner (Br. 36) and the federal government (Br. 25-26) argue that the free-choice-of-provider provision does not confer an individual right because it is one of many state plan requirements. They are mistaken.

As just explained, the free-choice-of-provider provision is a special provision that Congress enacted separately to protect an intensely personal right. It is not at all surprising that Congress placed that provision in the list of state plan requirements. Medicaid is a federal-state bargain; States receive federal funding as long as they satisfy the conditions listed in Section 1396a. *Armstrong*, 575 U.S. at 323; see 42 U.S.C. 1396c. So when Congress wanted to require a State to respect a particular individual right as a condition of funding, it naturally put that right in the list of plan requirements. That is not to say that every funding condition creates a privately enforceable right; indeed, it is the "atypical" condition that does so. *Talevski*, 599 U.S. at 183; see pp. 37-40, *infra*. But if Congress

were going to create rights for Medicaid beneficiaries, Section 1396a is exactly where one would expect those rights to be.

The fact that the Medicaid provision was modeled on the Medicare provision confirms Congress's intention to confer an individual right. The Medicare provision plainly was intended to confer an individual right; it is titled "Free choice by patient guaranteed." 42 U.S.C. 1395a; see 42 U.S.C. 1395a(a) (titled "Basic freedom of choice"). Because Medicare is administered primarily by the federal government, the Medicare provision does not mention state plan requirements; instead, it states that "[a]ny individual entitled to insurance benefits under" Medicare "may obtain health services from any institution, agency, or person qualified to participate" in Medicare and willing "to provide him such services." 42 U.S.C. 1395a(a).[7] The Medicaid Act uses the same operative language. 42 U.S.C. 1396a(a)(23)(A). The repetition of this key language confirms that both provisions confer an individual free-choice-of-provider right; the Medicaid provision's mention of state plan requirements does not change that.

Further, Congress specifically rejected the argument that a state plan requirement cannot be privately enforceable under Section 1983. In *Suter* v. *Artist M.*, 503 U.S. 347 (1992), this Court held that a provision of the Adoption Assistance and Child Welfare Act did not create a right enforceable under Section 1983. *Id.* at 357-363 (addressing 42 U.S.C. 671(a)(15) (1988)). Although the Court based its decision primarily on the view that the provision "impose[s] only a rather generalized duty on the State,"

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[7] No court has addressed whether a Medicare beneficiary can enforce this provision under Section 1983.

id. at 363, it also noted that the provision appeared in a list of state plan requirements, *id.* at 358-359.

Congress rejected that reasoning by enacting 42 U.S.C. 1320a-2. It provides: "In an action brought to enforce a provision of this chapter, such provision is not to be deemed unenforceable because of its inclusion in a section of this chapter requiring a State plan or specifying the required contents of a State plan." ("This chapter" is the Social Security Act, of which Medicare and Medicaid are a part, see 42 U.S.C. 301 *et seq*.) Congress added this provision (often termed the "*Suter* fix") to "overturn[]" *Suter*'s reasoning about state plan requirements not creating enforceable rights. 42 U.S.C. 1320a-2. Thus, Congress itself foreclosed the argument petitioner now makes.

3. Permitting funding in cases of substantial compliance does not negate an intent to confer an individual right

Petitioner contends (Br. 33-36) that the free-choice-of-provider provision does not confer a privately enforceable right because the Medicaid Act operates as a "substantial compliance" regime. That is mistaken.

Congress conferred an individual right by guaranteeing that individual Medicaid recipients may obtain care from their chosen providers. 42 U.S.C. 1396a(a)(23)(A). Congress then decided not to authorize the drastic remedy of withholding federal funding except when the State has "fail[ed] to comply substantially" with federal requirements. 42 U.S.C. 1396c. Petitioner argues (Br. 42) the substantial-compliance provision means a State has "discretion" about whether to respect the free-choice-of-provider right. That is wrong; the free-choice requirement is mandatory. 42 U.S.C. 1396a(a)(23)(A) (State "must" comply).

Petitioner's argument confuses apples and oranges. The fact that Congress limited one available remedy does not mean there is no individual right. Instead, it simply reflects Congress's reluctance to authorize a remedy that is so obviously counterproductive to the overall scheme of providing healthcare to the less fortunate. Pet. App. 100a. Congress could limit that remedy because it understood there was a more tailored one available – private enforcement under Section 1983. The individual Section 1983 remedy and the federal enforcement remedy are complementary, not inconsistent. In fact, the fact that the federal enforcement remedy is so limited supports (rather than undercuts) the view that Congress intended private enforcement here. See p. 44, *infra*.

