No. 23-1275

IN THE

Supreme Court of the United States

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

Petitioner,

V.

PLANNED PARENTHOOD SOUTH ATLANTIC, ET AL.,

Respondents.

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

BRIEF OF *AMICI CURIAE* THE NATIONAL HEALTH LAW PROGRAM AND TWENTY-SIX OTHER NONPROFIT ORGANIZATIONS IN SUPPORT OF RESPONDENTS

JANE PERKINS
SARAH SOMERS
NATIONAL HEALTH LAW PROGRAM
1512 E. Franklin St., Suite 100
Chapel Hill, NC 27514

DONALD B. VERRILLI, JR.
Counsel of Record
TAYLOR GLEICHAUF
MUNGER, TOLLES & OLSON LLP
601 Massachusetts Ave. NW
Suite 500 E
Washington, DC 20001
(202) 220-1100
Donald.Verrilli@mto.com
Taylor.Gleichauf@mto.com

COUNSEL FOR *AMICI CURIAE*

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INTEREST OF *AMICI CURIAE*[1]

The National Health Law Program (NHeLP) advocates, educates, and litigates at the federal and state levels to further its mission of improving access to quality healthcare for low-income people. For 55 years, NHeLP's work has focused on ensuring access and coverage for Medicaid beneficiaries, including children, people with disabilities, and older people, including by facilitating suits under § 1983 for private enforcement of federal statutory rights.

In addition to NHeLP, the *amici* are the National Disability Rights Network; Community Catalyst; the National Center on Law and Economic Justice; the Arc; the Judge David L. Bazelon Center for Mental Health Law; Justice in Aging; the Center for Medicare Advocacy; the Center for Public Representation; Compassion and Choices; the National Family Planning and Reproductive Health Association; Positive Women's Network – USA; AIDS United; the Autistic Women and Nonbinary Network; the William E. Morris Institute for Justice (Arizona); Maternal and Child Health Access (California); the Florida Health Justice Project; the Public Justice Center (Maryland); the Center for Civil Justice (Michigan); Nebraska Appleseed; the New York Legal Assistance Group; the Charlotte Center for Legal Advocacy (North Carolina); Pisgah Legal Services (North Carolina); the Pennsylvania Health Project; the Tennessee Justice Center; Disability Rights Wisconsin; Northwest

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[1] Pursuant to Supreme Court Rule 37.6, counsel for *amici* certify that no counsel for any party authored this brief in whole or in part, and no party or counsel for a party, or any other person other than *amici* or their counsel, made a monetary contribution intended to fund the preparation or submission of this brief.

Health Law Advocates (Washington); and Sylvia A. Law, the Elizabeth K. Dollard Professor of Law, Medicine, and Psychiatry Emerita at New York University School of Law.

Although each *amicus* has particular interests, the ability of individuals to enforce provisions of the Medicaid Act that meet this Court's well-established requirements for enforcing a statute under 42 U.S.C. § 1983 is essential to each of them and their missions. As such, *amici* have an interest in protecting Medicaid beneficiaries' rights to enforce provisions of the Medicaid Act through civil suits.

INTRODUCTION AND SUMMARY OF ARGUMENT

More than thirty years ago, in *Suter* v. *Artist M.*, 503 U.S. 347 (1992), this Court held that a plaintiff could not use 42 U.S.C. § 1983 to enforce a provision of the Social Security Act because that provision appeared in a list of plan requirements. Congress disagreed and promptly set the record straight: Congress can nest individual rights in plan requirements—and by that time it already had.

For more than thirty years, Congress has legislated against the backdrop of that rule. For more than thirty years, states that receive federal funding through Spending Clause legislation have been on notice that Congress may codify individually enforceable rights in plan requirements. And for more than thirty years, individual plaintiffs have enforced provisions of the Medicaid Act without controversy, producing a stable body of provision-by-provision enforcement history. Indeed, the subsection at issue in this case is one of the few to have generated attention of any kind.

Petitioner, now joined by the United States, seeks to upend this stable status quo, reprising arguments that were rejected just two terms ago in *Health and Hospital Corporation of Marion County* v. *Talevski*, 599 U.S. 166 (2023), or that, although initially adopted by the *Suter* Court, were swiftly corrected by Congress. Petitioner and the United States also newly insist that the particular indicia of an individually enforceable right identified in *Talevski* are necessary in all cases. But Congress's authority has never been that sharply curtailed: Congress need not use the word "right," parrot the Bill of Rights, or, as the fed-

eral government suggests, create a separate, separately subtitled provision in order to create an enforceable right. The test has always been more nuanced than that, requiring a careful parsing of the text, in context, on a provision-by-provision and case-by-case basis.

The specific provision at issue in this case, 42 U.S.C. § 1396a(a)(23)(A), passes with flying colors that well-established test for all of the reasons ably explained in Respondents' brief. The legislative history of that provision further reinforces what is plain from the text: Congress intended to create an individually enforceable right for Medicaid beneficiaries to choose their own healthcare providers. The replacement tests pressed by Petitioner and the United States are as unnecessary as they are misguided.

Amici believe that the decision below was correctly decided and should be upheld.

ARGUMENT

I. The free-choice-of-provider provision creates an individual right enforceable through 42 U.S.C. § 1983.

A. The text of § 1396a(a)(23)(A) is unambiguously rights creating, especially when considered in the context of § 1320a-2.