Further, petitioner's argument is flatly inconsistent with *Talevski*. Like Medicaid, "the FNHRA itself operates via a substantial compliance regime," Pet. App. 30a; it states that "[a] finding to deny payment * * * shall terminate when the State or Secretary * * * finds that the facility is in substantial compliance with all of the [statutory] requirements," 42 U.S.C. 1396r(h)(4). If petitioner were correct that a statute that operates on a substantial-compliance basis cannot give rise to a privately enforceable right, then *Talevski* would have come out differently. The same is true for *Wilder*, which held that a Medicaid Act provision about reimbursement rates is privately enforceable under Section 1983. See 496 U.S. at 513-515.[8]

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[8] Petitioner relies (Br. 40-41) on *Suter*'s holding to argue that the free-choice-of-provider provision is not privately enforceable. The statute in *Suter* required a State to take "reasonable efforts" to prevent placing a child in foster care. 42 U.S.C. 671(a)(15) (1988). According to petitioner (Br. 41), "reasonable efforts" is the same thing as "substantial compliance," so a statute with

Petitioner's view also is irreconcilable with the *Suter* fix. That provision assumes that at least some provisions of the Social Security Act are privately enforceable. But virtually all Social Security assistance programs operate on a substantial-compliance basis. See, *e.g.*, 42 U.S.C. 304(2) (Old-Age Assistance); 42 U.S.C. 609(a)(8) (Temporary Assistance for Needy Families); 42 U.S.C. 1397ff(c)(1) (Child Health Insurance Programs). Under petitioner's view, none of those could create any privately enforceable rights.

4. Private enforcement of the free-choice-of-provider provision has not opened any floodgates

Petitioner (Br. 36-40) and the federal government (Br. 27-29) argue that if the free-choice-of-provider provision is privately enforceable, many other Medicaid requirements will be as well. That is incorrect.

The free-choice-of-provider provision is "an unlikely springboard for implied rights of action under § 1983 across a broader range of contexts." Pet. App. 33a. It concerns a uniquely personal right with a long history. It is different in kind from most of the other provisions in Section 1396a, which use materially different language and do not involve personal rights.

Many provisions in Section 1396a are administrative in nature, governing the establishment and operations of state Medicaid programs, without referring

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either phrasing is not privately enforceable. That argument is irreconcilable with the holding in *Talevski* and inconsistent with the *Suter* fix. It also ignores key differences between the foster-care statute and the statute here: The foster-care statute is not sufficiently concrete to be rights-creating, 503 U.S. at 363, whereas the provision here categorically requires States to give each patient the choice of qualified provider, 42 U.S.C. 1396a(a)(23)(A).

to individual beneficiaries. See, *e.g.*, 42 U.S.C. 1396a(a)(4) (requiring the state to provide the "methods of administration" "necessary for the proper and efficient operation of the plan"); 42 U.S.C. 1396a(a)(6) (requiring the responsible state agency to make "reports" required by the Secretary of Health and Human Services). Others expressly provide the State with discretion. See, *e.g.*, 42 U.S.C. 1396a(a)(10)(A)(ii) (giving the State "the option" of extending Medicaid eligibility to 23 categories of people); 42 U.S.C. 1396a(a)(47)(A) (giving the State "the option" of making ambulatory prenatal care available to certain pregnant persons). And others focus on a State's practices in the aggregate, rather than on individual beneficiaries. See, *e.g.*, 42 U.S.C. 1396a(a)(30)(A) (requiring a State to show that it has "methods and procedures" to "safeguard against unnecessary" care and to ensure that there are "enough providers" in the State). Accordingly, most of the other provisions in Section 1396a do not unambiguously confer individual rights.

Petitioner identifies just 8 out of 87 provisions that she believes are sufficiently similar to the free-choice-of-provider provision that they could confer individual rights. Pet'r Br. 37-40; see U.S. Br. 28. That is hardly opening the floodgates. And in fact, petitioner's number is overstated. Petitioner lists (Br. 37-40) provisions that use mandatory language and include a reference to an individual – but that ignores the separate requirement of "rights-creating language." *Gonzaga*, 536 U.S. at 290.