The free-choice-of-provider provision of the Medicaid Act, 42 U.S.C. § 1396a(a)(23)(A), unambiguously confers on Medicaid beneficiaries an individual right enforceable pursuant to § 1983. Beginning with the text, as the Court of Appeals observed earlier in the life of this case: "It is difficult to imagine a clearer or more affirmative directive." *Planned Parenthood S.*

Atl. v. *Baker*, 941 F.3d 687, 694 (4th Cir. 2019). The provision has an "unmistakable focus," *Gonzaga Univ.* v. *Doe*, 536 U.S. 273, 284 (2002), on its intended class of beneficiaries: "any individual eligible for medical assistance" under the Medicaid Act, 42 U.S.C. § 1396a(a)(23)(A). The clause is "phrased in terms of the persons benefited," *Gonzaga*, 536 U.S. at 284 (citation omitted), and uses the requisite "individually focused terminology," *id.* at 287. It is, for all of the reasons Respondents explain, paradigmatic "rights-creating language." *Id.* at 284 n.3.

That a *different* provision of the Medicaid Act "says that the 'Secretary shall approve any plan which fulfills the conditions specified in [§ 1396a] subsection (a)," *Armstrong* v. *Exceptional Child Ctr.*, 575 U.S. 320, 331 (2015) (plurality op.) (quoting 42 U.S.C. § 1396a(b)), does not alter the straightforward meaning and unambiguous rights-creating language of the text found in § 1396a(a)(23)(A).[2] Nor is that unambiguous rights-creating language undermined by the fact that § 1396a(a)(23)(A) *also* speaks to the state. See § 1396a(a) ("A State plan for medical assistance must—"). "Indeed, it would be strange to hold that a statutory provision fails to secure rights

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[2] *Armstrong,* it bears mentioning, did not concern the availability of suit under § 1983. In that case, the Court considered whether the plaintiffs—Medicaid *providers*—could enforce statutory guarantees under the Supremacy Clause of the United States Constitution, federal courts' inherent equitable powers, or (in a passage joined by a mere plurality of the Court) the bare terms of the Medicaid Act itself. See 575 U.S. at 326, 328, 331. Although the Eighth Circuit has erroneously applied *Armstrong* to the § 1983 context, see *Does* v. *Gillespie,* 867 F.3d 1034, 1041 (8th Cir. 2017), the *Armstrong* plurality itself explicitly recognized that the plaintiffs had not "assert[ed] a § 1983 action," 575 U.S. at 330 n.*.

simply because it considers, alongside the rights bearers, the actors that might threaten those rights." *Talevski*, 599 U.S. at 185.

More importantly, Congress itself already has disposed of any contrary argument. Petitioner contends—notwithstanding the plain text of the free-choice-of-provider provision—that because that provision appears alongside eighty-odd other provisions in the Medicaid Act, it is best read as a plan requirement, not an individual right. See Pet. Br. at 20. But Congress says otherwise: a "provision is not to be deemed unenforceable because of its inclusion in a section of [the Medicaid Act] . . . specifying the required contents of a State plan." 42 U.S.C. § 1320a-2.

That provision means what it says. Congress amended the Social Security Act to add § 1320a-2 following this Court's decision in *Suter*, which held that plaintiffs could not use § 1983 to enforce a provision of the Adoption Assistance and Child Welfare title of the Social Security Act. *Suter*, 503 U.S. at 363. *Suter* reasoned that the provision at issue did not create an enforceable right primarily because it appeared in a subsection of the statute that listed mandatory elements of state plans. *Id.* at 358. That reasoning had potentially far-reaching ramifications, as most Social Security Act titles—including Medicaid—are written in terms of what a state plan must contain in order to receive federal funds.

In the wake of *Suter*, Congress amended the Social Security Act to make clear that a provision "is not to be deemed unenforceable because of its inclusion in a section of [the Act] requiring a State plan or specifying the required contents of a State plan." 42

U.S.C. § 1320a-2; *id.* § 1320a-10 (provision repeated). The provision continues:

> 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.

42 U.S.C. § 1320a-2; *id.* § 1320a-10 (provision repeated).

The text of § 1320a-2 is unambiguous, and the relevant legislative history powerfully reinforces that individuals who "have been injured by a State's failure to comply with the Federal mandates of the *State plan titles* of the Social Security Act are able to seek redress in the federal courts." H.R. Rep. No. 103-761, at 926 (1994) (Conf. Rep.), *as reprinted in* 1994 U.S.C.C.A.N. 2901, 3257 (emphasis added). The House Ways and Means Committee recognized that "[p]rior to [*Suter*], the Supreme Court ha[d] recognized, in a substantial number of decisions, that beneficiaries of Federal-State programs could seek to enjoin State violations of Federal statutes by suing under 42 U.S.C. § 1983." Report of the H. Comm. on Ways & Means, No. 102-631, 102 Cong., 2d Sess., at

364 (1992). Seeking to restore the status quo, the Committee reasoned:

> Social Security Act program beneficiaries, parents, and advocacy groups have brought hundreds of successful lawsuits alleging failure of the State and/or locality to comply with State plan requirements of the Social Security Act. . . . Much of this litigation has resulted in comprehensive reforms of Federal-State programs operated under the Social Security Act, and increased compliance with the mandates of Federal statutes[.]