Even when a provision uses language with some similarities to the free-choice-of-provider provision, a court still could determine that the provision does not create an individual right. That is what happened in *Polk* v. *Yee*, 36 F.4th 939 (9th Cir. 2022), which addressed one of petitioner's 8 provisions – Section

1396a(a)(32), which prohibits paying anyone except the service provider itself for a covered service. The Ninth Circuit explained that this provision has an "administrative focus" and is not "phrased in terms" that create individual rights. *Id.* at 945-946. No court of appeals has held to the contrary.

The courts of appeals have been applying *Gonzaga*'s guidance for decades. They have recognized that whether a provision creates a privately enforceable right depends on a close analysis of that particular provision's text and structure. *E.g.*, *Polk*, 36 F.4th at 944; see *Gonzaga*, 536 U.S. at 283. And they understand that "nothing 'short of an unambiguously conferred right' * * * may support a cause of action" under Section 1983. Pet. App. 55a (quoting *Gonzaga*, 536 U.S. at 283). Although most courts of appeals that have considered the free-choice-of-provider provision have found it privately enforceable, they have not reached the same conclusion for all the other provisions petitioner identifies. The sky has not fallen.

Petitioner argues (Br. 43-44, 53-54) that affirmance here would lead to an onslaught of litigation. But that assertion has been disproven by the experience in the federal courts. The first opinion to hold that the free-choice-of-provider provision is privately enforceable – Judge Sutton's opinion for the Sixth Circuit – is almost 20 years old. See *Harris* v. *Olszewski*, 442 F.3d 456, 461 (6th Cir. 2006). In the years since then, most circuits have agreed with the Sixth Circuit, and yet there has been no explosion of litigation.

The lack of other lawsuits is unsurprising. The potential plaintiffs are Medicaid patients – by definition, among the least-resourced members of society. They are not enthusiastic about the prospect of bringing lawsuits against States under Section 1983. They typically do so in cases of egregious violations, to obtain

injunctive relief (not money damages). *E.g.*, J.A. 16-17. States generally do not attempt to prevent needy patients from obtaining care from qualified and willing providers. But when they do, Congress expected individual patients to be able to obtain relief.

E. There Is No Alternative, Incompatible Federal Enforcement Scheme Showing An Intent To Preclude Section 1983 Enforcement

1. Petitioner does not attempt to satisfy Talevski *step 2*

Where, as here, a statute unambiguously confers an individual right, it is presumptively enforceable under Section 1983. *Talevski*, 599 U.S. at 185. That presumption is overcome only when Congress expressly has forbidden use of Section 1983 or has fashioned an alternative remedial scheme that is "incompatible with individual enforcement under Section 1983." *Id.* at 186 (internal quotation marks omitted).

Petitioner has not attempted to make that showing. The opening brief does not address *Talevski*'s second step at all. Instead, petitioner argues only (Br. 17-45) that the free-choice-of-provider requirement does not unambiguously confer an individual right. "This Court normally decline[s] to entertain arguments forfeited by the parties," and there is no reason to depart from that rule here. *Ohio* v. *EPA*, 603 U.S. 279, 298 (2024) (internal quotation marks omitted).

The court of appeals twice explained why there is no alternative federal enforcement scheme that shows Congress's intent to preclude Section 1983 review. Pet. App. 60a-62a, 98a-102a. In the most recent appeal, the State completely abandoned any argument on that point. *Id.* at 32a-33a ("We have held previously that the Medicaid Act provides no comprehensive enforcement scheme sufficient to overcome the

presumption" of enforceability, and "South Carolina does not ask us to revisit this question on this appeal." (internal quotation marks omitted)). Petitioner also did not raise any issue about an alternative federal enforcement scheme in the certiorari petition. Pet. i.