Id. at 364-365. Thus, in Congress's view, individual enforcement of rights contained in state plan requirements served an important function, complementing, not displacing, the federal government's ability to terminate funds to a state. And Congress provided still further evidence of its intent, explaining:

> [When] Congress places requirements in a statute, we intend for the States to follow them. If they fail in this, the Federal courts can order them to comply with the congressional mandate. For 25 years, this was the reading that the Supreme Court had given to our actions in Social Security Act State plan programs. The *Suter* decision represented a departure from this line of reasoning.

139 Cong. Rec. 5571 (1993) (Sen. Donald W. Riegle, Jr.).

In short, the legislative correction in § 1320a-2 of *Suter*'s reasoning is unequivocal and puts to rest any notion that because § 1396 lists federal requirements for state Medicaid plans, one of those requirements, here, § 1396a(a)(23)(A), cannot *also* establish a privately enforceable right. And yet, that is the argument that Petitioner (and now the United States) continue to press. See Pet. Br. at 20, 36; U.S. Br. at 13-14, 32-34.

Petitioner asserts that accepting Respondents' position would effectively abrogate *Suter*'s holding that 42 U.S.C. § 671(a)(15) is not enforceable as a private right. Pet. Br. at 40. But the Court's decision in *Suter* was grounded in "[c]areful examination of the language relied upon by respondents, in the context of the entire Act." *Suter*, 503 U.S. at 363. The decision was thus based on the *text* of the provision at issue and its *placement* in a list of plan requirements. Troubled by the Court's reliance on the placement of § 671(a)(15), Congress sprang into action and reversed the interpretive rule *Suter* had articulated in that respect. Such a step was necessary because as a "general rule, the principle of *stare decisis* directs [the Court] to adhere not only to the holdings of [its] prior cases, but also to their explications." *Cnty. of Allegheny* v. *ACLU Greater Pittsburgh Chapter*, 492 U.S. 573, 668 (1989) (Kennedy, J., concurring and dissenting).

At the same time, Congress agreed with this Court's conclusion in *Suter* that § 671(a)(15) itself did not unambiguously create an individually enforceable right. That is hardly surprising given that the subsection at the time read:

> (a) Requisite features of State plan

> In order for a State to be eligible for payments under this part, it shall have a plan approved by the Secretary which—
>
> . . . .
>
> (15) effective October 1, 1983, provides that, in each case, reasonable efforts will be made (A) prior to the placement of a child in foster care, to prevent or eliminate the need for removal of the child from his home, and (B) to make it possible for the child to return to his home[.]

42 U.S.C. § 671(a)(15) (1992). That text lacks any of the recognized hallmarks of rights-creating language. The takeaway from Congress's actions is clear: A provision may be deemed unenforceable based on its text, context, and traditional methods of statutory interpretation. But it may "not . . . be deemed unenforceable because of its inclusion in a section . . . requiring a State plan or specifying the required contents of a State plan." 42 U.S.C. § 1320a-2.

Petitioner's related substantial-compliance arguments are equally off base. See Pet. Br. at 34, 42. For one thing, if it were true that a provision cannot create an enforceable right if a state need only "comply substantially" with that provision to avoid the withholding of federal funds, then § 1320a-2 would be rendered meaningless (because Medicaid operates as a substantial compliance regime). So too would the entire *Gonzaga University* v. *Doe*, 536 U.S. 273 (2002) framework: That framework requires courts to examine the text of individual statutory provisions. But substantial compliance is not tethered to any particu-

lar provision; thus, if substantial compliance were enough to defeat private enforcement, courts would never have occasion or reason to consider the text of individual provisions. Equally to the point, this Court's recent decision in *Talevski* would be rendered meaningless, as the Federal Nursing Home Reform Act (FNHRA) itself operates via a substantial compliance regime, see 42 U.S.C. § 1396r(h)(4). That § 1396a(a) operates the same way therefore cannot undercut the clear and unambiguous rights-creating language of subsection (23)(A).[3]

As is evident from the face of the provision itself, § 1320a-2 "restore[d] the right of individuals to turn to Federal courts when States fail to implement Federal standards under the Social Security Act." 138 Cong. Rec. 34,090 (1992) (statement of Sen. Donald W. Riegle, Jr.). Because "[t]extualists do not read statutes as if they were messages picked up by a powerful radio telescope from a distant and utterly unknown civilization," *Bostock* v. *Clayton Cnty.*, 590 U.S. 644, 706 (2020) (Alito, J., dissenting), the text of § 1396a(a)(23)(A) must be viewed in light of the context set forth above, which leaves no doubt about the meaning and operation of the provision. So viewed, Congress's intent to create an individual right enforceable through § 1983 in the free-choice-of-provider provision is unmistakable.

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[3] Petitioner suggests that the Court give cumulative weight to the combined force of the "Medicaid Act's substantial compliance regime, its directive to the Secretary, [and] its articulation of dozens of plan requirements," Pet. Br. at 36, but those three things are just the characteristics of *any* statutory provision codified in a section "specifying the required contents of a State plan," 42 U.S.C. § 1320a-2.

B. Congress did not intend to preclude § 1983 enforcement of § 1396a(a)(23)(A), as illustrated by that provision's legislative history.

Because § 1396a(a)(23)(A)'s text unambiguously confers a presumptively enforceable right, the next question is whether Congress intended to preclude § 1983 enforcement. See *Talevski*, 599 U.S. at 180. Here, much like in *Talevski*, there is no "comprehensive enforcement scheme that is incompatible with individual enforcement under § 1983." *Id.* at 186 (citation omitted); see *Gonzaga*, 536 U.S. at 274. From "text and context," it is clear that Section 1396a(a)(23)(A) "lacks any indicia of congressional intent to preclude § 1983 enforcement, such as an express private judicial right of action." *Talevski*, 599 U.S. at 187-188. And, apart from § 1983, there is no way for affected patients to challenge the termination, lawful or not, of their preferred providers. See *City of Rancho Palos Verdes* v. *Abrams*, 544 U.S. 113, 121 (2005) (collecting cases and observing that "in *all* of the cases in which [the Court] ha[s] held that § 1983 *is* available for violation of a federal statute, [the Court] ha[s] emphasized that the statute at issue . . . *did not* provide a private judicial remedy"). Unsurprisingly then, Petitioner did not contest this second prong of the operative test in the Court of Appeals. See Resp. Br. at 40.

At this step of the analysis the focus is properly on whether Congress has evinced its "intent to preclude the use of § 1983" enforcement. *Talevski*, 599 U.S. at 180. In this case, Congress's intent is clear from the text of § 1396a(a)(23)(A)—and it is further reinforced by the origins of that provision. Despite Petitioner's suggestion, Pet. Br. at 5, 27, that "any-qualified-

provider" is more "accurate" nomenclature, § 1396a(a)(23)(A) has always been about securing Medicaid beneficiaries the right to choose their preferred provider—just the same as full-paying patients. Indeed, the section's original title was "Free Choice By Individuals Eligible for Medical Assistance[.]" 81 Stat. 821, 903 (1968).

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. 286, 291. Even so, freedom of choice was a focus of the 1965 debates, with some legislators fearful that federal health insurance might diminish patient autonomy and free market competition. The senator who introduced the Medicare free-choice-of-provider provision explained that it was necessary because "people who must rely on this program because of insufficient income and resources are entitled to the same prerogatives" as others. 111 Cong. Rec. 15,791 (1965) (statement of Sen. John J. Williams). "The choice of one's own doctor and other provider of health services is a right which should be enjoyed by all Americans." *Id.* Other representatives were concerned about the effect that the "socialization of the medical profession" would have given that "the American people and most Members of Congress want free choice of hospital and doctor." 111 Cong. Rec. 505 (1965) (statement of Rep. Thomas Minor Pelley). And still others were wary of "limit[ing] in any way the relationship of the medical profession to its patients, either in choice of physician by the patient, the professional decisions that physicians may make with respect to the care of their patients, or even the pay-

ment of physicians." 111 Cong. Rec. 16,085 (1965) (statement of Sen. John Sherman Cooper).

When those fears came to pass, Congress codified in Medicaid the same guarantee of free choice it originally had set forth only in Medicare. Shortly after 1965—and without a free-choice-of-provider provision in Medicaid—things soon soured for Medicaid beneficiaries.

For example, in Puerto Rico, Medicaid patients were permitted to receive care only from designated government facilities. Massachusetts refused to reimburse physicians at teaching hospitals for treating Medicaid patients. See President's Proposals for Revision in the Soc. Sec. Sys.: Hearing on H.R. 5710 before the H. Comm. on Ways & Means, 90th Cong. 2273, 2301 (1967) (President's Proposals).[4] And, in a particularly prescient statement, the President of the Association of New York State Physicians and Dentists shared that New York had adopted "arbitrary requirements in excess of State licensure," thereby excluding as purportedly unqualified "a large segment of professional personnel" from participating in New York's Medicaid program. Hearings on the Social Security Act Amendments of 1967 Before the S. Finance Committee, H.R. 12080, 90th Cong., 1597, 1599 (1967). New York had justified its actions by pointing out that "the [M]edicaid program unlike [M]edicare includes no provision that requires States

[4] The Massachusetts Medical Society explained that "change" was "needed in Massachusetts where . . . private physicians rendering care to Medicaid beneficiaries in 19 so-called 'teaching hospitals' will not be reimbursed for services actually rendered to such patients. This . . . we feel, is not consistent with the intent of [Medicaid]. It is a deterrent to the patient's free choice of physician and hospital." *Id.*

to allow free choice of physician." *Id.* at 1597-98 (internal citation omitted). Congress responded by adding, nearly verbatim, Medicare's free-choice-of-provider provision to Medicaid. *Compare* 42 U.S.C. § 1395a(a), *with* 42 U.S.C. § 1396a(a)(23)(A).

Congress's intent is unmistakable. Even Petitioner agrees that Congress added (23)(A) "because some states were forcing recipients to choose from a very narrow list of public providers," Pet. Br. at 5—that is, because some states were denying Medicaid beneficiaries their free choice of provider. The House added (23)(A) "to assure that any individual eligible for medical assistance will be free to obtain such assistance from the qualified institution, agency, or person of his choice." H.R. Rep. No. 90-1030, at 64 (1967) (Conf. Rep.). The Senate "amendments modified the House provision to include community pharmacies and drugs among the providers and services with respect to which *free choice is assured*." *Id.* (emphasis added). The committee prints too speak with one voice, highlighting that (23)(A) was added to ensure that Medicaid beneficiaries would be able to freely choose their medical providers.[5] As the American

[5] See Staff of Comm. on Ways & Means, 90th Cong., Summary of Provisions of H.R. 12080: The "Social Security Amendments of 1967" 14 (Comm. Print. 1967) ("Effective July 1, 1969 (July 1, 1972, for Puerto Rico, the Virgin Islands, and Guam), people covered under the [M]edicaid program *would have free choice* of qualified medical facilities and practitioners." (emphasis added)); Staff of Comm. Ways & Means, 90th Cong., Section-by-Section Analysis and Explanation of Provisions of H.R. 5710: The "Social Security Amendments of 1967" 10 (Comm. Print 1967) ("*Free choice by individual eligible for medical assistance*[:] An individual eligible for medical assistance *would be free to choose* any institution, agency, or person (including a prepayment plan) qualified to perform the services required and