Because petitioner has forfeited any argument about *Talevski*'s second step, petitioner (Br. 42) and the federal government (Br. 30-32) instead suggest that other enforcement mechanisms are somehow relevant to *Talevski*'s first step, about whether the free-choice-of-provider provision confers a right in the first instance. But *Talevski* made clear that these are two separate steps. At the first step, the Court looks to the "text" and "structure" of the provision at issue to determine whether that provision unambiguously confers an individual right. 599 U.S. at 183-186 (internal quotation marks omitted). If it does confer a right, the Court then considers whether Congress elsewhere showed an intent to preclude enforcement of the right through Section 1983 by expressly prohibiting Section 1983 suits or by creating an alternative enforcement mechanism that is incompatible with Section 1983 enforcement. *Id.* at 186-187. The presence of an alternative enforcement mechanism does not cast doubt on whether there is a right in the first place; if anything, it confirms that such a right exists.[9] Accordingly, if this Court determines that Section

[9] This Court in *Gonzaga* noted that FERPA's administrative remedial scheme "buttressed" its conclusion that the provision did not create a privately enforceable right. 536 U.S. at 289. But the administrative scheme did not bear on whether the language of the provision created rights in the first instance, see *ibid.*, and *Talevski* clarified that enforcement mechanisms matter in the second step, see 599 U.S. at 183-186.

1396a(a)(23)(A) unambiguously confers an individual right, it should affirm.

2. There is no comprehensive alternative scheme that shows an intent to preclude Section 1983 enforcement

If the Court considers other possible enforcement mechanisms, the result is the same: They do not show any congressional intent to foreclose enforcement of the free-choice-of-provider provision under Section 1983.

It is undisputed that the Medicaid Act does not expressly preclude enforcement under Section 1983. Nor does it implicitly do so. For implicit preclusion, Congress must have not only created an individual enforcement mechanism, but must also have put conditions or restrictions on that mechanism that make clear that Congress intended for it to be "*the exclusive avenu*e" for enforcing that right. *Talevski*, 599 U.S. at 187 (quoting *Fitzgerald* v. *Barnstable Sch. Comm.*, 555 U.S. 246, 252 (2009)). Put another way, the statutory enforcement mechanism must "supplant" – not merely "complement" – a Section 1983 remedy. *Id.* at 190 (internal quotation marks omitted).

That is a high bar. The Court has found implicit preclusion on only three occasions: *Middlesex County Sewerage Authority* v. *National Sea Clammers Association*, 453 U.S. 1, 19-21 (1981); *Smith* v. *Robinson*, 468 U.S. 992, 1008-1013 (1984); and *Rancho Palos Verdes*, 544 U.S. at 120-123. *Talevski*, 599 U.S. at 189. The statute at issue in each case had its own dedicated enforcement scheme that included a private right of action. *Ibid.* Each scheme "required plaintiffs to comply with particular procedures and/or to exhaust particular administrative remedies" before "suing under its

dedicated right of action." *Ibid.* (internal quotation marks omitted).

Further, each dedicated right of action "offered fewer benefits than those available under § 1983." *Talevski*, 599 U.S. at 189. Allowing a lawsuit under Section 1983 thus would have thwarted Congress's design – it would have allowed the plaintiff to "circumvent" the pre-filing requirements and to obtain remedies Congress did not make available in the dedicated rights of action. *Ibid.* Nothing in the Medicaid Act compares to those comprehensive and restrictive enforcement schemes. Pet. App. 32a.

Indeed, this Court already has held that the limited administrative remedies required by the Medicaid Act are "insufficient to demonstrate an intent to foreclose relief" under Section 1983. *Wilder*, 496 U.S. at 522. The Court has never expressed any doubt about that holding of *Wilder*. To the contrary, the Court cited that holding with approval in *Rancho Palos Verdes*. 544 U.S. at 122 ("The Medicaid Act contains no * * * provision for private judicial or administrative enforcement comparable to those in *Sea Clammers* and *Smith*." (internal quotation marks omitted)).

The *Suter* fix reinforces that conclusion. In that statute, Congress made clear that it intended at least some portions of the Social Security Act to be privately enforceable under Section 1983. See *New York State Citizens' Coal. for Child.* v. *Poole*, 922 F.3d 69, 83 n.7 (2d Cir. 2019). And no state administrative remedy precludes Section 1983 review, both because of the inherent limitations on those procedures, and because the State admitted that state administrative review would be "futile." J.A. 53, 56.

None of the three possible administrative remedies permits an individual Medicaid recipient to vindicate her free-choice-of-provider right. Pet. App. 100a-101a.

a. First, the Secretary of Health and Human Services may withhold Medicaid funds from a State that is not in substantial compliance with federal requirements. See 42 U.S.C. 1316(a), 1396c. That remedy belongs solely to the federal government; there is no individual right of action. See Pet. App. 32a. That remedy stands in contrast to the remedy in *Gonzaga*, under which an individual had a federal enforcement mechanism (a proceeding before the Department of Education review board to adjudicate an unauthorized release of educational information). See 536 U.S. at 289-290 (citing 20 U.S.C. 1232g(f)).