Medical Association (AMA) put it in supporting the amendment, "American medicine has long maintained that the highest level of medical care is rendered when the patient has a free choice of both physician and facility." President's Proposals at 1663. Noting the inconsistency between Medicare and Medicaid, the AMA observed that the discrepancy "made 'second class' patients of public assistance recipients." *Id.* The AMA, accordingly, supported the proposed "perfecting" amendment. *Id.*

One of the issues that emerged around the enactment of (23)(A) brings Congress's intent into even sharper relief. The issue concerned the schedule for Puerto Rico's (23)(A) compliance, with Puerto Rico requesting additional time to gather necessary funds. See 113 Cong. Rec. 23,121 (1967) (statement of Resident Commissioner of Puerto Rico Santiago Polanco-Abreu). The related debate underscores that individual rights were top of mind. As subsection (23)(A) was being discussed, in a statement to the House Committee on Ways and Means, the Resident Commissioner of Puerto Rico told Congress that Puerto Rico was "in full agreement with the principle of free choice," but explained that the "existing medical assistance system and severe financial limitations" would make it "impossible" for the island to "comply with [the new] requirement in two years." *Id.* at 23,117, 23,221. "The irony of this situation," the Commissioner told the House, was that Puerto Rico was "in agreement with the free-choice principle embodied in [the amendment]." *Id.* at 23,120. He continued: "If it were at all possible for us to meet this

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who undertakes to provide such services to him." (emphases added)).

requirement, we would be welcoming it right now. We too, want to offer our citizens without means the same medical services available to their more fortunate neighbors." *Id.*

Up until then, "[i]ndigent patients" in Puerto Rico had been "'forced' to receive hospital and medical services only in Commonwealth facilities." President's Proposals at 2273. In the end, Congress agreed with the advocates for free choice in Puerto Rico that, in their words, the "right to choose where to receive [medical] services should apply to all, indigent and solvent patients" alike. *Id.*[6] That record demonstrates that § 1396a(a)(23)(A) has always been about freedom of choice, and, more specifically, Congress's decision to endow Medicaid beneficiaries with the right to choose any qualified provider who undertakes to provide such services.

As the above illustrates, whether individual Medicaid beneficiaries can *enforce* pursuant to § 1983 the

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[6] The Puerto Rico Medical Association recommended adoption of the amendment believing that "quality of medical care is closely associated with the democratic right of a patient to freely choose his physician." *Id.* at 1637; see *id.* ("The patient prefers not only the physician who is well prepared professionally but the one who not only knows him but also knows his close relatives, one who knows his good points, his weaknesses, to whom he can pour out his problems knowing that his secrets will remain so for the rest of his life."); *id.* at 1638 ("The act by which the patient chooses one freely from among one's competitors represents the blood that nourishes our vocation."). So too did the Colegio de Cirujanos Dentistas and the Puerto Rico Dental Association, urging that "[f]ree choice of doctor, hospital and dentist, is the democratic way of providing medical services of the highest quality and it stimulates the medical profession to serve its patients with more dedication and to improve themselves professionally." *Id.* at 1640.

free-choice-of-provider provision is entirely separate and distinct from the scope of that right—here, whether Petitioner lawfully terminated Planned Parenthood's enrollment. *See, e.g.*, *Harris* v. *Olszewksi*, 442 F.3d 456, 456 (6th Cir. 2006) (Sutton, J.) (recognizing that the free-choice-of-provider provision creates an enforceable right but reversing district court conclusion regarding the scope of that right).[7] Petitioner's intimations, Pet. Br. at 8, that it properly deemed Planned Parenthood "unqualified"—*i.e.*, that Petitioner did not violate the individual right codified in § 1396a(a)(23)(A)—are not presented by this case, as this Court recognized in denying certiorari on the question.

II. The Court of Appeals' decision should be affirmed.

A. The Courts of Appeals have no difficulty applying the test articulated by this Court in a consistent and principled manner.

Decades of experience illustrate that the *Gonzaga* standard, as recently reaffirmed and clarified by *Talevski*, is clear and workable, and has produced consistent and predictable results. For more than twenty years, *Gonzaga* has supplied the relevant test:

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[7] The Fifth Circuit most recently conflated the two inquiries, reasoning that *O'Bannon* v. *Town Court Nursing Center*, 447 U.S. 773 (1980), "establishes that § 1396a(a)(23) does not give Medicaid beneficiaries a right to question a State's determination that a provider is unqualified." *Planned Parenthood of Greater Texas Fam. Plan. & Preventative Health Servs., Inc.* v. *Kauffman*, 981 F.3d 347, 357 (5th Cir. 2020) (en banc); *accord id.* at 370 (Elrod, J., concurring). This Court correctly recognized the above-described distinction in granting certiorari only as to the first question presented.

Plaintiffs cannot vindicate statutory entitlements under § 1983 based on "anything short of an unambiguously conferred right" to do so. *Gonzaga*, 536 U.S. at 283; *Talevski*, 599 U.S. at 183 ("*Gonzaga* sets forth our established method for ascertaining unambiguous conferral."). If the text meets that high bar, the reviewing court must then consider whether Congress nevertheless "inten[ded] to preclude the use of § 1983." *Talevski*, 599 U.S. at 180.

Although § 1396a(a)(23)(A) may have split the circuits, other statutory provisions of the Medicaid Act have not. In the decades since *Gonzaga*, appellate decisions regarding whether a given Medicaid provision is privately enforceable have been remarkably consistent. See Jane Perkins, *Pin the Tail on the Donkey: Beneficiary Enforcement of the Medicaid Act Over Time*, 9 St. Louis U. J. Health L. & Pol'y 207, 226 tbl.2 (2016).

Petitioner urges this Court to reject "Respondents' lax test" by pointing to eight other provisions of § 1396a(a) that contain "individual-focused, benefit-conferring language" and the apparently negative "implications" of recognizing that each creates an enforceable right. Pet. Br. at 37-40. But with one exception, every Court of Appeals to have considered the identified provisions has already recognized that each is enforceable. *Amici* provide the survey below:

- Three courts of appeals (in the Second, Fifth, and Sixth Circuits) agree that § 1396a(a)(3) is enforceable, and no circuit disagrees.[8]

[8] See *Davis* v. *Shah*, 821 F.3d 231 (2d Cir. 2016); *Blanchard* v. *Forrest*, 71 F.3d 1163 (5th Cir. 1996); *Gean* v. *Hattaway*, 330 F.3d 758 (6th Cir. 2003).

- Seven courts of appeals (in the First, Third, Fourth, Fifth, Sixth, Tenth, and Eleventh Circuits) agree that § 1396a(a)(8) is enforceable, and no circuit disagrees.[9]
- Two courts of appeals (in the Second and Sixth Circuits) agree that § 1396a(a)(10)(B) is enforceable, and no circuit disagrees.[10]
- The Court of Appeals for the Second Circuit has found § 1396a(a)(10)(D) enforceable, and no circuit disagrees.[11]
- The exception noted above, the Court of Appeals for the Ninth Circuit has found § 1396a(a)(32) unenforceable.[12] No circuit disagrees with the Ninth Circuit's conclusion.
- The Court of Appeals for the Fifth Circuit has found § 1396a(a)(34) enforceable, and no circuit disagrees.[13]

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[9] See *Bryson* v. *Shumway*, 308 F.3d 79 (1st Cir. 2002); *Sabree* v. *Richman*, 367 F.3d 180 (3d Cir. 2004); *Doe* v. *Kidd*, 501 F.3d 348 (4th Cir. 2007); *Romano* v. *Greenstein*, 721 F.3d 373 (5th Cir. 2013); *Waksul* v. *Washtenaw Co. Cmty. Mental Health*, 979 F.3d 426 (6th Cir. 2020); *Lewis* v. *N.M. Dep't of Health*, 261 F.3d 970 (10th Cir. 2001); *Doe* v. *Chiles*, 136 F.3d 709 (11th Cir. 1998). Note, however, that the Fifth Circuit recently held that that provision did not establish a privately enforceable right to transportation services. See *Thurman* v. *Med. Transp. Mgmt., Inc.*, 982 F.3d 953, 958 (5th Cir. 2020) ("Paragraphs 8 and 19 do not mention transportation at all. And there is no basis for reading a transportation right into those paragraph.").

[10] See *Davis* v. *Shah*, 821 F.3d 231 (2d Cir. 2016); *Waksul* v. *Washtenaw Co. Cmty. Mental Health*, 979 F.3d 426 (6th Cir. 2020).

[11] See *Davis* v. *Shah*, 821 F.3d 231 (2d Cir. 2016).

[12] See *Polk* v. *Yee*, 36 F.4th 939 (9th Cir. 2022).

[13] See *Blanchard* v. *Forrest*, 71 F.3d 1163 (5th Cir. 1996).

- Petitioner also cites § 1396a(a)(12), § 1396a(a)(53)(A)-(B), and § 1396a(a)(84)(A)-(B). The United States, for its part, separately emphasizes the apparent import of § 1396a(a)(12). U.S. Br. at 27-28. As far as *amici* are aware, however, none of those provisions, including § 1396a(a)(12), has been litigated in any court, state or federal, trial or appellate.

Critically, the consistency of the courts of appeals cuts in both directions. For instance, every circuit to have considered the question has held that private parties cannot sue under § 1983 to enforce Medicaid's reasonable standards provision, 42 U.S.C. § 1396a(a)(l7). They have likewise uniformly reached the same conclusion for Medicaid's equal access provision, 42 U.S.C. § 1396a(a)(30)(A), and for Medicaid's third-party-liability provision, 42 U.S.C. § 1396a(a)(25). That record makes crystal clear that courts are not lacking in guidance and understanding when it comes to this area of the law.

Petitioner nonetheless asks this Court to address the precedential status of *Wilder* v. *Virginia Hospital Association*, 496 U.S. 498 (1990), and *Blessing* v. *Freestone*, 520 U.S. 329 (1997). But *Talevski* already did the latter, clarifying that the sole governing test is "set forth" by *Gonzaga*. See 599 U.S. at 183 ("*Gonzaga* sets forth our established method for ascertaining unambiguous conferral" of private rights in the Spending Clause context); *id.* at 193 (Barrett, J., concurring) ("*Gonzaga University* v. *Doe* sets the standard for determining when a Spending Clause statute confers individual rights[.]").

If the Court affirms the decision of the Fourth Circuit in this case, moreover, there will be no need to overturn *Wilder*. *Gonzaga* already addressed *Wilder*'s methodological holding. See *Gonzaga*, 536 U.S. at 283 ("We now reject the notion that our cases permit anything short of an unambiguously conferred right to support a cause of action brought under § 1983."). And *Wilder*'s substantive holding is of no continuing relevance as the statutory provision that was at issue in the case has since been repealed. See Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4711, 111 Stat. 251, 507-508. Finally, *Wilder*'s arguable secondary holding—that the "administrative scheme" of the Medicaid Act "cannot be considered sufficiently comprehensive to demonstrate a congressional intent to withdraw the private remedy of § 1983," 496 U.S. at 521-522—is entirely consistent with *Talevski*. See *Talevski*, 599 U.S. at 188-192; *id.* at 182 (explaining that the FNHRA "like other aspects of Medicaid" "anticipates 'cooperative federalism'"). There, this Court observed that the FNHRA, much like its § 1396a peers, "establishes a detailed administrative scheme" and "authorizes government actors to sanction and correct noncompliant facilities, or, if appropriate, exclude them from the Medicaid program." *Id.* at 182. And yet, none of that rose to the level of displacing enforceability under § 1983.

Although Petitioner conjures up a parade of horribles, here "the best indication that the sky will not fall" if the decision below is affirmed "is that it has not done so already." *Melendez-Diaz* v. *Massachusetts*, 557 U.S. 305, 325 (2009). Some provisions of the Medicaid Act already have been found enforceable, and a stable body of provision-by-provision enforcement history has emerged, as demonstrated

above. In contrast, nothing but speculation supports the consequences that Petitioner posits. For instance, Petitioner tells this Court that when private rights are found "buried in state plan requirements," the cost of Medicaid for states "increase[s] exponentially." Pet. Br. 53. But Petitioner admits that "[t]he cost of these federal lawsuits is not easily quantified." *Id.* at 44. In all events, if Petitioner were correct, these cost increases would have manifested themselves long ago, given that the courts of appeals have already addressed the very provisions to which Petitioner points. See *id.* at 37-40, 44. Given that Petitioner cannot point to any real world problems in the here and now, there is no reason to credit such hyperbolic speculation about adverse consequences for the states in the future.

Nor would affirming the decision below result, in any meaningful sense, in additional litigation. Petitioner has asserted that, because the words "individual" and "individuals" appear throughout § 1396a, if the Court were to agree with Respondents, then the "federal code teems with implied private rights enforceable under § 1983." Pet. Cert. Reply at 9. That argument can charitably be described as confused: The absolute number of privately enforceable rights in § 1396a is a poor litmus test for, well, anything. Medicaid is a gargantuan statute, by itself spanning multiple volumes of the United States Code. That some private rights might appear in one section—a section directing states to create programs that respect certain enumerated individual rights no less, see § 1396a(a)—is hardly dispositive or predictive of the remainder of the Medicaid Act. In future litigation, individual Medicaid provisions will be examined by courts according to the "established method" set

forth in *Gonzaga* and ordinary rules of statutory construction. See *Talevski*, 599 U.S. at 183. The Court's decision in this case will not blanket the entirety of the Medicaid Act. Instead, *Talevski*'s bar will remain high, and only those Medicaid provisions that can meet it will be deemed privately enforceable under § 1983.

B. Petitioner's proposed test is unnecessary and unworkable.

In truth, what Petitioner seeks is a new test. On its telling, a private right is enforceable through § 1983 when, and only when, Congress "explicitly uses the label 'right' or lifts language from the rights-creating provisions of the Constitution." Pet. Br. at 23. "Absent such language," says Petitioner, Congress cannot create an individually enforceable right. *Id.* at 16. For its part, the United States suggests that Congress must either use a synonym for "right" or, instead, must "create[] a separate, separately subtitled provision focused expressly on rights" as was the case in *Talevski*. U.S. Br. at 26. Taken together, Petitioner and the United States would have this Court adopt not a rule, but a flowchart: (1) consider whether the statute uses the label "right," (2) if no, consider whether the statute uses language "lifted" from the Bill of Rights, (3) if no, consider whether the statute uses a synonym for "right," (4) if no, consider whether the statute creates a separate, separately subtitled provision expressly focused on rights. That approach finds no support in this Court's approach to construing federal statutes. The authority of Congress flows from Article I of the Constitution, not incantations of magical language. So long as Congress speaks unambiguously, it can create an enforceable right through whatever language it chooses to use.

See *Alexander* v. *Sandoval*, 532 U.S. 275, 286 (2001) ("The judicial task is to interpret the statute Congress has passed to determine whether it displays an intent to create not just a private right but also a private remedy.").

Petitioner's desired "rule," moreover, ignores the other elements of the established method set forth in *Gonzaga*, including, for instance, whether the focus of a given provision is aggregate or individual. In short, the Court should not make what was plainly sufficient in *Talevski*, see 599 U.S. at 184, a necessity moving forward. Because it "is always appropriate to assume that our elected representatives, like other citizens, know the law," *Cannon* v. *Univ. of Chicago*, 441 U.S. 677, 696-697 (1979), changing the rules of play at this late stage does not accord Congress the respect it is due as an equal branch of the government.

But even accepted on its own erroneous terms, Petitioner's argument fails to persuade. Petitioner contends that certain provisions of Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d *et seq.*, and of Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681 *et seq.*, contain clear rights-creating language because Congress used "language lifted from the Constitution's Bill of Rights." Pet. Br. at 16. But Petitioner nowhere identifies that reasoning in relevant decisions from this Court. And the phrase on which Petitioner hangs so much, "no person . . . shall . . . . be subjected to," *e.g.*, Pet. Br. at 26, is simply the mirror image of "any individual . . . may obtain," 42 U.S.C. § 1396a(a)(23)(A). The phrase "any individual . . . may obtain such assistance from any institution . . . qualified to perform the service," *id.*, is indistinguishable in substance from the phrase

"no person shall be prevented from obtaining such assistance from any institution qualified to perform the service." Of course, Congress could have used the phrase "no person shall," but it was not required to do so.

The outcome of this case is clear under *Talevski*. Turning away from such a recently decided decision would not be prudent or reasonable. Nor is it remotely necessary in light of the circuit-level consensus and established, decades-long record of consistent and principled judicial decision-making regarding which provisions of the Medicaid Act may be enforced via § 1983 and which may not. See pages 19-21 *supra*. There is no good reason to adopt anything like the "magic words" tests that Petitioner and the United States press—and doing so would severely undermine access to quality healthcare for low-income and underserved individuals.

Take the facts of this case: Patients, like Respondent Julie Edwards, who are insured through Medicaid choose Planned Parenthood South Atlantic (PPSAT) for many reasons, including that it has designed its services to help low-income patients overcome barriers to accessing care. See Resp. Br. at 7. 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" for patients who do not speak English. *Id.* For low-income patients who work full-time in one or multiple jobs, finding time to go to the doctor can be a challenge. The ability to choose a facility that can accommodate a difficult schedule is often the difference between going to the doctor and not. Allowing patients to choose a doctor who they trust and with whom they feel com-

fortable, moreover, is a crucial component of patient autonomy, satisfaction, and even health outcomes. In that regard, freedom of access to qualified providers complements Medicaid's primary goal of increasing access to healthcare for all. It is irrelevant that, in Petitioner's view, "South Carolinians in the Medicaid program have access to plenty of providers." Pet. Br. at 42. It is not for Petitioner to persuade this Court that "Waverly Women's Health" would have been a better care choice for Respondent Edwards, see *id.* at 9-11; instead it is for Waverly Women's Health to compete for, and earn, her patronage.

Petitioner's treatment of Planned Parenthood, moreover, is subject to no limiting principle. As multiple Courts of Appeals have recognized: "If the states are free to set any qualifications they want—no matter how unrelated to the provider's fitness to treat Medicaid patients—then the free-choice-of-provider requirement could be easily undermined by simply labeling any exclusionary rule as a 'qualification.'" *Planned Parenthood Ariz. Inc.* v. *Betlach*, 727 F.3d 960, 970 (9th Cir. 2013) (quoting *Planned Parenthood of Ind., Inc.* v. *Comm'r of Ind. State Dept. Health*, 699 F.3d 962, 978 (7th Cir. 2012)).

Worse still, the effects of that limitless discretion will be unequally borne: As the Fifth Circuit recognized, "a state agency may determine that a Medicaid provider is unqualified and terminate its Medicaid provider agreement *even if* the provider is lawfully permitted to provide health services to the general public." *Planned Parenthood of Greater Texas Fam. Plan. & Preventative Health Servs., Inc.* v. *Kauffman*, 981 F.3d 347, 369 (5th Cir. 2020) (en banc). Indeed, Petitioner has never disputed Planned Parenthood's medical qualifications to perform the family-planning

services on which Respondent Edwards relies. See *Planned Parenthood South Atlantic* v. *Kerr*, 95 F.4th 152, 169 (4th Cir. 2024). And Planned Parenthood continues to provide its services, from cancer screenings to contraceptive counseling, to South Carolinians the state over, provided they can pay their own way.

Congress unambiguously conferred federal rights in § 1396a(a)(23)(A), but, in truth, it is a seldom litigated provision that overwhelmingly has been invoked in response to partisan efforts to disqualify Planned Parenthood from providing necessary medical care to eligible patients living below the poverty level. For patients with means, Planned Parenthood presumably remains in all respects "qualified." Indeed, of the six decisions composing the circuit split that this Court granted certiorari to resolve, the vast majority—all but one, see *Harris*, 442 F.3d at 456—involve Planned Parenthood or its affiliates. That is not a coincidence. But "neutrally applying the law is all the more important when political issues are in the background." *Gee* v. *Planned Parenthood of Gulf Coast, Inc.*, 586 U.S. 1057, 1059 (2018) (Thomas, J., dissenting from denial of certiorari). And, as the Court put it just this term: "Rather than choose sides in a policy debate, this Court must apply the statute as written[.]" *E.M.D. Sales, Inc.* v. *Carrera*, 604 U.S. 45, 53 (2025).

CONCLUSION

In view of the above, *amici* respectfully request that the Court affirm the opinion below.

Respectfully submitted,

JANE PERKINS
SARAH SOMERS
NATIONAL HEALTH LAW PROGRAM
1512 E. Franklin St., Suite 100
Chapel Hill, NC 27514

DONALD B. VERRILLI, JR.
Counsel of Record
TAYLOR GLEICHAUF
MUNGER, TOLLES & OLSON LLP
601 Massachusetts Ave. NW
Suite 500E
Washington, DC 20001
(202) 220-1100
Donald.Verrilli@mto.com
Taylor.Gleichauf@mto.com

Counsel for *Amici Curiae*

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