Further, the federal government's ability to terminate funding is not adequate to protect an individual's free-choice-of-provider right. The federal government may take that step only if the State has failed to substantially comply with a condition on federal funding in Section 1396a. 42 U.S.C. 1396c; see p. 36, *supra*. Congress limited that remedy because terminating funding is a drastic step that would prevent Medicaid beneficiaries from obtaining necessary care. It would be "illogical" to say that "a wholesale cutoff of funding * * * vindicate[s] the interests of individual Medicaid beneficiaries." Pet. App. 100a. The limited nature of this remedy thus supports, rather than undercuts, the view that Congress intended to permit individual enforcement of the free-choice-of-provider right.

b. Second, a Medicaid patient may challenge a claim denial in a state administrative proceeding. See 42 U.S.C. 1396a(a)(3). Notably, petitioner has never suggested that Ms. Edwards should have brought such a challenge here, for good reason. That

procedure is limited to the situation when a patient receives notice that her "Medicaid benefits are denied, discontinued or changed." S.C. Code. Ann. Reg. 126-380; see 42 U.S.C. 1396a(a)(3) (procedure is for when a "claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness"). Because Medicaid reimbursement claims are submitted only after patients receive care, a patient who cannot obtain care from a disqualified provider will not receive an appealable claim denial. See DHHS, *Appeals and Hearings 101*, at 8 (2010), https://perma.cc/9X8H-XS9N.

The patient thus cannot use the administrative process to challenge a provider's disqualification. Even if she could, the State admitted that the remedy would be futile here. Pet. App. 101a n.4, 137a-138a. And it is well established that a person is not required to exhaust administrative remedies before filing suit under Section 1983. *Patsy* v. *Board of Regents of State of Fla.*, 457 U.S. 496, 516 (1982); see Pet. App. 101a n.4.

c. Third, a provider may bring an administrative proceeding to challenge its exclusion from a State's Medicaid program. See 42 C.F.R. 1002.213. But a state administrative proceeding brought by a provider is inadequate to vindicate the patient's right. It is the provider's decision whether to bring such a proceeding, and an individual cannot participate. See Pet. App. 32a. Further (as petitioner acknowledges, Br. 6), this is not a remedy that *Congress* required; Congress merely recognized that "appeal rights" may be "applicable." 42 U.S.C. 1396a(kk)(8)(B)(ii). So this procedure cannot show Congress's intention to preclude Section 1983 enforcement.

In any event, a provider may use the state administrative process only to challenge terminations on

certain grounds – namely, when the termination is because of a criminal conviction or because of "abuse," which is defined as practices "that are inconsistent with sound fiscal, business, or medical practices" and create "unnecessary cost[s]" for the Medicaid program, or practices "that fail to meet professionally recognized standards for health care." S.C. Code Ann. Reg. 126-400(E), 126-404. Here, DHHS did not disqualify PPSAT on any of those grounds. Rather, it admitted that PPSAT is a "medically and professionally qualified provider" but terminated its participation because it performs abortion outside of Medicaid. Pet. App. 74a, 158a. As the State admitted to the district court, the state administrative process would be "futile" because "there is no relief that [the state hearing officer] could grant given the directive of the Governor" to terminate PPSAT's participation in the State Medicaid program. J.A. 53, 56; see Pet. App. 101a n.4.[10]

In short, nothing in the Medicaid Act comes close to meeting the high bar for implicit preclusion of Section 1983 enforcement here.

F. There Is No Question That PPSAT Is A Qualified Provider And That Petitioner Violated Ms. Edwards' Free-Choice-Of-Provider Right

1. Petitioner argues (Br. 21) that the Medicaid Act gives States the unfettered power to decide whether a provider is "qualified," so they can deem providers unqualified for any reason at all. In petitioner's view

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[10] Petitioner suggests (Br. 42-43) that allowing Ms. Edwards to bring suit under Section 1983 would interfere with a provider's administrative challenge. But there was no chance of interference here, because the State has admitted that the administrative proceeding could not provide any relief. J.A. 53, 56.

(*ibid.*), the fact that the State can define "qualified" as anything it wants means that the free-choice-of-provision does not confer any right.

That issue is not before the Court. The certiorari petition presented two questions: (1) whether the free-choice-of-provider provision is privately enforceable under Section 1983; and (2) if it is, whether the State did not violate the right because it has an absolute right to determine whether a provider is "qualified." Pet. i. This Court granted certiorari only on the first question. See *Kerr* v. *Planned Parenthood*, No. 23-1275, 2024 WL 518085, at *1 (U.S. Dec. 18, 2024). That left in place the court of appeals' holding that a State's ability to disqualify a provider is not unfettered, and that "qualified to perform the service or services required" means "professionally competent" to provide medical care. Pet. App. 108a-109a. Petitioner's argument (Br. 21) is just a backdoor attempt to challenge that holding, and it should not be allowed.

2. In any event, petitioner's argument is wrong. A State may not terminate a provider's Medicaid participation for any reason and then "simply label[]" that "exclusionary rule as a 'qualification'" under the free-choice-of-provider provision. Pet. App. 110a. The ordinary meaning of "qualified" is "professionally capable or competent." *Id.* at 108a; see *Collins English Dictionary* (14th ed. 2023) ("[h]aving the abilities, qualities, attributes, etc., necessary to perform a particular job"). Further, the free-choice-of-provider provision does not use "qualified" in the abstract, but instead refers to providers that are "qualified to perform the service or services required." 42 U.S.C. 1396a(a)(23)(A). The "qualifications" at issue thus are those that "relate to a provider's competency to perform a particular medical service, and not to any

conceivable state interest as applied to the Medicaid program." Pet. App. 108a.

Petitioner cites (Br. 21) 42 U.S.C. 1396a(p)(1), but that provision does not permit a State to redefine "qualified" however it chooses. Pet. App. 112a-117a. Section 1396a(p)(1) states that, "[i]n addition to any other authority," a State may exclude a provider from participating in Medicaid "for any reason for which the Secretary [of Health and Human Services]" could exclude the provider under federal law. 42 U.S.C. 1396a(p)(1). All of the federal-law bases for exclusion are related to professional malfeasance. Pet. App. 113a (citing 42 U.S.C. 1320a-7). Petitioner cites the savings clause ("in addition to any other authority"), but that does not mean any state-law ground for exclusion, for any reason. It is not an affirmative grant of authority; it merely refers to whatever other authority the State may have, and that authority is constrained by the free-choice-of-provider provision. *Id.* at 114a-117a.

As the court of appeals explained, petitioner's argument (Br. 21) would "strip the free-choice-of-provider provision of all meaning" and "shortchange the federal side of the bargain." Pet. App. 110a. If petitioner were correct, a State could "easily [] undermine[]" the provision by "labeling any exclusionary rule as a qualification." *Ibid.* (internal quotation marks omitted).

3. Here, it is undisputed that PPSAT is professionally qualified. "There has never been any question during the long path of this litigation that Planned Parenthood is professionally qualified to provide the care that [Ms. Edwards] seeks." Pet. App. 33a. The State has never "contest[ed] [that] fact." *Id.* at 107a; see *id.* at 41a ("All parties agree" that PPSAT "is perfectly competent to provide" the healthcare Ms.

Edwards seeks); *id.* at 98a n.3 ("PPSAT's qualifications are simply not in dispute" in this case); *id.* at 114a ("Here, it bears repeating, no one disputes PPSAT's medical qualifications to perform the family-planning services required.").

The State terminated PPSAT's participation in Medicaid because it provides safe, legal abortion outside of Medicaid. But that has no relation to PPSAT's fitness for the Medicaid program, as the State acknowledges. See Pet'r Br. 7. And if accepted, the State's position would have far-reaching consequences well beyond the abortion context: A State could exclude any provider that it disfavors for any reason. See Pet. App. 110a.

Further, petitioner's assertion (Br. 7) that including PPSAT in Medicaid indirectly subsidizes abortion outside of Medicaid is flat wrong. This factual issue was litigated before the district court and decided in respondents' favor, Pet. App. 139a-140a; the court of appeals affirmed that finding, *id.* at 90a, 118a; and petitioner did not seek any further review.

In particular, the district court found that "PPSAT's inclusion in South Carolina's Medicaid program results in neither the direct nor indirect use of State funds to pay for abortions." Pet. App. 139a-140a. Medicaid generally does not cover abortion, so there is no direct use of state funds for abortion. See n.1, *supra*. There is no indirect subsidy, either. Medicaid providers are "reimbursed through the Medicaid program on a fee-for-service basis for covered services," meaning that they receive set amounts of money for each service they perform. Pet. App. 139a; see 42 C.F.R. 447.203. South Carolina's Medicaid reimbursement rates are so low that they "do not even fully cover the cost of the Medicaid services PPSAT provides." Pet. App. 139a-140a. Thus, petitioner is

wrong to say (Br. 7) that the money that PPSAT receives from Medicaid "frees up their other funds to provide more abortions."

As Judge Wilkinson explained for the Fourth Circuit, this case "is not about funding or providing abortions"; it is about "preserving an affordable choice and quality care for" Medicaid patients in South Carolina. Pet. App. 34a. In clear terms, Congress "extend[ed] a choice of medical providers to the less fortunate among us, individuals who experience the same medical problems as the more fortunate in society," but "who lack under their own means the same freedom to choose their healthcare provider[s]." *Id.* at 64a. If that right is to mean anything, individuals must be able to enforce it.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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MARCH 2025

APPENDIX

APPENDIX

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1. 42 U.S.C. 1320a-2 provides:

Effect of failure to carry out State plan

In an action brought to enforce a provision of this chapter, such provision is not to be deemed unenforceable because of its inclusion in a section of this chapter requiring a State plan or specifying the required contents of a State plan. This section is not intended to limit or expand the grounds for determining the availability of private actions to enforce State plan requirements other than by overturning any such grounds applied in Suter v. Artist M., 112 S. Ct. 1360 (1992), but not applied in prior Supreme Court decisions respecting such enforceability; provided, however, that this section is not intended to alter the holding in Suter v. Artist M. that section 671(a)(15) of this title is not enforceable in a private right of action.

2. 42 U.S.C. 1395a provides in pertinent part:

Free choice by patient guaranteed

(a) Basic freedom of choice

Any individual entitled to insurance benefits under this subchapter may obtain health services from any institution, agency, or person qualified to participate under this subchapter if such institution, agency, or person undertakes to provide him such services.

* * * * *

3. 42 U.S.C. 1396a provides in pertinent part:
State plans for medical assistance

(a) Contents

A State plan for medical assistance must –

* * * * *

(23) provide that

(A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services, and

(B) an enrollment of an individual eligible for medical assistance in a primary care case-management system (described in section 1396n(b)(1) of this title), a medicaid managed care organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive services under section 1396d(a)(4)(C) of this title, except as provided in subsection (g), in section 1396n of this title, and in section 1396u-2(a) of this title, except that this paragraph shall not apply in the case of Puerto Rico, the Virgin Islands, and Guam, and except that nothing in this paragraph shall be construed as requiring a State to provide medical assistance for such services furnished by a person or entity convicted of a felony under Federal or State law for an offense

> which the State agency determines is inconsistent with the best interests of beneficiaries under the State plan or by a provider or supplier to which a moratorium under subsection (kk)(4) is applied during the period of such moratorium;
>
> * * * * *

4. 42 U.S.C. 1396c provides:

Operation of State plans

If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this subchapter, finds –

> (1) that the plan has been so changed that it no longer complies with the provisions of section 1396a of this title; or
>
> (2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

5. 42 U.S.C. 1396d provides in pertinent part:

Definitions

For purposes of this subchapter –

(a) Medical assistance

The term "medical assistance" means payment of part or all of the cost of the following care and services or the care and services themselves * * * –

* * * * *

(4)

* * * * *

(C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies * * * ;

* * * * *

6. 42 U.S.C. 1396n provides in pertinent part:

Compliance with State plan and payment provisions

* * * * *

(b) Waivers to promote cost-effectiveness and efficiency

The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection (s)) (other than sections 1396a(a)(15), 1396a(bb),

and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State –

> (1) to implement a primary care case-management system or a specialty physician services arrangement which restricts the provider from (or through) whom an individual (eligible for medical assistance under this subchapter) can obtain medical care services (other than in emergency circumstances), if such restriction does not substantially impair access to such services of adequate quality where medically necessary * * * .

No waiver under this subsection may restrict the choice of the individual in receiving services under section 1396d(a)(4)(C) of this title. Subsection (h)(2) shall apply to a waiver under this subsection.

* * * * *

7. 42 U.S.C. 1983 provides:

Civil action for deprivation of rights

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in such officer's judicial capacity, in-

junctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable. For the purposes of this section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia.