NO. _____

IN THE

Supreme Court of the United States

JOSHUA BAKER, in his official capacity as Director, South Carolina Department of Health and Human Services,

Petitioner,

v.

JULIE EDWARDS, on her behalf and on behalf of all others similarly situated, et al.,

Respondents.

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

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

Last Term, three members of this Court urged review of an "important and recurring" question at the heart of a (now) 6-1 circuit split—whether Medicaid recipients have a private right to demand a provider of their choice. *Gee* v. *Planned Parenthood of Gulf Coast, Inc*, 139 S. Ct. 408, 409 (2018) (Thomas, J., dissenting from denial of certiorari). That question results from a broader circuit conflict, equally "worthy of this Court's attention," involving inconsistent application of this Court's precedents when deciding whether to read private rights into ambiguous statutory text in Spending Clause statutes. *Ibid.*; App.41a (Richardson, J., concurring). The result has been confusion and disparate treatment of litigants.

The questions presented are:

1. Whether Medicaid recipients have a private right of action under 42 U.S.C. 1983 and 42 U.S.C. 1396a(a)(23) to challenge a state's determination that a specific provider is not qualified to provide certain medical services.

2. What is the proper framework for deciding whether a statute creates a private right enforceable under 42 U.S.C. 1983?

PARTIES TO THE PROCEEDING

Petitioner is Joshua Baker, the Director of the South Carolina Department of Health and Human Services ("the Department"). Respondents are Julie Edwards, who sued on her own behalf and on behalf of all others who are similarly situated, and her preferred Medicaid provider, Planned Parenthood South Atlantic.

LIST OF ALL PROCEEDINGS

1. United States Court of Appeals for the Fourth Circuit, No. 18-2133, *Planned Parenthood S. Atlantic* v. *Baker*, judgment entered October 29, 2019.

2. United States District Court for the District of South Carolina, No. 3:18-cv-02078-MGL, temporary restraining order and preliminary injunction ordered August 28, 2018.

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The district court opinion granting Respondents a temporary restraining order and a preliminary injunction is reported at 326 F. Supp. 3d 39 (D.S.C. 2018) and reprinted at App.46a–66a. The Fourth Circuit's opinion affirming the district court is reported at 941 F.3d 687 (4th Cir. 2019) and reprinted at App.1a–45a.

STATEMENT OF JURISDICTION

The Fourth Circuit entered judgment on October 29, 2019. On January 8, 2020, the Chief Justice extended the time to petition for a writ of certiorari until March 27, 2020. Petitioner invokes this Court's jurisdiction under 28 U.S.C. 1254(1).

PERTINENT STATUTES

The relevant portions of the pertinent statutes are reprinted at App.67a–68a.

INTRODUCTION

The Fourth Circuit has joined "five of six" circuits in holding that the Medicaid Act's any-qualified-provider provision confers on Medicaid recipients "a private right, enforceable under § 1983." App.16a–17a. In subjecting South Carolina to a lawsuit based on statutory text that provides no private rights, the Fourth Circuit had to reconcile this Court's directives regarding private rights in Spending Clause statutes, a task "assuredly not for the timid." *Sabree ex rel. Sabree* v. *Richman*, 367 F.3d 180, 183 (3d Cir. 2004). Those precedents have produced a host of differing lower-court results, "suggest[ing] that [the Court's] opinions in this area may not be models of clarity." *Gonzaga Univ.* v. *Doe*, 536 U.S. 273, 278 (2002).

This Court tried to "resolve [that] ambiguity" in *Gonzaga*. *Ibid.* A plurality tried again in *Armstrong* v. *Exceptional Child Center, Inc.*, 575 U.S. 320 (2015). Neither effort was successful; in trying to reconcile *Gonzaga* and *Armstrong* with the Court's older decisions, most lower courts have misread them.

Accordingly, this petition asks the Court to resolve "a conflict on a federal question with significant implications: whether Medicaid recipients have a private right of action to challenge a State's determination of 'qualified' Medicaid providers." *Gee*, 139 S. Ct. at 408 (Thomas, J., dissenting from denial of certiorari). It also asks the Court to resolve the "broader question" spawning many additional circuit splits: what is the proper framework for deciding whether a statute creates a right, privately enforceable under § 1983? App.41a (Richardson, J., concurring). Review is crucial to resolve these significant, recurring questions.

STATEMENT OF THE CASE

A. Statutory background

1. Congress passes the Medicaid Act to fund state efforts to provide free/low-cost medical services to people in need

In 1965, Congress created Medicaid, "a federal program that subsidizes the States' provision of medical services" to families and individuals "whose income and resources are insufficient to meet the costs of necessary medical services." *Armstrong*, 575 U.S. at 323 (quoting 42 U.S.C. 1396–1). The program "is a cooperative federal-state program that provides medical care to needy individuals." *Douglas* v. *Indep. Living Ctr. of S. Cal., Inc.*, 565 U.S. 606, 610 (2012).

"Like other Spending Clause legislation, Medicaid 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*, 575 U.S. at 323. States create "plans for medical assistance" and submit them to the Secretary of Health and Human Services for approval and disbursement of funds. 42 U.S.C. 1396-1. If the Secretary later finds "that in the administration of the plan there is a failure to comply substantially" with the Act's requirements, the Secretary may withhold all or part of the state's funds until the Secretary "is satisfied that there will no longer be any such failure to comply." 42 U.S.C. 1396c.

2. Congress adds any-qualified-provider requirement

Two years later, Congress amended the Medicaid Act to add § 1396a(a)(23)(A) in response to concerns states were forcing Medicaid recipients to use one of a limited number of specific providers. *E.g.*, President's Proposals for Revision in the Social Security System, Hearing on H.R. 5710 before the H. Comm. On Ways and Means, Part 4 (April 6 and April 11, 1967), at 2273 (in Puerto Rico, "[i]ndigent patients [were being] 'forced' to receive hospital and medical services only in Commonwealth facilities"); 2301 (in Massachusetts, private physicians at "teaching hospitals" were not being reimbursed).

The added provision requires that plans "must" allow "any individual eligible for medical assistance" to "obtain such assistance from any [provider] qualified to perform the service or services required . . . who undertakes to provide" them. 42 U.S.C. 1396a(a)(23)(A). Some courts call this provision the "free-choice-of-provider" provision. But that overlooks the provision's requirement that recipients can choose from a "range of *qualified* providers." *O'Bannon* v. *Town Court Nursing Ctr.*, 447 U.S. 773, 785 (1980). So § 1396a(a)(23)(A) is actually an "any-*qualified*-provider" provision.

The Medicaid Act does not define "qualified." But it specifies that states retain broad authority to exclude providers "for any reason for which the Secretary could exclude the individual or entity from participation in" the *Medicare* program, "[i]n addition to any other authority" states retain to exclude providers. 42 U.S.C. 1396a(p)(1).

3. South Carolina procedures and remedies for excluded providers

The Medicaid Act contemplates states will provide administrative procedures and remedies for excluded providers. *E.g.*, 42 U.S.C. 1396a(a)(4)(A), (39), (41), (77); 1396a(p); 1396a(kk)(8)(B)(ii). And federal regulations require states to provide "administrative procedures" and "any additional appeals rights that would otherwise be available under procedures established by the State." 42 C.F.R. 1002.210; 1002.213.

Consistent with those requirements, South Carolina provides Medicaid providers the right to a hearing before a proposed exclusion, suspension, or termination based on certain grounds. S.C. CODE ANN. REGS. 126-404. South Carolina also provides an administrative appeal process to anyone "possessing a right to appeal." S.C. CODE ANN. REGS. 126-150.

That right to appeal can result from "statutory, regulatory and/or contractual law." *Ibid.* And the Department's enrollment agreements state that "for any dispute arising under [them], the provider shall have as his sole and exclusive remedy the right to request a hearing" from the Department within 30 days of the contested action. R.15, Joint Appendix, *Planned Parenthood S. Atlantic* v. *Baker*, (4th Cir. Nov. 26, 2018) ("JA") at JA115, JA139. Those proceedings must align with the Department's "appeals procedures and S.C. Code Ann. 1-23-310 et. seq." *Ibid.* Judicial review is under S.C. Code Ann. 1-23-380. *Ibid.*

B. Factual background

1. South Carolina deems Planned Parenthood unqualified

On July 13, 2018, South Carolina's Governor issued an executive order directing the Department to (1) deem abortion clinics unqualified to provide family planning services, (2) terminate any enrollment agreements with them, and (3) deny future enrollment applications from them. App.78a. This order is consistent with recent regulations excluding abortion providers from Title X funding for the federal government's family planning program. 42 C.F.R. 59.16.

The Governor's order also follows S.C. CODE ANN. § 43-5-1185, which prohibits the use of funds to pay for abortions, because "the payment of taxpayer funds to abortion clinics, *for any purpose*, results in the subsidy of abortion and the denial of the right to life." App.76a–77a (emphasis added). Disqualifying clinics promotes the state's interest in defending life while ensuring that agencies that do not perform abortions receive funding to provide "access to necessary medical care and important women's health and family planning services." *Ibid.*

The same day the Governor issued the executive order, the Department sent a letter to Planned Parenthood South Atlantic notifying it of the order and that Planned Parenthood was "no longer . . . qualified to provide services to Medicaid beneficiaries." App.80a–81a. Thus, "Planned Parenthood's enrollment agreements . . . [were] terminated effective July 13, 2018." App.81a. Though Planned Parenthood could qualify for South Carolina Medicaid funding by discontinuing abortions, it has not done so.

2. Planned Parenthood and a client sue in federal court; Planned Parenthood eventually files administrative appeal

Two weeks later, Planned Parenthood South Atlantic and Julie Edwards, one of its Medicaid clients, sued the Director in federal district court. JA7. Three days after that, they moved for a temporary restraining order and a preliminary injunction. JA21. They argued that by terminating Planned Parenthood's enrollment agreements, the Director violated Medicaid recipients' right "to obtain family planning and other preventive health care services from the qualified provider of their choosing under 42 U.S.C. § 1396a(a)(23)." *Ibid.*

The Director opposed the motion because the any-qualified-provider provision "does not unambiguously create a federal right enforceable by providers and individual patients under 42 U.S.C. § 1983." JA84. Citing *O'Bannon* v. *Town Court Nursing Center*, 447 U.S. 773 (1980), the Director added that Planned Parenthood and Edwards were reading the alleged right too broadly. JA87–89.

In several places in the Director's opposition brief, he referenced Planned Parenthood's right to an administrative appeal and resulting judicial review, and Planned Parenthood's apparent decision to forgo such an appeal. JA82, JA88, JA90. On August 14, 2018, Planned Parenthood filed an administrative appeal—a day *after* the contractual, 30-day deadline—which remains pending.

C. Decisions below

1. The district court grants a TRO and a preliminary injunction

The district court granted Edwards's motion for a temporary restraining order and preliminary injunction and, because that ruling resolved the issue, declined to analyze Planned Parenthood's right to that relief. App.47a, 65a–66a. On the "issue of whether § 1396a(a)(23)(A) creates a private right of action enforceable through § 1983," the court applied the three factors this Court enunciated in *Blessing* v. *Freestone*, 520 U.S. 329 (1997), and held that it does. App.52a–55a.

2. The Fourth Circuit notes circuit split and affirms

The Director appealed, and the Fourth Circuit affirmed, holding that (1) "Congress's intent to create an individual right enforceable under § 1983 in the free-choice-of-provider provision is unambiguous," and (2) "a plain-language reading of the provision's mandate . . . bars states from excluding providers for reasons unrelated to professional competency." App.4a.

On the threshold question, the court of appeals started with the *Blessing* factors, assessed whether "Congress expressly or implicitly foreclosed a § 1983 remedy," and "join[ed] the Fifth, Sixth, Seventh, Ninth, and Tenth Circuits in finding . . . a private right enforceable under § 1983." App.16a–23a. The court mentioned—but did not discuss—the Eighth Circuit's contrary holding in *Does* v. *Gillespie*, 867 F.3d 1034 (8th Cir. 2017). App.17a, 23a.

"Taking the first *Blessing* factor," the court held that "the phrase 'any individual' is a prime example of the kind of 'rights-creating' language required to confer a personal right." App.16a–17a. The court spurned the Director's point that, in context, the any-qualified-provider provision is "no more than a 'plan requirement,'" not an individual right. App.24a–25a.

"As for the second *Blessing* factor," the court concluded that the provision "is not so vague and amorphous that its enforcement would strain judicial competence." App.18a (cleaned up). The court disregarded the Director's argument that—considering all the reasons a provider could be *un*qualified—courts will have trouble making that determination. App.18a–19a.

On the third *Blessing* factor, the court said that the provision's text "unambiguously imposes a binding obligation on the States" because "states 'must provide' a Medicaid recipient with his or her choice of provider qualified to perform the service at issue." App.19a (cleaned up).

Finally, the court determined that Medicaid's enforcement scheme does not "foreclose a private right of action." App.20a. The court did not deny "the Secretary's ability to cut Medicaid funds" to states that fail to comply. App.21a. But the court disparaged that remedy—calling it "drastic" and "illogical"—and cited the now-discredited *Wilder* v. *Virginia Hospital Association*, 496 U.S. 498 (1990), as evidence that the Court "has already held that the Medicaid Act's administrative scheme" is not "comprehensive" enough "to foreclose a private right of action." App.21a–22a.

The court professed a recognition that it "must be especially cautious in finding that a provision in Spending Clause legislation, such as the Medicaid Act, creates a private right enforceable under § 1983." App.25a. Still, the court protested that courts should not relieve "sovereign signatories to a 'contract' such as the Medicaid Act" of the "consequences" of their agreement, including conferring private rights on third parties. App.26a. This Court's decisions "suggest a move away from inferring private rights of action in Spending Clause legislation," the court closed. *Ibid.* But "for now [that] argument remains speculative and conjectural." *Ibid.*

Judge Richardson expanded on that point in his concurrence: "As lower court judges," the court was "bound to do [its] level best to apply the law as it is, not how it may become." App.40a. "But when binding precedents present [the court] with a bit of 'a mess of the issue,'" its "job becomes particularly challenging." App.40a–41a (quoting *Gee*, 139 S. Ct. at 409 (Thomas, J., dissenting from denial of certiorari)).

"The challenge here derives from a broader question lurking in the background." App.41a. "What is the proper framework for determining whether a given statute creates a right that is privately enforceable?" *Ibid.* That question begs a more specific one: has *Wilder* "been repudiated (or even effectively overruled)?" *Ibid.* "There are indications that it has." *Ibid.* (citing *Armstrong*, 575 U.S. at 330 n.*). But lower courts "do not lightly conclude that the Supreme Court has overruled its prior cases—that job is for the Supreme Court alone." *Ibid.*

REASONS FOR GRANTING THE WRIT

This case presents an ideal opportunity for the Court to resolve "a conflict on a federal question with significant implications: whether Medicaid recipients have a private right of action to challenge a State's determination of 'qualified' Medicaid providers under 42 U.S.C. § 1396a(a)(23)" and § 1983. *Gee*, 139 S. Ct. at 408 (Thomas, J., dissenting from denial of certiorari). Now, six "Circuits have held that Medicaid recipients have such a right." *Id.* at 408–09. "[O]ne Circuit," the Eighth, "has held that they do not." *Id.* at 409. And one Circuit, the Fifth, may be on the brink of reversing its earlier decision. See *Planned Parenthood of Greater Tex. Family Planning & Preventative Health Servs., Inc.* v. *Smith*, 914 F.3d 994, 996 (5th Cir. 2019) (granting rehearing en banc "on the Court's own motion" to reconsider previous panel decision and 7-7 denial of rehearing en banc).

This case also "implicates fundamental questions about the appropriate framework for determining when a cause of action is available under § 1983—an important legal issue independently worthy of this Court's attention." *Gee*, 139 S. Ct. at 409 (Thomas, J., dissenting from denial of certiorari). "The division in the lower courts stems, at least in part, from this Court's own lack of clarity on the issue." *Ibid.* That defect has spawned "confusion" and "uncertainty" as "courts have relied on the same set of opinions," *Gonzaga*, 536 U.S. at 278, 283, to reach very different results—generating *multiple* circuit splits across a broad spectrum of statutes. Those splits will deepen and continue to multiply unless the Court clears up numerous unresolved questions:

What is the proper framework for deciding whether a statute creates a private right under § 1983? Which of the Court's cases on that issue—or which *portions* of those cases—remain good law? Has the Court overruled *Wilder in toto*, or just repudiated it in part? Does the plurality portion of *Armstrong* represent *the Court's* position that courts should treat Spending Clause statutes like contracts between two governments, or may courts continue to ignore it? Should courts reflexively apply the three *Blessing* factors? Or should they focus on the broader question in *Gonzaga*? Should they find a way to do both?

These are important and recurring questions involving numerous lower courts that continue to find congressional intent to provide private rights in ambiguous statutory text. The Court should grant the petition and reverse.

I. Courts of appeals are split over the narrow Medicaid Act issue and over the broader framework issue underlying it.

A. This Court's conflicting signals created a circuit split over the Medicaid Act's any-qualified-provider provision.

At the time of this filing, courts of appeals are split 6-1 over the first question presented: whether Medicaid recipients have a private right of action to challenge a state's determination that a provider is not qualified to provide certain medical services. That split could soon deepen if the Fifth Circuit sitting en banc in *Smith* overrules its decision in *Gee*. Either way, the split will not resolve itself without this Court's intervention.

The lower-court conflict "can be explained in part by an evolution" in this Court's cases. *Does*, 867 F.3d at 1043. That is perhaps "a tactful way of saying that this Court made a mess of the issue." *Gee*, 139 S. Ct. at 409 (Thomas, J., dissenting from denial of certiorari). Tracing that "evolution" illuminates the source of confusion.

1. In *Wright* and *Wilder*, the Court was hasty to infer privately enforceable rights from Spending Clause statutes.

Three decades ago, this Court decided two cases that undergird the circuit splits at issue here.

In *Wright* v. *Roanoke Redevelopment and Housing Authority*, a closely divided Court found a privately enforceable right to reasonable utility rates under an amendment to the Housing Act. 479 U.S. 418, 419 (1987). Looking to "legislative history" and "agency actions," the Court disagreed that the administrative scheme "foreclosed private enforcement" and that a "reasonable allowance" provision was "too vague and amorphous to confer on tenants an enforceable right." *Id.* at 424–25, 431 (cleaned up). Drawing a negative inference from silence, the Court held that nothing "evidence[d] that Congress intended to *preclude* [a] § 1983 claim." *Id.* at 424–25, 429 (emphasis added).

Four justices dissented. Starting with "the face of the statute," they saw "nothing to suggest that Congress intended that utilities be *included* within the statutory entitlement." *Id.* at 434 (O'Connor, J., dissenting) (emphasis added). Nor did the law's "legislative history, nor [the agency's] interpretation" support "the conclusion that Congress intended to create [such] an entitlement." *Id.* at 441.

Three years later, in *Wilder*, an equally divided Court held that a Medicaid Act amendment "create[d] a right enforceable by health care providers under § 1983" to "reasonable and adequate" reimbursement rates. 496 U.S. at 509–10. Healthcare providers were the intended beneficiaries, the Court reasoned. *Id.* at 510. And the Court in *Wright* had established that "reasonable" requirements were not too "vague and amorphous" to be enforceable. *Id.* at 511–12, 519. The amendment's language about what a state plan "must" provide was "cast in mandatory rather than precatory terms." *Id.* at 512. And "the Secretary [was] authorized to withhold funds for noncompliance with [the] provision." *Id.* at 512, 521. Considered together and in light of the amendment's "legislative history," the Court believed "that Congress intended to require States to adopt rates that actually are reasonable and adequate," and further "intended that health care providers be able to sue in federal court" to enforce their rights. *Id.* at 515–16.

Again, four justices dissented. Citing the "traditional rule" that analysis starts and ends with the statutory text, the dissent chided the majority for "virtually ignor[ing] the relevant text of the Medicaid statute." *Id.* at 526–27 (Rehnquist, C.J., dissenting). The pertinent provision was "simply a part of the thirteenth listed requirement for [state] plans." *Id.* at 527. Thus, it followed that the provision was "addressed to the States and merely establishe[d] one of many conditions for receiving Medicaid funds." *Ibid.* The "text [did] not clearly confer any substantive rights on Medicaid services providers." *Ibid.* And the majority's contrary holding took serious "liberties with the statutory language." *Id.* at 528–29.

2. In *Suter* and *Blessing*, the Court pulled back—adding a multi-factored test and rebuttable presumption in the process.

Two years later, in *Suter* v. *Artist M.*, this Court reversed a Seventh Circuit decision that, "[r]elying heavily" on *Wilder*, had held "that the 'reasonable efforts' clause of the Adoption Act could be enforced" through § 1983. 503 U.S. 347, 353–54 (1992). Distinguishing *Wilder*, this Court held that "[c]areful examination of the [statutory] language," read "in the context of the entire Act," confirmed that "the 'reasonable efforts' language [did] *not* unambiguously confer an enforceable right upon the Act's beneficiaries." *Id.* at 359, 363 (emphasis added). Instead, the phrase could be "read to impose only a generalized duty on the State, to be enforced not by private individuals, but by the Secretary" through his "authority to reduce or eliminate payments to a State" for non-compliance or for a "substantial failure" to comply with the state's own plan. *Id.* at 360, 363.

This time, only two justices dissented. In their view, the Court's conclusion conflicted with *Wilder*. *Id.* at 365 (Blackmun, J., dissenting). They complained that "the Court's reasoning [was] consistent with the *dissent* in *Wilder*," but that it "flatly contradict[ed] what the Court *held* in that case." *Id.* at 373. And it did so "by resurrecting arguments" *Wilder* "decisively rejected." *Id.* at 377.

Five years later, in *Blessing*, a unanimous Court continued *Suter*'s trajectory, reversing a decision holding that mothers whose children were eligible to receive child support services had an enforceable right under § 1983 to force the state to achieve "substantial compliance" with the Social Security Act's requirements. 520 U.S. at 332–33. The Ninth Circuit had "reconcil[ed] *Suter* and *Wilder*" by reading *Suter* as "an elaboration and amplification of the *Wilder* test rather than an unannounced and unacknowledged departure." *Freestone* v. *Cowan*, 68 F.3d 1141, 1148 (9th Cir. 1995).

This Court reversed, announcing a three-factored test. *Blessing*, 520 U.S. at 340. "First, Congress must have intended that the provision in question benefit the plaintiff." *Ibid.* "Second, the plaintiff must demonstrate that the right assertedly protected by the statute is not so vague and amorphous that its enforcement would strain judicial competence." *Id.* at 340–41 (cleaned up). "Third, the statute must unambiguously impose a binding obligation on the States." *Id.* at 341. Finally, "[e]ven if a plaintiff demonstrates that a federal statute creates an individual right, there is only a rebuttable presumption that the right is enforceable under § 1983." *Ibid.* That presumption can be rebutted if Congress has "expressly" forbidden "recourse to § 1983 in the statute itself," or if it has done so "impliedly" by "creating a comprehensive enforcement scheme that is incompatible with individual enforcement under § 1983." *Ibid.*

Careful not to "foreclose the possibility that some provisions of Title IV–D give rise to individual rights," the Court held that the Ninth Circuit painted "with too broad a brush." *Id.* at 342, 345. "[T]he substantial compliance standard [was] designed simply to trigger penalty provisions that increase the frequency of audits and reduce" the state's grant. *Id.* at 344. It "[did] not give rise to individual rights." *Ibid.* Leaving "open the possibility that Title IV–D may give rise to some individually enforceable rights," the Court offered that "the Secretary's oversight powers [were] not comprehensive enough to close the door on § 1983 liability" in all circumstances. *Id.* at 346, 348.

Two justices concurred. Since they agreed with the Court's holding "under the test set forth" in *Wright* and *Wilder*, it was "unnecessary to reach the question whether § 1983 *ever* authorizes the beneficiaries of a federal-state funding and spending agreement—such as Title IV-D—to bring suit." *Id.* at 349 (Scalia, J., concurring). The concurrence noted that the "law at the time § 1983 was enacted" appeared to be that a "third-party beneficiary was generally regarded as a stranger to the contract," and thus "could not sue upon it." *Id.* at 349–50. That argument "was not raised" in *Wright* or *Wilder*. *Id.* at 350. But the concurring justices joined the majority "because, in ruling against respondents under the *Wright/Wilder* test," it left open the "possibility that third-party-beneficiary suits simply do not lie." *Ibid.*

3. In *Gonzaga*, the Court tried to resolve the uncertainty in its cases, clarifying that only an unambiguously conferred right can create a cause of action.

Five years after *Blessing*, this Court granted certiorari "to resolve [a] conflict among the lower courts." *Gonzaga*, 536 U.S. at 278. In *Gonzaga*, the Washington Supreme Court had held that a student could sue his private university to enforce FERPA, the Family Educational Rights and Privacy Act, which prohibited "the federal funding of educational institutions [with] a policy or practice of releasing education records to unauthorized persons." *Id.* at 276, 278. This Court reversed, holding that the relevant provisions did not create any "personal rights to enforce" under § 1983. *Id.* at 276. Recognizing that the Court's opinions "may not be models of clarity," the Court tried to clarify the rules going forward. *Id.* at 278.

First, the Court noted that it had never held that "spending legislation drafted in terms resembling those of FERPA can confer enforceable rights." *Id.* at 279. Instead, the Court had "made clear that unless Congress 'speak[s] with a clear voice,' and manifests an 'unambiguous' intent to confer individual rights, federal funding provisions provide no basis for private enforcement by § 1983." *Id.* at 280 (quoting *Pennhurst State Sch. and Hosp.* v. *Halderman*, 451 U.S. 1, 17, 28 & n.21 (1981)).

Second, the *Gonzaga* Court distinguished *Wright* and *Wilder*. The provisions there, unlike here, had "explicitly conferred specific monetary entitlements *upon the plaintiffs*." *Id.* at 280 (emphasis added).

Third, the Court reiterated that its "more recent decisions [had] rejected attempts to infer enforceable rights from Spending Clause statutes." *Id.* at 281 (discussing *Suter* and *Blessing*). The Court eschewed any "loose standard for finding rights enforceable by § 1983." *Id.* at 282. Referencing *Blessing*'s "factors," the Court noted that some of the "language in [its] opinions might be read to suggest that something less than an unambiguously conferred right is enforceable by § 1983." *Ibid.* So the Court made sure to "now reject the notion that [its] cases permit anything short of an unambiguously conferred right to support a cause of action brought under § 1983." *Id.* at 283.

Fourth, the Court rebuffed the idea "that [its] implied right of action cases are separate and distinct from [its] § 1983 cases." *Ibid. Wilder* appeared "to support [that] notion." *Ibid. Suter* and *Pennhurst* appeared "to disavow it." *Ibid.* So the Court clarified that its "implied right of action cases should guide" analysis under § 1983. *Ibid.* Under both, if "the text and structure of a statute provide no indication that Congress intends to create new individual rights, there is no basis for a private suit." *Id.* at 286. Period.

Fifth, the Court rebutted the dissent's separation-of-powers argument. *Ibid.* Appearing to disparage *Blessing*'s three-factored test, the Court "fail[ed] to see how relations between the branches are served by having courts apply a multifactor balancing test to pick and choose which federal requirements may be enforced by § 1983." *Ibid.* If "Congress intends to alter the usual constitutional balance between the States and the Federal Government, it must make its intention to do so *unmistakably clear* in the language of the statute." *Ibid.* (emphasis added, cleaned up).

Considering all this, there was "no question that FERPA's nondisclosure provisions fail[ed] to confer enforceable rights." *Id.* at 287. The statute's "focus" on the Secretary of Education's "distribution of public funds to educational institutions" was "two steps removed from the interests of individual students and parents." *Id.* at 287, 290. "Recipient institutions" could "avoid termination of funding so long as they" substantially complied "with the Act's requirements." *Id.* at 288. The provisions "therefore create[d] no rights enforceable under § 1983." *Id.* at 290.

Two justices concurred; two dissented. The dissent accused the majority of requiring "more of plaintiffs" than the test "articulated in *Blessing*." *Id.* at 302 (Stevens, J., dissenting). And the dissent believed the majority had "*sub silentio* overrule[d] cases such as *Wright* and *Wilder*" by endorsing the implied-right-of-action framework. *Id.* at 300 n.8.

4. In *Harris*, *Commissioner of Indiana*, and *Betlach*, three Circuits found privately enforceable rights in the any-qualified-provider provision.

Even after *Gonzaga*, lower courts continued to reflexively apply *Blessing*'s test and to rely heavily on *Wilder*'s discredited decision to find privately enforceable rights in Spending Clause statutes.

In *Harris* v. *Olszewski*, the Sixth Circuit did exactly that regarding the Medicaid Act's any-qualified-provider provision. 442 F.3d 456 (6th Cir. 2006). After applying *Blessing*—and drawing mainly from *Wilder*—the court rejected the State's argument that the Act's enforcement scheme "implicitly foreclose[s]" private enforcement. *Id.* at 461–63.

Six years later, the Seventh Circuit also held that the provision "unambiguously creates private rights presumptively enforceable by § 1983." *Planned Parenthood of Ind., Inc.* v. *Comm'r of Ind. State Dep't of Health*, 699 F.3d 962, 974–75 (7th Cir. 2012) (cleaned up). That holding allowed the plaintiff to challenge a law eliminating "indirect subsidization of abortion" by "prohibiting abortion providers from receiving *any* state-administered funds." *Id.* at 967.

Like the Sixth Circuit, the Seventh applied the *Blessing* factors, found them satisfied, and held that Indiana failed to rebut the resulting presumption that the provision creates privately enforceable rights. *Id.* at 973. Indiana's position was "hard to reconcile" with *Wilder*. *Id.* at 976. And the state's "categorical argument" that Spending Clause statutes cannot create privately enforceable rights went further than this Court had gone in *Gonzaga*. *Ibid.*

Less than a year later, the Ninth Circuit followed suit, "joining the only two other circuits that [had] decided the issue." *Planned Parenthood Ariz. Inc.* v. *Betlach*, 727 F.3d 960, 963 (9th Cir. 2013). Like the courts before it, the Ninth Circuit applied the *Blessing* factors, quoting *Gonzaga* out of context to declare that, if "all three prongs are satisfied, 'the right is presumptively enforceable' through § 1983." *Id.* at 966 (quoting *Gonzaga*, 536 U.S. at 284). (Quite the opposite; in *Gonzaga*, this Court confirmed that a "right is presumptively enforceable by § 1983" *only* after "a plaintiff demonstrates that a statute confers an individual right." 536 U.S. at 284. *Gonzaga* did *not* endorse using *Blessing*'s "multifactor balancing test to pick and choose which federal requirements may be enforced by § 1983 and which may not." *Id.* at 286.)

5. In *Armstrong*, this Court repudiated *Wilder*, and a plurality applied contract principles to reject the argument for a private right under part of the Medicaid Act.

Less than two years after *Betlach*, this Court cast more doubt on *Wilder*, holding Medicaid providers cannot sue to enforce a provision requiring plans to reimburse them at sufficiently high rates. *Armstrong*, 575 U.S. at 324–25, 329. The providers had argued for such a right either under the Supremacy Clause or the Court's equitable powers. *Id.* at 326–27. The Court rejected both arguments. *Id.* at 327–29.

In a footnote, the Court added that the providers had "not claim[ed] that *Wilder* establishes precedent for a private cause of action." *Id.* at 330 n.*. The Court's "later opinions [had] plainly repudiate[d] the ready implication of a § 1983 action that *Wilder* exemplified." *Ibid.* For example, *Gonzaga* had "expressly reject[ed]" *Wilder*'s implicit notion that "anything short of an unambiguously conferred right" can support a § 1983 action. *Ibid.* (cleaned up).

In a plurality portion, four justices went further: "The last possible source of a cause of action" was "the Medicaid Act itself," which the providers "rightly" did not claim. *Id.* at 331 (plurality). "[P]hrased as a directive to the federal agency charged with approving" state plans, the provision "lack[ed] the sort of rights-creating language needed to imply a private right of action." *Ibid.* And "the explicitly conferred means" of enforcement, namely "the Secretary's withholding [of] funding," indicated that "other means" were "precluded." *Id.* at 331–32.

"Spending Clause legislation like Medicaid," the plurality emphasized, "is much in the nature of a contract." *Id.* at 332 (cleaned up). And "modern jurisprudence permitting intended beneficiaries to sue does not generally apply to contracts between a private party and the government—much less to contracts between two governments." *Ibid.* (cleaned up). Moreover, "a private right of action under federal law is not created by mere implication." *Ibid.* It "must be unambiguously conferred." *Ibid.* (cleaned up). And "[n]othing in the Medicaid Act suggests that Congress meant to change that" for the plan requirement before the Court. *Ibid.*

6. In *Gee*, *Does*, and *Andersen*, three Circuits reached conflicting results over private rights and the any-qualified-provider provision.

Following *Armstrong*, three more Circuits—the Fifth, Eighth, and Tenth—weighed in on the first question presented here.

The Fifth Circuit went first, "[j]oining every other circuit" to address the issue and holding that the any-qualified-provider provision created "a private right of action under § 1983." *Planned Parenthood of Gulf Coast, Inc.* v. *Gee*, 862 F.3d 445, 457 (5th Cir. 2017). To support its conclusion, the court applied the *Blessing* factors, *id.* at 458–59, cited other Circuits reaching the same result, *ibid.*, and distinguished a portion of *Armstrong*'s majority opinion, *id.* at 461–62. The court did not discuss the plurality's application of contract principles to Spending Clause legislation. The full court divided 7-7 over whether to rehear the case en banc. 876 F.3d 699 (5th Cir. 2017).

In *Does*, the Eighth Circuit took a more principled approach. Rather than rely on *Wilder* or apply the three *Blessing* factors, the court applied *Gonzaga* and *Armstrong* and examined the plain statutory text—leading the court to conclude that the any-qualified-provider provision "does not unambiguously create a federal right for individual patients that can be enforced under § 1983." *Does*, 867 F.3d at 1037.

Gonzaga and *Armstrong* proved that the "standard for identifying enforceable federal rights in spending statues is more rigorous" than "*Wilder* and *Blessing* might have suggested." *Id.* at 1039 (cleaned up). While the statutory provisions in *Wilder* had since been repealed—leaving the Court "no occasion formally to overrule" it—the Court's "repudiation" of *Wilder* was "the functional equivalent of overruling" it since "the Court uses the terms interchangeably." *Ibid.* (cleaned up). And for a host of reasons, the any-qualified-provider provision could not clear the "more rigorous" bar. *Id.* at 1039, 1041–43.

A dissenting judge would have applied *Blessing* and "join[ed] the four other circuit courts" finding a private right of action. *Id.* at 1049 (Melloy, J., dissenting). In his view, *Gonzaga* merely "amended the first prong of the [*Blessing*] analysis." *Ibid.*[1] And *Armstrong* was distinguishable. *Id.* at 1052.

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[1] Others have tried to reconcile *Blessing* and *Gonzaga* differently. *E.g.*, *Health Sci. Funding, LLC* v. *N.J. Dep't of Health & Human Servs.*, 658 F. App'x 139, 141 (3d Cir. 2016) ("We have interpreted *Gonzaga University* as requiring us to first apply the three components of the *Blessing* test and then, to inquire into whether the statutes in question unambiguously confer a substantive right.") (cleaned up).

The Tenth Circuit then joined the circuit majority. *Planned Parenthood of Kan.* v. *Andersen*, 882 F.3d 1205, 1224 (10th Cir. 2018). Quoting *Gonzaga* out of context (like *Betlach* had done), the court posited that, "if the plaintiff satisfies the three *Blessing* requirements, 'the right is presumptively enforceable' under § 1983." *Id.* at 1225 (quoting *Gonzaga*, 536 U.S. at 284). Reasoning that the factors were satisfied, *id.* at 1225–28, *Armstrong* was distinguishable and not entirely binding, *id.* at 1226–29, and "*Wilder* still is," *id.* at 1229 and n.16, the court felt "comfortable joining four out of the five circuits" that had addressed the any-qualified-provider provision's private enforceability, *id.* at 1224.

7. In *Smith*, the Fifth Circuit sitting en banc is poised to decide whether to overturn its prior decision.

Early last year, a Fifth Circuit panel decided another any-qualified-provider case after Texas terminated its provider agreements with Planned Parenthood affiliates. *Planned Parenthood of Greater Tex. Family Planning & Preventative Health Servs., Inc* v. *Smith*, 913 F.3d 551, 554 (5th Cir. 2019). The panel was "constrained" by its decision in *Gee* "to affirm the district court's conclusion that the plaintiffs possess[ed] a private right of action." *Id.* at 554. But Judge Jones wrote a separate concurring opinion to urge rehearing en banc on that issue, "which has divided the appellate courts." *Ibid.*

In her concurrence, Judge Jones primarily argued that "*Gee* is inconsistent with [this] Court's decision in *O'Bannon*." *Id.* at 571–72 (Jones, J., concurring). But she also highlighted the Eighth Circuit's decision in *Does* and its reasoning that "structural indications" in the Medicaid Act conflict with *Gonzaga*'s requirement that "Congress clearly intended to create an enforceable federal right." *Id.* at 572 (quoting *Does*, 867 F.3d at 1039).

The Fifth Circuit then granted rehearing en banc "on the Court's own motion." *Smith*, 914 F.3d at 996. In its en banc brief, Texas argued that "*Gonzaga* supplanted the *Wilder* and *Blessing* inquiry," and that *Gee* "is inconsistent with *Gonzaga* and *Armstrong* and should be overruled." Appellants' En Banc Brief at 20, 33, *Planned Parenthood of Greater Tex. Family Planning & Preventative Health Servs., Inc* v. *Smith*, No. 17-50282 (5th Cir. March 7, 2019) (en banc).

The full court heard oral argument on May 14, 2019. During argument, one judge asked counsel for both parties whether this Court had ever applied the *Blessing* factors after *Gonzaga*, noting the Court had only mentioned the factors there to disapprove of them. Oral Argument at 45:37–46:08, 46:24–34, 47:08–28, 1:04:55–1:05:02, *Planned Parenthood of Greater Tex. Family Planning & Preventative Health Servs., Inc* v. *Smith*, No. 17-50282 (5th Cir. May 14, 2019), https://bit.ly/2QHcDRH. Neither counsel was able to provide an example, but counsel for Planned Parenthood still argued that the *Blessing* factors apply. *Id.* at 46:10–18, 46:35–47:08, 47:30–45, 1:05:02–04. As of this filing, the en banc Fifth Circuit has not yet decided *Smith*.

8. The Fourth Circuit continues to apply *Wilder* and *Blessing* while mostly ignoring *Armstrong*, and a concurring judge asks this Court for clarity.

The Fourth Circuit's decision below presents an ideal vehicle for this Court to resolve the substantial disagreement among the lower courts over the state of play post-*Gonzaga* and *Armstrong*. Following the example of the circuit majority, the Fourth Circuit applied the *Blessing* factors—reading *Gonzaga* as merely a gloss on the first—and then, citing *Wilder*, asserted that this Court had "already held that the Medicaid Act's administrative scheme is not sufficiently comprehensive to foreclose a private right of action enforceable under § 1983." App.21a. Recognizing that *Gonzaga* had "cut back" on *Wilder*, the court maintained that "*Wilder*'s reasoning as to the comprehensiveness of the Medicaid Act's enforcement scheme has not been overturned." App.21a–22a.

Finally, the Fourth Circuit ignored the *Armstrong* plurality's position that "intended beneficiaries" to "contracts between two governments" do not have a right to sue to enforce those contracts. *Armstrong*, 575 U.S. at 332. Instead, the court cited two words from that part of the opinion—the phrase "unambiguously conferred"—and turned the plurality's position on its head by insisting courts should not relieve "sovereign signatories to a contract" of the "consequences" of their agreement, including conferring private rights of action on third parties. App.26a (cleaned up).

Against this backdrop, it is easy to appreciate Judge Richardson's plea for this Court to provide "clarity." App.45a. The lower courts disagree vigorously over whether *Wilder* has "been repudiated (or even effectively overruled)." App.41a. And the same goes for the *Blessing* factors. App.43a. In *Gonzaga*, the Court "seemed to consider this multifactor test problematic, to say the least." *Ibid.* But so far, only one Circuit has followed *Gonzaga* and *Armstrong* to their logical end. *Does*, 867 F.3d at 1039–43.

"So are *Wilder*, specifically, and the *Blessing* factors, generally, still good law?" App.44a. Lower courts feel powerless to answer these questions. App.41a ("But we do not lightly conclude that the Supreme Court has overruled its prior cases—that job is for the Supreme Court alone."). Accord *Sabree*, 367 F.3d at 194 ("While the analysis and decision of the [lower court] may reflect the direction that future Supreme Court cases in this area will take, currently binding precedent supports the decision of the Court.") (Alito, J., concurring). After years of confusion and litigation, this Court should answer these questions now.

B. This Court's conflicting signals have created multiple circuit splits in private-right-of-action cases.

The "confusion" and "uncertainty" spawned by *Wright*, *Wilder*, *Suter*, *Blessing*, *Gonzaga*, and *Armstrong*, has hardly been limited to Medicaid Act cases. Deep disagreement over how to interpret "the same set of opinions from this Court," *Gonzaga*, 536 U.S. at 278, has been spreading for at least a decade in a variety of statutory contexts.

1. Two separate splits exist over whether provisions of the Adoption Assistance and Child Welfare Act create privately enforceable rights.

This Court recently denied certiorari in a case asking the Court to resolve a circuit split over whether a provision in the Adoption Assistance and Child Welfare Act "grants foster parents a right to [] payments enforceable through a Section 1983 action." *New York State Citizens' Coal. for Children* v. *Poole*, 922 F.3d 69, 74 (2d Cir. 2019), *cert. denied,* No. 19-574, 2020 WL 411681 (U.S. Jan. 27, 2020). "The Sixth and Ninth Circuits have held that it does." *Ibid.* (citing *Cal. State Foster Parent Ass'n* v. *Wagner*, 624 F.3d 974 (9th Cir. 2010); *D.O.* v. *Glisson*, 847 F.3d 374 (6th Cir. 2017)). "The Eighth Circuit has held that it does not." *Ibid.* (citing *Midwest Foster Care and Adoption Ass'n* v. *Kincade*, 712 F.3d 1190 (8th Cir. 2013)). And in *Poole*, the Second Circuit "join[ed] the Sixth and Ninth Circuits in holding that the Act creates" a privately enforceable "entitlement." *Ibid.*

That holding garnered a dissent from Judge Livingston, who scolded the majority for citing cases like *Wilder* and *Wright* "repeatedly" while "gloss[ing] over the nearly three decades of case law" since. *Id.* at 93 (Livingston, J., dissenting). In her view, "*Wilder*'s precedential value (along with *Wright*'s) is limited at best." *Id.* at 99. And "mechanistically" applying the *Blessing* factors was inappropriate, especially given the "more recent jurisprudence call[ing] into question" *Blessing*'s "vitality." *Id.* at 93–94. Finally, the dissent chided the majority for misconstruing *Armstrong* in its "hurried desire to create a right enforceable under § 1983." *Id.* at 97–98.

For its part, the majority discounted the dissent's "attempt[] to cast doubt on whether *Blessing*'s three-factor test remains good law after *Gonzaga*," and its bid to "glom[] on to one sentence of dicta in a footnote in *Armstrong* . . . to suggest that *Wright* and *Wilder* are no longer good law." *Id.* at 79, 81 n.4. The majority refused to "read the tea leaves to predict" what this Court might do in the future. *Id.* at 79.

The Ninth Circuit identified—and deepened—a second circuit split over a different Child Welfare Act provision in *Henry A.* v. *Willden*, 678 F.3d 991 (9th Cir. 2012). There, the district court had "adopted the reasoning of the Eleventh Circuit" in holding that "language describing a case review system" for foster children had "an aggregate or system wide focus," and thus did not confer privately enforceable rights. *Id.* at 1008 (quoting *31 Foster Children* v. *Bush*, 329 F.3d 1255, 1272 (11th Cir. 2003)).

The Ninth Circuit "disagree[d]," instead "join[ing] the federal courts that have found the records provisions of the CWA to be privately enforceable." *Id.* at 1008 (citing *Lynch* v. *Dukakis*, 719 F.2d 504, 512 (1st Cir. 1983), and two district court decisions).[2] The Ninth Circuit was "persuaded by the statute's repeated focus on the individuals benefitted," by its "mandatory terms," and by its "detailed, concrete requirements." *Id.* at 1008–09. So the court of appeals reversed, deepening the circuit split. *Id.* at 1009.

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[2] See also *L.J. By & Through Darr* v. *Massinga*, 838 F.2d 118, 123 (4th Cir. 1988) (also holding that the records provisions "are privately enforceable" under § 1983). But see *Estate of Place* v. *Anderson*, 398 F. Supp. 3d 816, 842–44 (D. Colo. 2019) (reaching the opposite conclusion) (appeal pending on different grounds).

2. Circuits are split over whether Article 36 in the Vienna Convention creates privately enforceable rights.

In *Earle* v. *District of Columbia*, the D.C. Circuit identified—but did not take sides in—a 5-1 circuit split over whether Article 36 of the Vienna Convention creates rights that are privately enforceable. 707 F.3d 299, 304 (D.C. Cir. 2012) (comparing *Gandara* v. *Bennett*, 528 F.3d 823, 827–29 (11th Cir. 2008) (no privately enforceable rights), *Mora* v. *New York*, 524 F.3d 183, 196–97 (2d Cir. 2008) (same), *Cornejo* v. *County of San Diego*, 504 F.3d 853, 855 (9th Cir. 2007) (same), *United States* v. *Emuegbunam*, 268 F.3d 377, 392 (6th Cir. 2001) (same), and *United States* v. *Jimenez–Nava*, 243 F.3d 192, 198 (5th Cir. 2001) (same), with *Jogi* v. *Voges*, 480 F.3d 822, 834–36 (7th Cir.2007) (Article 36 *does* create privately enforceable rights)).

That disagreement similarly stems from divisions over how to apply *Gonzaga*. In *Jogi*, the Seventh Circuit held that the article's "text satisfies [*Gonzaga*'s] strict test of clarity." 480 F.3d at 833. But in *Gandara*, *Mora*, and *Cornejo*, the Eleventh, Second, and Ninth Circuits all cited *Gonzaga* while reaching the opposite conclusion. 528 F.3d at 827–29; 524 F.3d at 195–97, 205; 504 F.3d at 855, 858, 860–61. In *Cornejo*, that decision provoked a strong dissent accusing the majority of relying on "a fundamental misunderstanding of the reasoning in *Gonzaga*." 504 F.3d at 864 (Nelson, J., dissenting).

3. Two Circuits and multiple federal district courts have reached different results over whether the Federal Nursing Home Reform Amendments create privately enforceable rights.

Just last year, the Ninth Circuit held that nursing home residents may use § 1983 to "challenge a state's violation" of an appeals requirement in FNHRA, the Federal Nursing Home Reform Amendments to the Medicaid Act. *Anderson* v. *Ghaly*, 930 F.3d 1066, 1069 (9th Cir. 2019). The majority applied *Blessing*'s factors and the purported rebuttable presumption. *Id.* at 1073–80. But one judge concurred, expressing that she would not have reached the "more difficult questions discussed" in those parts of the Court's opinion. *Id.* at 1081 (Friedland, J., concurring).

The Third Circuit previously had reached the same result regarding a different FNHRA provision, holding that it satisfied *Gonzaga*'s "insistence on rights-creating language" and "*Blessing*'s remaining factors." *Grammer* v. *John J. Kane Reg'l Ctrs.-Glen Hazel*, 570 F.3d 520, 532 (3d Cir. 2009). But a dissenting judge disagreed, mainly because the Medicaid Act "is Spending Clause legislation," which "rarely confers upon funding beneficiaries the right to bring private actions 'before thousands of federal- and state-court judges.'" *Id.* at 532 (Stafford, D.J., dissenting) (quoting *Gonzaga*, 536 U.S. at 290).

While in the minority there, the dissent is in good company among district courts. *E.g.*, *Shanklin* v. *Coulee Med. Ctr.*, No. 2:17-CV-377-RMP, 2019 WL 1601360, at *5 (E.D. Wash. Apr. 15, 2019) (calling *Grammer* "inconsistent" with *Gonzaga*); *Liptak* v.

County, No. CV 16-225 ADM/JSM, 2016 WL 5349429, at *5 (D. Minn. Sept. 23, 2016) (collecting cases showing *Grammer* has been "met with criticism"); *Duncan* v. *Johnson-Mathers Health Care, Inc.*, No. 5:09-CV-00417-KKC, 2010 WL 3000718, at *8 (E.D. Ky. July 28, 2010) (dubbing *Grammer* "inconsistent" with both *Gonzaga* and *Pennhurst*). That division foreshadows yet another future circuit split.

In sum, "the disagreement over § 1396a(a)(23) implicates fundamental questions about the appropriate framework" for deciding when a statute is privately enforceable under § 1983. *Gee*, 139 S. Ct. at 409 (Thomas, J., dissenting from denial of certiorari). That "important legal issue" is "independently worthy of this Court's attention." *Ibid.*

II. This case raises important and recurring issues with far-reaching consequences, and the Fourth Circuit got it wrong.

Whether Medicaid's any-qualified-provider provision creates a private right is a recurring question of great national importance. More than "70 million Americans are on Medicaid, and the question[s] presented directly affect[] their rights." *Gee*, 139 S. Ct. at 409 (Thomas, J., dissenting from denial of certiorari). "Tens of thousands of provider entities are subject to the Medicaid program's detailed scheme of integrated federal and state regulation." *Smith*, 913 F.3d at 570 (Jones, J., concurring). And "[b]ecause of this Court's [past] inaction, patients in different States—even patients with the same providers—have different rights to challenge their State's provider decisions." *Gee*, 139 S. Ct. at 409 (Thomas, J., dissenting from denial of certiorari).

"Another pragmatic consideration," merits review: "the complexity and cost to state agencies that administer and regulate Medicaid." *Smith*, 913 F.3d at 571 (Jones, J., concurring). "The program is already one of the most expensive components of state budgets." *Ibid.* And the majority rule imposes the "threat of a federal lawsuit—and its attendant costs and fees—whenever [a state makes] changes" to its program. *Gee*, 139 S. Ct. at 409 (Thomas, J., dissenting from denial of certiorari). Lawsuits are a financial burden, and even the "potential for complex litigation inevitably will dissuade state officials from making decisions that they believe to be in the public interest." *Ibid.* Similar concerns abound in the foster-care context. *Poole*, 922 F.3d at 97 (Livingston, J., dissenting).

Under this Court's decisions in *Gonzaga* and *Armstrong*, the Fourth Circuit's decision below is wrong for at least four reasons. This Court can correct these mistakes while alleviating widespread confusion over whether an ambiguous federal statute—especially a Spending Clause statute—can be read to create private rights.

First, in deciding the threshold question, the Fourth Circuit mostly ignored *Gonzaga* while applying *Blessing*'s three-factored test and the rebuttable presumption. App.16a–23a. In *Gonzaga*, this Court did not apply *Blessing*'s "multifactor balancing test." 536 U.S. at 286. Instead, the Court repeatedly criticized *Blessing* and the "confusion" it had inspired, ultimately "reject[ing] the notion that [the Court's] cases permit anything short of an unambiguously conferred right to support a cause of action brought under § 1983." *Id.* at 282–83, 286.

The Eighth Circuit's decision in *Does* exemplifies a principled, post-*Gonzaga* approach to deciding whether a given statute creates privately enforceable rights under § 1983. Applying *Gonzaga*, the court highlighted three "significant difficulties with the contention" that the any-qualified-provider provision "unambiguously creates an enforceable federal right." 867 F.3d at 1041. First, the "focus" of the provision—on the "federal agency charged with approving" state plans—is "two steps removed from the interests of the patients who seek services from a Medicaid provider." *Ibid.* "Second, Congress expressly conferred another means of enforcing" compliance with the provision: the "withholding of federal funds by the Secretary." *Ibid.* And "[t]hird, statutes with an 'aggregate' focus," like the Medicaid Act's "substantial compliance regime," do not "give rise to individual rights." *Id.* at 1042 (quoting *Gonzaga*, 536 U.S. at 288).

The Eighth Circuit's reasoning is sound. And it proves that, untethered from *Blessing*'s "multifactor balancing test," *Gonzaga*, 536 U.S. at 286, courts can more easily heed this Court's admonition that nothing "short of an unambiguously conferred right," *id.* at 283, can confer a cause of action under § 1983.

Second, the Fourth Circuit relied too heavily on the dubious *Wilder* decision. App.21a–22a. According to the court of appeals, this "Court has already held [in *Wilder*] that the Medicaid Act's administrative scheme" does not "foreclose a private right of action." App.21a. But courts should place "little stock in [*Wilder*'s] paradigm after *Armstrong*'s express disavowal of *Wilder*'s mode of analysis." *Does*, 867 F.3d at 1042.

Third, "[i]n its hurried desire to create a right enforceable under § 1983," the Fourth Circuit "also misconstrue[d] the controlling precedent provided by [this] Court's 2015 *Armstrong* decision." *Poole*, 922 F.3d at 97–98 (Livingston, J., dissenting). The *Armstrong* majority focused on the fact that the "sole remedy . . . for a State's failure to comply with Medicaid's requirements—for the State's 'breach' of the Spending Clause contract—is the withholding of Medicaid funds by the Secretary." 575 U.S. at 328. And the majority rejected the "dissent's complaint" that the "cut-off of funding" is "too massive to be a realistic source of relief." *Id.* at 331.

Resurrecting that overruled complaint, the Fourth Circuit dismissed Congress's chosen remedy as a "drastic" and "illogical" means of "vindicating the interests of individual Medicaid beneficiaries." App.21a. The court also got *Armstrong*'s plurality portion backwards, refusing to relieve "sovereign signatories to a contract" of the "consequences" of their agreement, App.26a (cleaned up), even where the signatories themselves have brought no such claim.

Fourth, the Fourth Circuit read the any-qualified-provider provision broadly to "confer[] an individual right on Medicaid recipients to select the willing and competent provider of their choice." App.34a. But this Court's decision in *O'Bannon* proves that any alleged right "is far more narrow [at best]: the right to choose among a range of qualified providers." *Does*, 867 F.3d at 1046 (Shepherd, J., concurring).

Thus, even if the Court decides that the any-qualified-provider provision creates *some* private right, this case presents an opportunity to resolve the growing disagreement over the scope of that alleged right under *O'Bannon*. See, *e.g.*, *Planned Parenthood of Gulf Coast, Inc.* v. *Gee*, 876 F.3d 699, 700 (5th Cir. 2017) (Elrod, J., joined by six of her colleagues, dissenting from denial of rehearing en banc and blaming the court's "discord" on its "disregard for [this] Court's binding precedent in *O'Bannon*"); *Andersen*, 882 F.3d at 1231–32 (distinguishing *O'Bannon*); *Comm'r of Ind.*, 699 F.3d at 977 (same). See also *Kelly Kare, Ltd.* v. *O'Rourke*, 930 F.2d 170, 178 (2d Cir. 1991) (reading *O'Bannon* to mean that "[n]o cognizable property interest can arise in the Medicaid recipient unless the provider is both qualified and participating in the Medicaid program"). The Court should grant review for this additional reason.

In sum, this case is "not about abortion rights." *Gee*, 139 S. Ct. at 410 (Thomas, J., dissenting from denial of certiorari). It is about "private rights of action under the Medicaid Act." *Ibid.* And by extension, it is about every Spending Clause statute "in the nature of a contract" between states and the federal government. *Armstrong*, 575 U.S. at 332 (plurality). Certiorari is warranted to eradicate confusion in this Court's caselaw and to make clear that Spending Clause statutes like the Medicaid Act do not—and cannot—create private rights "by mere implication." *Ibid.* No court should be reading private rights into silent statutory text.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX

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PUBLISHED

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 18-2133

PLANNED PARENTHOOD SOUTH ATLANTIC; JULIE EDWARDS, on her behalf and on behalf of all others similarly situated,

Plaintiffs – Appellees,

v.

JOSHUA BAKER, in his official capacity as Director, South Carolina Department of Health and Human Services,

Defendant – Appellant.

ACCESS REPRODUCTIVE CARE-SOUTHEAST; AMERICAN ACADEMY OF PEDIATRICS; AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS; AMERICAN COLLEGE OF PHYSICIANS; AMERICAN MEDICAL ASSOCIATION; CENTER FOR REPRODUCTIVE RIGHTS; IPAS; IN OUR OWN VOICE: NATIONAL BLACK WOMEN'S REPRODUCTIVE JUSTICE AGENDA; NATIONAL ASIAN PACIFIC AMERICAN WOMEN'S FORUM; NATIONAL HEALTH LAW PROGRAM; NATIONAL LATINA INSTITUTE FOR REPRODUCTIVE HEALTH;

SEXUALITY INFORMATION AND EDUCATION COUNCIL OF THE UNITED STATES; SOCIETY FOR ADOLESCENT HEALTH AND MEDICINE; SOCIETY FOR MATERNAL FETAL MEDICINE; WOMEN'S RIGHTS AND EMPOWERMENT NETWORK,

Amici Supporting Appellee.

Appeal from the United States District Court for the District of South Carolina, at Columbia. Mary G. Lewis, District Judge. (3:18-cv-02078-MGL)

Argued: September 20, 2019

Decided: October 29, 2019

Before WILKINSON, WYNN, and RICHARDSON, Circuit Judges.

Affirmed by published opinion. Judge Wilkinson wrote the opinion, in which Judge Wynn and Judge Richardson joined. Judge Richardson wrote a concurring opinion.

ARGUED: Kelly McPherson Jolley, JOLLEY LAW GROUP, LLC, Columbia, South Carolina, for Appellant. Alice Joanna Clapman, PLANNED PARENTHOOD FEDERATION OF AMERICA, Washington, D.C., for Appellees. **ON BRIEF**: Ariail B. Kirk, JOLLEY LAW GROUP, LLC, Columbia,

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WILKINSON, Circuit Judge:

This case raises a question of statutory construction. We ask whether, and on what basis, the Medicaid Act's free-choice-of-provider provision affords a private right of action to challenge a state's exclusion of a healthcare provider from its Medicaid roster. The district court here issued a preliminary injunction in favor of the individual plaintiff, a Medicaid recipient, in her suit challenging South Carolina's decision to terminate Planned Parenthood South Atlantic's (PPSAT) provider agreement because it offers abortion services. The plaintiff was likely to succeed on the merits of this claim, the district court held, for two interrelated reasons: first, the Medicaid Act's free-choice-of-provider provision, 42 U.S.C. § 1396a(a)(23)(A), confers on "any individual" a private right to sue that may be enforced under 42 U.S.C. § 1983; and second, South Carolina denied plaintiff the right to select the willing, qualified family-planning provider of her choice.

We now affirm. Based on the Supreme Court's precedents, Congress's intent to create an individual right enforceable under § 1983 in the free-choice-of-provider provision is unambiguous. In addition, a plain-language reading of the provision's mandate—that states "must" furnish Medicaid recipients the right to choose among providers "qualified to perform the service or services required"—bars states from excluding providers for reasons unrelated to professional competency. *See* 42 U.S.C. § 1396a(a)(23)(A), (p)(1). Finding the remaining preliminary injunction factors satisfied, we shall uphold the trial court's judgment.

I.

A.

Medicaid is the nation's public health insurance program for those of limited means. The original beneficiaries of this program were low-income children and their parents, the indigent elderly, the blind, and the disabled. *Schweiker v. Gray Panthers*, 453 U.S. 34, 37 (1981). Since 1965, Congress has periodically expanded the program, adding, for instance, pregnant women with family incomes up to 133% of the federal poverty level as a distinct beneficiary class. *See* 42 U.S.C. § 1396a(a)(10)(A)(i), (*l*); Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 302, 102 Stat. 683, 750; Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6401, 103 Stat. 2106, 2258.

A joint federal-state effort ensures that the healthcare needs of these beneficiaries are met. In broad strokes, the Medicaid Act "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.*, 135 S. Ct. 1378, 1382 (2015). The Act, to that end, charges the federal government with crafting baseline eligibility requirements for recipients and providers, determining covered medical services, and establishing reimbursement standards to the states. *See* 42 U.S.C. § 1396 *et seq.*; *NFIB v. Sebelius*, 567 U.S. 519, 541-42 (2012). Cooperating states then implement the program, agreeing to abide by federal conditions in return for federal matching funds that are used for expenses such as provider reimbursements. *See Armstrong*, 135 S. Ct. at 1382. Such funds are substantial; federal

coffers finance anywhere from fifty to eighty-three percent of state expenses, 42 U.S.C. § 1396d(b), an aggregate figure that accounts for over ten percent of most states' total revenue, *NFIB*, 567 U.S. at 542.

Congress designed the Medicaid program to ensure that states dispense federal funds in compliance with federal rules. At the outset, states must propose and submit Medicaid plans for the approval of the Centers for Medicare and Medicaid Services. *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 565 U.S. 606, 610 (2012). State departures from federal requirements provide grounds for the Secretary of Health and Human Services (HHS) to withhold Medicaid funding, either in whole or in part. *See* 42 U.S.C. § 1396c; 42 C.F.R. § 430.12(c). If federal requirements are met, however, states have "substantial discretion to choose the proper mix of amount, scope, and duration limitations on coverage, as long as care and services are provided in 'the best interests of the recipients.'" *Alexander v. Choate*, 469 U.S. 287, 303 (1985) (quoting 42 U.S.C. § 1396a(a)(19)).

At issue here is the Medicaid Act's free-choice-of-provider provision, 42 U.S.C. § 1396a(a)(23), which states:

> A State plan for medical assistance must—provide that any individual eligible for medical assistance . . . 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). That provision

guarantees patients access to qualified and willing providers. A state plan must generally allow Medicaid recipients to obtain care from any provider who is "qualified to perform the service or services required" and "who undertakes to provide . . . such services."

In its mechanics, the free-choice-of-provider provision comports with the Medicaid Act's dual emphasis on federal standard-setting and state flexibility. While Medicaid beneficiaries may generally seek medical services from willing providers of their choice, states retain discretionary authority to determine whether entities are medically "qualified to perform the service or services required." States may also exclude providers from their plans "for any reason for which the [federal] Secretary of [Health and Human Services] could exclude the individual or entity," 42 U.S.C. § 1396a(p)(1), or on certain state-law grounds, *see* 42 C.F.R. § 431.51(c)(2).

B.

This dispute arose following South Carolina's termination of two Planned Parenthood centers as Medicaid providers. PPSAT operates two healthcare centers in South Carolina, one in Charleston and the other in Columbia. These centers provide a range of family planning and preventative care services, including physical exams, cancer screenings, contraceptive counseling, and pregnancy testing. For four decades, PPSAT has been a South Carolina Medicaid provider that receives reimbursements for care provided to Medicaid beneficiaries. In recent years, PPSAT's South Carolina centers have treated hundreds of patients insured through Medicaid annually.

Among those patients is the individual plaintiff in this case, who suffers from diabetes and its resulting complications. J.A. 75-78. Because doctors have advised that these complications would make it quite dangerous for her to carry a pregnancy to term, the plaintiff considers it imperative that she have access to safe, effective birth control. After the plaintiff had difficulty finding a doctor who accepted Medicaid patients and was willing to provide her preferred form of birth control, she turned to PPSAT's Columbia center. At her PPSAT appointment, the doctors inserted an intrauterine device to prevent pregnancy and informed her that her blood pressure was elevated. As a result, she sought follow-up care from her endocrinologist to control her blood pressure. Because the plaintiff was impressed with the care she received at PPSAT, she planned to switch her gynecological and reproductive health care there.

In July 2018, South Carolina's Department of Health and Human Services (SCDHHS) terminated PPSAT's Medicaid provider agreement. SCDHHS did not contend that PPSAT was providing subpar service to its Medicaid patients, or to any other patients. Instead, PPSAT was terminated solely because it performed abortions outside of the Medicaid program.[1]

According to SCDHHS, PPSAT's termination was part of a plan by Governor Henry McMaster designed

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[1] South Carolina does not provide Medicaid reimbursements for abortion services except in cases where it is required to do so by federal law. Such cases involve rape, incest, or the need to protect the mother's life. *See* Consolidated Appropriations Act, 2018, Pub. L. No. 115-141, div. H, tit. V, §§ 506-507, 132 Stat. 348, 763-64 (Hyde Amendment).

to prevent the state from indirectly subsidizing abortion services. In 1995, the South Carolina legislature passed a law preventing state funds appropriated for family planning services from being used to fund abortions. S.C. Code Ann. § 43-5-1185 (1995). After taking office in 2017, Governor McMaster issued two executive orders designed to further this objective. The first, Executive Order 2017-15, directed state agencies "to take any and all necessary actions . . . to the extent permitted by law, to cease providing State or local funds . . . to any physician or professional medical practice affiliated with an abortion clinic . . . ." J.A. 56-58. The second, Executive Order 2018-21, directed SCDHHS to "deem abortion clinics . . . and any affiliated physicians or professional medical practices . . . that are enrolled in the Medicaid program as unqualified to provide family planning services and, therefore, to immediately terminate them . . . ." J.A. 70-71. SCDHHS responded quickly. On the day the second order was issued, SCDHHS Officer of Health Programs Amanda Williams notified PPSAT by letter that "[t]he Governor's actions result in Planned Parenthood no longer being qualified to provide services to Medicaid beneficiaries" and that PPSAT's enrollment agreement with South Carolina was terminated effective immediately. J.A. 73. As a result, PPSAT's two South Carolina centers began to turn away Medicaid patients. J.A. 13-14.

C.

On July 27, 2018, PPSAT and the individual plaintiff (collectively, "plaintiffs") filed suit in federal district court in South Carolina against Joshua Baker, in his official capacity as Director of SCDHHS. The individual plaintiff brought suit on her own

behalf and that of a purported class of South Carolina Medicaid beneficiaries who received, or would like to receive, healthcare services at PPSAT. Plaintiffs brought this action under 42 U.S.C. § 1983, seeking injunctive and declaratory relief on the grounds that SCDHHS violated their rights under the Medicaid Act and the Fourteenth Amendment. On July 30, plaintiffs filed for preliminary injunctive relief solely on the basis of their Medicaid Act claims. The district court held hearings on plaintiffs' motion on August 23. In their complaint and at the hearing, plaintiffs argued that the Medicaid Act's free-choice-of-provider provision confers on recipients a private right, enforceable under 42 U.S.C. § 1983, to use the qualified and willing provider of their choice, and that South Carolina violated this right when it terminated PPSAT for reasons unrelated to its professional competence to provide medical services.

The district court agreed with the plaintiffs and granted a preliminary injunction on August 28, 2018. Because the district court held that injunctive relief was appropriate based on the individual plaintiff's Medicaid Act claim alone, it did not analyze PPSAT's Medicaid Act claim. First, it held that the individual plaintiff's Medicaid Act claim was likely to succeed on the merits. It agreed that the free-choice-of-provider provision confers a private right, enforceable under 42 U.S.C. § 1983, on Medicaid-eligible patients, guaranteeing their right to choose any willing provider "qualified to perform" the relevant service. Critically, the court held that "qualified" should be given its ordinary meaning—professionally competent. Relatedly, the district court rejected South Carolina's contention that § 1396a(p)(l) of the Medicaid Act gives a state plenary authority to exclude providers from its

program "for any reason whatsoever as long as the reason is bolstered by State law." *Planned Parenthood S. Atl. v. Baker*, 326 F. Supp. 3d 39, 47-48 (D.S.C. 2018). To the contrary, it held that the state's authority to exclude providers is limited by the free-choice-of-provider provision.

Finally, the district court found that the other conditions necessary for a preliminary injunction—irreparable harm, balancing of the equities, and the public interest—were satisfied. In weighing the equities, the district court rejected South Carolina's argument that the state would be forced to subsidize abortions if it were enjoined from terminating PPSAT's provider agreement. *Baker*, 326 F. Supp. 3d at 49-50. First, because South Carolina's Medicaid program does not cover abortions except in the narrow circumstances required by federal law, there was no direct subsidization of non-covered abortions. *See id.* at 47. Second, because "PPSAT is reimbursed for Medicaid services on a fee-for-service basis," *id.* at 49, at rates that do not cover its costs, PPSAT's participation in Medicaid did not generate excess funds that could be used to indirectly subsidize abortions. *See id.* at 47, 49-50. Accordingly, the district court granted a preliminary injunction preventing South Carolina from terminating PPSAT's Medicaid enrollment agreement.

South Carolina timely appealed.

II.

The free-choice-of-provider provision lies at the heart of this appeal. As noted above, the provision states that:

> 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* (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services . . . .

42 U.S.C. § 1396a(a)(23)(A) (emphases added).

It is difficult to imagine a clearer or more affirmative directive. The provision applies to "*any* individual" eligible for Medicaid; grants these individuals the right to obtain medical treatment from "*any* institution" willing and "qualified to perform the service or services required"; and provides that state plans "*must*" comply.[2]

Congress could have made an exception for providers offering abortion services. But it did not do so. Because we "presume that a legislature says in a statute what it means and means in a statute what it

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[2] Violation of a Medicaid recipient's statutory right under the free-choice-of-provider provision visits "concrete" harm that is "real" and "tangible," because the recipient can no longer receive care at his or her provider of choice. *See Spokeo, Inc. v. Robins*, 136 S. Ct. 1540, 1548-49 (2016). This is the exact harm that Congress intended the provision to prevent. *See id.*

says there," *Connecticut Nat'l Bank v. Germain*, 503 U.S. 249, 253-54 (1992), this court cannot write into a statute an exception that Congress did not create. Accordingly, we take the free-choice-of-provider provision to mean that a Medicaid recipient has the right to challenge a state's exclusion of a provider from its Medicaid plan on grounds unrelated to that provider's willingness and professional competency to furnish the required medical service.

III.

A.

It is important at the outset to place this case in proper context. As a matter of black letter law, inferring a private right of action is a matter of statutory interpretation. If Congress is silent or ambiguous, courts may not find a cause of action "no matter how desirable that might be as a policy matter." *Alexander v. Sandoval*, 532 U.S. 275, 286-87 (2001).

But it was not always this way, and a brief overview of this history is useful background to the present lawsuit. We begin with *J.I. Case Co. v. Borak*, 377 U.S. 426 (1964), where the Supreme Court stated that federal courts were partners of Congress, making it "the duty of the courts to be alert to provide such remedies as are necessary to make effective the congressional purpose" expressed by a statute. *Id.* at 433. During the *Borak* era, the "exercise of judicial power" was not "justified in terms of statutory construction," but rather as a means of crafting "substantive social policy." *Bivens v. Six Unknown Named Agents of Fed. Bureau of Narcotics*, 403 U.S. 388, 402, 402 n.4 (1971) (Harlan, J., concurring in judgment).

Some years later, Justice Powell derided *Borak*'s approach in an oft-quoted dissent. *Cannon v. Univ. of Chicago*, 441 U.S. 677, 742 (1979) (Powell, J., dissenting). In Powell's view, freely implying private rights of action posed two related constitutional problems. First, to infer from silence the right to file suit in federal court interferes with Congress's Article III power to set "the jurisdiction of the lower federal courts." *Id.* at 730. Second, an expansive approach to implied private rights of action "cannot be squared with the doctrine of the separation of powers." *Id.* This is because a court's "substitut[ion of] its own views as to the desirability of private enforcement," *id.* at 740, dispatches Congress's Article I "policymaking authority" to the Third Branch of government, *id.* at 743. "When Congress chooses not to provide a private civil remedy, federal courts should not assume the legislative role of creating such a remedy and thereby enlarge their jurisdiction." *Id.* at 730-31. Therefore, "[a]bsent the most compelling evidence of affirmative congressional intent, a federal court should not infer a private cause of action." *Id.* at 731.

Justice Powell's dissent primed the Court for a doctrinal about-face. The Court incrementally swore "off the habit of venturing beyond Congress's intent," *Sandoval*, 532 U.S. at 286-87 (tracing this doctrinal evolution), instead limiting its focus to the specific statutory text at issue. In *Sandoval*, the Court summed up the result of this doctrinal progression: "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." *Id.* at 286.

But there was a loose end remaining—what to do with implied rights of action brought under § 1983.

Some litigants argued that § 1983 provided plaintiffs with a separate cause of action if they fell "within the general zone of interest" of a federal statute. *Gonzaga Univ. v. Doe*, 536 U.S. 273, 282-83 (2002) (citing *Blessing v. Freestone*, 520 U.S. 329, 340-41 (1997)). The Court swiftly corrected this misunderstanding in *Gonzaga*, instructing that § 1983 creates a cause of action to enforce a federal statute only when the underlying statute itself unambiguously "confers an individual right" on the plaintiff. *Id.* at 284-85. If so, the § 1983 remedy follows as a matter of course; litigants need not separately demonstrate Congress's intent to create a private remedy. *Id.*

B.

With this background as guidance, we review the district court's entry of a preliminary injunction for "abuse of discretion, accepting the court's findings of fact absent clear error, but reviewing its conclusions of law *de novo*." *Child Evangelism Fellowship of Md., Inc. v. Montgomery Cty. Pub. Sch.*, 373 F.3d 589, 593 (4th Cir. 2004). To that end, the individual plaintiff "must establish that [s]he is likely to succeed on the merits, that [s]he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in h[er] favor, and that an injunction is in the public interest." *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). We are mindful at once that a preliminary injunction is an "extraordinary remedy," *id.* at 22, but its issuance "is committed to the sound discretion of the trial court," *Centro Tepeyac v. Montgomery Cty.*, 722 F.3d 184, 188 (4th Cir. 2013) (en banc) (quoting *Quince Orchard Valley Citizens Ass'n v. Hodel*, 872 F.2d 75, 78 (4th Cir. 1989)).

IV.

First we consider the threshold question whether the Medicaid Act's free-choice-of-provider provision creates a private right enforceable under § 1983. Section 1983 creates a federal remedy against anyone who, under color of state law, deprives a person "of any rights, privileges, or immunities secured by the Constitution and laws." 42 U.S.C. § 1983. Of course, it "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). Rather a plaintiff seeking redress "must assert the violation of a federal *right*, not merely a violation of federal *law*." *Blessing*, 520 U.S. at 340.

Three factors guide us in determining whether a statute creates a private right enforceable under § 1983. *Id.* at 340-41. "First, Congress must have intended that the provision in question benefit the plaintiff." *Id.* at 340. "Second, the plaintiff must demonstrate that the right assertedly protected by the statute is not so 'vague and amorphous' that its enforcement would strain judicial competence." *Id.* at 340-41. "Third, the statute must unambiguously impose a binding obligation on the States" by speaking "in mandatory, rather than precatory, terms." *Id.* at 341. If these three factors are satisfied, there is "a rebuttable presumption that the right is enforceable under § 1983," *id.*, which may be defeated by showing that Congress expressly or implicitly foreclosed a § 1983 remedy, *City of Rancho Palos Verdes*, 544 U.S. at 120.

Applying these principles, we agree with the district court—and five of our six sister circuits to have addressed this issue—that the free-choice-of-

provider provision confers a private right, enforceable under § 1983, on Medicaid recipients. *See Planned Parenthood of Kan. & Mid-Mo. v. Andersen*, 882 F.3d 1205, 1224 (10th Cir. 2018); *Planned Parenthood of Gulf Coast, Inc. v. Gee*, 862 F.3d 445, 457 (5th Cir. 2017); *Planned Parenthood Ariz. Inc. v. Betlach*, 727 F.3d 960, 965-66 (9th Cir. 2013); *Planned Parenthood of Ind., Inc. v. Comm'r of Ind. State Dep't of Health*, 699 F.3d 962, 968, 972-74 (7th Cir. 2012); *Harris v. Olszewski*, 442 F.3d 456, 461 (6th Cir. 2006). *But see Does v. Gillespie*, 867 F.3d 1034, 1037, 1041, 1046 (8th Cir. 2017).

Taking the first *Blessing* factor, the free-choice-of-provider provision "unambiguously gives Medicaid-eligible patients an individual right" to their choice of provider qualified to perform a medical service. *Planned Parenthood of Ind.*, 699 F.3d at 974. The provision has an "unmistakable focus," *Gonzaga*, 536 U.S. at 284, on its intended class of beneficiaries: "any individual eligible for medical assistance" under the Medicaid Act, 42 U.S.C. § 1396a(a)(23)(A). *See Doe v. Kidd*, 501 F.3d 348, 356 (4th Cir. 2007) (finding that 42 U.S.C. § 1396a(a)(8), which refers to "all individuals wishing to make application for medical assistance," confers an individual right).

Congress's use of the phrase "any individual" is a prime example of the kind of "rights-creating" language required to confer a personal right on a discrete class of persons—here, Medicaid beneficiaries. *See*, *e.g.*, *Sandoval*, 532 U.S. at 288 (providing an example of rights-creating language: "No person . . . shall . . . be subjected to discrimination . . . ."). Put differently, by adopting as its benchmark whether the "needs of any particular person have been satisfied," *Gonzaga*, 536 U.S. at 288, Congress left no doubt that

it intended to guarantee each Medicaid recipient's free choice of provider.

As for the second *Blessing* factor, the free-choice-of-provider provision is not so "vague and amorphous," *Blessing*, 520 U.S. at 340-41, that its enforcement would strain judicial competence. The provision protects the right of a Medicaid recipient to seek care from his or her provider of choice, subject to two criteria: (1) the provider must be "qualified to perform the service or services required," and (2) the provider must "undertake[ ] to provide [the recipient] such services." 42 U.S.C. § 1396a(a)(23)(A). These criteria are objective. The second is "a simple factual question no different from those courts decide every day." *Betlach*, 727 F.3d at 967. And the first, which "may require more factual development or expert input," still falls squarely "within the range of judicial competence." *Id.*

In an attempt to create ambiguity, South Carolina focuses on the word "qualified" in isolation, Appellant's Reply Brief at 9-10, ignoring the reality that the term is "tethered to an objective benchmark: 'qualified *to perform the service or services required*.'" *Betlach*, 727 F.3d at 967-68 (quoting 42 U.S.C. § 1396a(a)(23)(A)). That omission makes all the difference. Courts can "readily determine" whether a provider is qualified to perform a service by "drawing on evidence such as descriptions of the service required; state licensing requirements; the provider's credentials, licenses, and experience; and expert testimony regarding the appropriate credentials for providing the service." *Id.* at 968. This factual determination "is no different from the sorts of

qualification or expertise assessments that courts routinely make in various contexts." *Id.*[3]

Finally, the free-choice-of-provider provision "unambiguously impose[s] a binding obligation on the States." *Blessing*, 520 U.S. at 341. Under the provision, states "must provide" a Medicaid recipient with his or her choice of provider qualified to perform the service at issue. 42 U.S.C. § 1396a(a)(23)(A). Thus the provision is "couched in mandatory, rather than precatory, terms." *Blessing*, 520 U.S. at 341; *see also Kidd*, 501 F.3d at 356 (holding, as mandatory, a Medicaid provision requiring that state plans "must" provide for reasonably prompt medical assistance).

Since the three *Blessing* factors are satisfied, the individual plaintiff benefits from a rebuttable presumption that the free-choice-of-provider provision is enforceable under § 1983. *Blessing*, 520 U.S. at 341. That presumption has not been overcome. As an initial matter, nowhere in the Medicaid Act did Congress declare an express intent to "specifically foreclose[ ] a remedy under § 1983." *Id.* (internal quotations omitted).

Nor can such an intent be implied: the Medicaid Act does not contain a "comprehensive enforcement scheme . . . incompatible with individual enforcement

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[3] A distinct note of caution is in order. To say that the term "qualified" is susceptible to federal judicial measurement for purposes of the second prong of *Blessing* is not the same thing as saying that states lack discretion in defining professional qualifications under 42 U.S.C. § 1396a(p)(1), or that they are not due deference in their termination decisions. *See infra* Section VI.B. In this case, PPSAT's qualifications are simply not in dispute.

under § 1983." *Id.* Because South Carolina assumed that the free-choice-of-provider requirement did not confer an individual right, it did not expressly press a rebuttal argument before this court. Even if it had, we conclude that the Medicaid Act's enforcement scheme is not sufficiently "comprehensive" to foreclose a private right of action enforceable under § 1983. Three alternative remedies are provided for in the Act: (1) the Secretary of HHS's authority to review state Medicaid plans for noncompliance and curtail or cut off Medicaid funding as a matter of discretion, 42 U.S.C. §§ 1316(a), 1396c; 42 C.F.R. § 430.12; (2) a state administrative process for providers to challenge termination decisions, 42 U.S.C. § 1396a(a)(4); 42 C.F.R. § 1002.213; and (3) a state administrative process for Medicaid recipients to challenge a claim denial, 42 U.S.C. § 1396a(a)(3).

These remedies, taken together, are quite different from the "unusually elaborate enforcement provisions" that the Supreme Court has taken as evidence that Congress intended to preclude individual enforcement under § 1983. *Middlesex Cty. Sewerage Auth. v. Nat'l Sea Clammers Ass'n*, 453 U.S. 1, 13-14 (1981). The relevant pollution control statute at issue in *Middlesex County* is illustrative. That statute authorized governmental officials to respond to violations of the act with compliance orders and civil suits; permitted the imposition of penalties up to $10,000 per day; and made criminal penalties available. *Id.* at 13. Separately, the act also conferred on "any interested person" the right to seek judicial review of relevant acts by federal officials, such as the issuance of an effluent permit. *Id.* at 13-14. By prescribing the particular remedies available to public and private actors, Congress demonstrated its

intent to foreclose forms of relief otherwise available to plaintiffs bringing § 1983 claims. See *id.* at 14-15.

Nothing comparable to this detailed enforcement scheme exists in the Medicaid Act. To state the obvious, individuals are not ordinarily plaintiffs in provider suits, and an individual's administrative remedy to challenge, for example, a denial of Medicaid coverage for a particular "service" does not also provide a forum for contesting the disqualification of a preferred provider. This much is clear to South Carolina, so it seems to latch onto the Secretary's ability to cut Medicaid funds as itself indicative of a comprehensive administrative enforcement scheme. *See* Appellant's Opening Brief at 26-27. But a remedy is not comprehensive solely because it is drastic, and to view a wholesale cutoff of funding to the states as vindicating the interests of individual Medicaid beneficiaries in their choice of provider would be illogical.

The illogic of this argument aside, the Supreme Court has already held that the Medicaid Act's administrative scheme is not sufficiently comprehensive to foreclose a private right of action enforceable under § 1983. *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 521-22 (1990); *see also Kidd*, 501 F.3d at 356 (holding that the Medicaid Act neither explicitly nor implicitly "forbid[s] recourse to § 1983"). The Court's decision in *Gonzaga* cut back on *Wilder*'s treatment of implied rights of action in the § 1983 context; specifically, *Gonzaga* clarified that Congress must create an "unambiguously conferred right" rather than merely confer a "benefit" on a plaintiff to establish a cause of action enforceable under § 1983. *Gonzaga*, 536 U.S. at 282. But *Wilder*'s reasoning as to the comprehensiveness of the Medicaid Act's

enforcement scheme has not been overturned. *See Andersen*, 882 F.3d at 1229, 1229 n.16 (recognizing the same).

In sum, the Medicaid Act's enforcement scheme is not sufficiently "comprehensive" because, inter alia, it does not provide a private remedy—either judicial or administrative—for patients seeking to vindicate their rights under the free-choice-of-provider provision.[4] *See City of Rancho Palos Verdes*, 544 U.S. at 121 ("[I]n *all* of the cases in which we have held that § 1983 *is* available for violation of a federal statute, we have emphasized that the statute at issue . . . *did not* provide a private judicial remedy (or, in most of the cases, even a private administrative remedy) for the rights violated."). The reason Congress did not specify a method of private enforcement is plain: Section 1983 was to be the remedy for patients seeking to enforce their rights under the free-choice-of-provider provision. Permitting private enforcement of this type of suit, Congress realized, "in no way interferes" with the Secretary of HHS's authority to audit and sanction

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[4] South Carolina's contention that the individual plaintiff had a state administrative remedy she was required to exhaust before bringing a § 1983 suit is misguided. "[A]s a general rule, a plaintiff bringing a suit pursuant to 42 U.S.C. § 1983 does not have to exhaust state administrative remedies before filing suit in federal court." *Talbot v. Lucy Corr Nursing Home*, 118 F.3d 215, 218 (4th Cir. 1997) (citing *Patsy v. Bd. of Regents of State of Fla.*, 457 U.S. 496, 512 (1982)). At any rate, we agree with the district court that even if the individual plaintiff had a state administrative remedy available to her, it would, given the circumstances here, be futile. *Baker*, 326 F. Supp. 3d at 46-47.

noncompliant state Medicaid plans. *Planned Parenthood of Ind.*, 699 F.3d at 975.

Thus, the Medicaid Act provides no comprehensive enforcement scheme sufficient to overcome the presumption that the free-choice-of-provider provision is enforceable under § 1983. *Blessing*, 520 U.S. at 341. The plain, direct language of that provision unmistakably confers on a discrete class of individual Medicaid beneficiaries the right to seek medical assistance from any qualified medical provider who is willing to provide the required medical service. If that language does not suffice to confer a private right, enforceable under § 1983, upon the plaintiff here, it is difficult to see what language would be adequate. To hold in South Carolina's favor here would simply be to remove § 1983 as a vehicle for private rights enforcement and essentially to require Congress to set forth a cause of action enforceable purely on its own terms. We do not believe that the Court has channeled the expression of congressional intent in such a fashion, nor do we believe that we are free to do so. *See Blessing*, 520 U.S. at 340-41. Because South Carolina has not rebutted the presumption that a private right of action exists, we join the Fifth, Sixth, Seventh, Ninth, and Tenth Circuits in finding that the free-choice-of-provider provision creates a private right enforceable under § 1983. *See Andersen*, 882 F.3d at 1224; *Gee*, 862 F.3d at 457; *Betlach*, 727 F.3d at 965-66; *Planned Parenthood of Ind.*, 699 F.3d at 968, 972-74; *Harris*, 442 F.3d at 461. *But see Gillespie*, 867 F.3d at 1041, 1046.

V.

We are mindful of two principal, and principled, objections to according the plaintiff her requested relief. First, we should not freely infer private rights of action that are enforceable under § 1983. Second, because Spending Clause legislation is in the nature of a contract, we should not construe it so as to ambush states with terms that the states did not foresee or bargain for. These are doctrines of importance and great force, but both presuppose some level of textual ambiguity. Because that ambiguity is absent here, we begin and end our search for Congress's intent with the plain text of the free-choice-of-provider provision.

First, courts are most definitely not at liberty to imply private rights of action willy-nilly. Congress's intent to make a private right enforceable under § 1983 must be "unmistakably clear." *Gonzaga*, 536 U.S. at 286 (internal citations omitted). This requirement ensures that courts enforce private rights under § 1983 only when Congress has so intended. Here, Congress unambiguously intended to create a private right—in favor of "any individual" receiving Medicaid assistance—in the free-choice-of-provider provision. Medicaid recipients, it is clear, are not merely within the provision's "general zone of interest." *See id.* at 283.

We do not reach this conclusion lightly, but only after closely examining Congress's intent underlying the "specific statutory provision" at issue. *Blessing*, 520 U.S. at 342-43. South Carolina reaches beyond the plain and narrow text of the free-choice-of-provider provision—to eighty-two other provisions in the Medicaid Act—to conclude that the provision is no

more than a "plan requirement," rather than an individual right. Appellant's Opening Brief at 23. However, Congress foreclosed any argument that an individual plan requirement in the Medicaid Act cannot be enforceable through an implied private right of action. 42 U.S.C. § 1320a–2 (A provision "is not to be deemed unenforceable because of its inclusion in a section of [the Act] . . . 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 . . . ."). Quite apart from that clause, however, ignoring Congress's clearly expressed intent to create a private right of action here is no less a usurpation of Congress's "policy-making authority," *see Cannon*, 441 U.S. at 743 (Powell, J., dissenting), than reading a cause of action into a statute where Congress did not create one, *see Borak*, 377 U.S. at 433.

Second, courts must be especially cautious in finding that a provision in Spending Clause legislation, such as the Medicaid Act, creates a private right enforceable under § 1983. Spending Clause legislation, as noted, has been likened to a contract: "[I]n return for federal funds, the States agree to comply with federally imposed conditions. The legitimacy of Congress' power to legislate under the spending power thus rests on whether the State voluntarily and knowingly accepts the terms of the 'contract.'" *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981). Since a state cannot voluntarily and knowingly accept conditions unknown to it, "if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously." *Id.*

So much is true here. The terms of the Medicaid agreement are clear; in return for substantial federal funds, states are required to comply with the unambiguous terms of the free-choice-of-provider provision. And for the reasons described above, this obligation is enforceable by recipients, the intended beneficiaries of the provision. When, as here, the private cause of action is "unambiguously conferred" on a third party, *see Armstrong*, 135 S. Ct. at 1388 (plurality), courts cannot deprive the sovereign signatories to a "contract" such as the Medicaid Act of the benefit of their bargain.

Nor may courts relieve them of the agreement's consequences. Here, South Carolina would like to avoid the obligations imposed by this fair bargain. In essence, the state argues that some Supreme Court decisions might suggest a move away from inferring private rights of action in Spending Clause legislation. *See*, *e.g.*, Appellant's Opening Brief at 29-30 ("The [*Gonzaga*] Court noted that '[m]ore recent decisions have rejected attempts to infer enforceable rights from Spending Clause statutes.'") (quoting *Gonzaga*, 536 U.S. at 281). South Carolina may or may not be correct in its doctrinal forecast, but for now its argument remains speculative and conjectural. As the Seventh Circuit noted:

> [N]othing in *Armstrong*, *Gonzaga*, or any other case we have found supports the idea that plaintiffs are now flatly forbidden in section 1983 actions to rely on a statute passed pursuant to Congress's Spending Clause powers. There would have been no need, had that been the Court's intent, to send lower courts off on a search for "unambiguously conferred rights." A simple

"no" would have sufficed.

BT Bourbonnais Care, LLC v. Norwood, 866 F.3d 815, 820-21 (7th Cir. 2017). We agree. At bottom, the Court's cases require us to find an "unambiguously conferred" right, *Armstrong*, 135 S. Ct. at 1387-88 (plurality), which is exactly what we have done here. In the end, the concerns identified above are not controlling in this case, because the free-choice-of-provider provision unambiguously creates a private right in favor of the individual plaintiff.

VI.

Having decided that Congress unambiguously intended to create a private right of action in the free-choice-of-provider provision, we turn now to consider the scope of the right it confers on Medicaid recipients. A reasoned textual analysis in this case requires only two steps. First, "[a]s always, we start with the specific statutory language in dispute." *Murphy v. Smith*, 138 S. Ct. 784, 787 (2018). In the free-choice-of-provider provision, "qualified to perform the service or services required" means what it says: professionally fit to perform the medical services the patient requires. Second, we look to § 1396a(p)(1), which describes a state's authority to exclude providers from its Medicaid plan. In the end, we find that the free-choice-of-provider provision in § 1396a(a)(23)(A) and the state's discretionary authority under § 1396a(p)(1) work in tandem to accomplish Congress's overall objectives in this cooperative federalism scheme.

A.

First principles guide us in deciding what it means for a provider to be "qualified to perform the

service or services required" under the free-choice-of-provider provision. "Unless otherwise defined, statutory terms are generally interpreted in accordance with their ordinary meaning." *BP Am. Prod. Co. v. Burton*, 549 U.S. 84, 91 (2006). Because the Medicaid Act does not define the term "qualified," we consider its plain meaning—namely, "having an officially recognized qualification to practice as a member of a particular profession; fit, competent." Oxford English Dictionary (3d ed. 2007); *see also* Black's Law Dictionary 1360 (9th ed. 2009) (defining "qualified" as "[p]ossessing the necessary qualifications; capable or competent").

Every circuit to have considered this issue is in accord with that straightforward definition. *See*, *e.g.*, *Andersen*, 882 F.3d at 1230; *Gee*, 862 F.3d at 459-60; *Betlach*, 727 F.3d at 967-68; *Planned Parenthood of Ind.*, 699 F.3d at 978. *But see Gillespie*, 867 F.3d at 1046 (declining to reach this question after concluding that the free-choice-of-provider provision does not provide patients with a private right of action enforceable under § 1983).

South Carolina does not contest the fact that PPSAT is professionally qualified to deliver the services that the individual plaintiff seeks. Nowhere in its submissions to this court does the state seek to raise doubts that PPSAT satisfies the ordinary definition of "qualified" as being professionally capable or competent. Instead, the state seeks to persuade us that "qualified" means something other than what it says or that the structure of the statute as a whole entrusts the word to the states to define its meaning.

The term, however, is in a federal statute and we are obliged to give it the meaning that Congress intended, so long as that meaning is clear to its state partners in this cooperative program. There is no question that the ordinary meaning of the term "qualified" is the one Congress intended. Were there any doubt as to its intent, Congress provided more specificity in the terms surrounding "qualified." The free-choice-of-provider provision guarantees Medicaid recipients the right to "obtain [medical] assistance from any institution, agency . . . or person[ ] qualified *to perform the service or services required*." 42 U.S.C. § 1396a(a)(23)(A) (emphasis added). The plain import of this language is to tie the word "qualified" to the performance of a service—and not just any service, but a medical service. Tellingly, the statute does not differentiate among different types of medical services, laying bare what can be the only reasonable interpretation of "qualified" in this context: capable of "carry[ing] out a particular *activity*—'perform[ing] the [medical] service' that a given Medicaid recipient requires.' " *Betlach*, 727 F.3d at 969. It follows that the types of "qualifications" that are intended 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.

Reading "qualified to perform" in the free-choice-of-provider provision to mean professionally competent accords with the way Congress ordinarily uses the phrase. *See Mount Lemmon Fire Dist. v. Guido*, 139 S. Ct. 22, 26 (2018) (finding it "instructive" that a phrase "occurs dozens of times throughout the U.S. Code, typically carrying [its ordinary meaning]"). Consider, for example, 8 U.S.C. § 1188(c)(3), which directs the Secretary of Labor to find that "there are

not sufficient workers in the United States who are able, willing, and qualified to perform the labor or service needed" before admitting temporary H-2A workers. This provision, like many others in the U.S. Code, specifies some service or function as the object of the phrase "qualified to perform." *See*, *e.g.*, 49 U.S.C. § 5329(e) (awarding states funding to carry out a federal public transportation safety program if, among other things, members of the state agency "responsible for rail fixed guideway public transportation safety oversight" are "qualified to perform such functions through appropriate training"); 37 U.S.C. § 301b(b)(3) (defining "covered officers" as including those "qualified to perform operational flying duty"). To read the phrase as denoting anything other than fitness to perform the activity identified would be highly unusual.

In short, Congress's handiwork here makes good sense. As a matter of ordinary English, one's preferred dry cleaner is not made unqualified to perform cleaning services because he disfavors bicycles or because he did not vote in the last state election, even though the state may prefer otherwise. Yet that is precisely the sort of result produced by South Carolina's reading of "qualified," which would allow the state to exclude providers based on any conceivable state interest. PPSAT, as South Carolina all but admits, is perfectly competent to perform the family-planning services required by plaintiff and is licensed to do so. The state nevertheless suggests that it may disqualify a competent provider under state law so long as there is "good reason." *See* Appellant's Opening Brief at 24. Today that reason is PPSAT's provisioning of abortion services, but we cannot glean

any principled limit to the state's exclusion authority under South Carolina's interpretation.

And there's the rub. If credited, South Carolina's submission that the term "qualified" means whatever the state says would strip the free-choice-of-provider provision of all meaning and shortchange the federal side of the bargain. South Carolina argues the provision would still have *some* meaning by ensuring that recipients could see any provider that meets the state's qualifications. But we do not believe that Congress could have intended to confer a right so empty in terms so strong. "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 of Ind.*, 699 F.3d at 978.

South Carolina nonetheless contends that the Medicaid Act's silence as to the meaning of "qualified" is grounds for interpreting it to allow states expansive exclusionary powers. *See* Appellant's Reply Brief at 10 ("Congress leaving the term 'qualified' undefined purposely creates a vague or amorphous provision with the idea being that doing so allows the states to tailor their State Plan."). That, however, is not how we ordinarily interpret undefined statutory terms, let alone a term pegged to a phrase as clear as "to perform the [medical] service or services required." 42 U.S.C. § 1396a(a)(23)(A).

The state next seeks refuge in the canon against surplusage. If "qualified" means professionally competent, South Carolina argues, then its inclusion in the free-choice-of-provider provision is "pointless

and redundant" because state licensing schemes already exclude incompetent providers from the Medicaid pool. *See* Appellant's Reply Brief at 13. But this view ignores the language of the free-choice-of-provider provision. We do not lightly impute to Congress an intent to use terms that "have no operation at all." *Marbury v. Madison*, 5 U.S. (1 Cranch) 137, 174 (1803). And as noted above, South Carolina's reading works precisely this result by allowing states—at their discretion—to nullify the free-choice-of-provider provision entirely. Granted, South Carolina agrees that a state's policies cannot eliminate "all recipient choice," which the state interprets to require only that at least two "qualified" providers remain available. *See* Appellant's Opening Brief at 36-37. But that cannot be right. The free-choice-of-provider provision "does not simply bar the states from ending *all* choice of providers, it guarantees to every Medicaid beneficiary the right to choose *any* qualified provider." *Planned Parenthood of Ind.*, 699 F.3d at 979. In order to do that, a state must be restricted in its ability to terminate providers for reasons unrelated to professional competency.

The case law also does not support South Carolina's position. On this front, the state argues that the Court's decision in *O'Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773 (1980), interpreted the free-choice-of-provider provision to apply only to providers that "continue[ ] to be qualified" in the Medicaid program as a matter of state law. Appellant's Opening Brief at 35 (quoting *O'Bannon*, 447 U.S. at 785). Not so. *O'Bannon* spoke to the narrow question whether residents of a nursing home had a right to a pre-termination hearing before the state could close a home that all parties agreed was

professionally "unqualified" to render patient care. *See* 447 U.S. at 775-76; *see also id.* at 776 n.3 (cataloguing the home's noncompliance with statutes governing, among other topics, nursing services, physical environment, and medical records). In point of fact, the patients there did not bring a substantive claim seeking to vindicate their rights under the free-choice-of-provider provision, but rather sued for violation of their procedural due process rights. *Id.* at 775. Along with three of the four circuits to have addressed this issue, we cannot read *O'Bannon* to resolve the very different claim raised by plaintiff in the instant case. *See Andersen*, 882 F.3d at 1231-32; *Gee*, 862 F.3d at 460-61; *Planned Parenthood of Ind.*, 699 F.3d at 977. *But see Gillespie*, 867 F.3d at 1047 (Shepherd, J., concurring).

B.

Although the free-choice-of-provider provision imposes limits on a state's qualification authority, states retain discretionary authority with regards to healthcare providers. Section 1396a(p)(1) speaks to this balance, providing:

> In addition to any other authority, a State may exclude any individual or entity for purposes of participating under the State plan under this subchapter for any reason for which the Secretary [of Health and Human Services] could exclude the individual or entity from participation in a program under subchapter XVIII under section 1320a–7, 1320a–7a, or 1395cc(b)(2) of this title.

This provision confirms that states may and do set standards that relate to providers' ability to practice in a professionally competent manner. Take

the cross-references to start. They identify various forms of misconduct including patient abuse, failure to furnish medically necessary services, fraud, license revocation, excessive charges, and failure to disclose necessary information to state regulators. 42 U.S.C. § 1320a–7. In short, federal regulations confirm the authority vested in states to "set[ ] reasonable standards relating to the qualifications of providers" on analogous state-law grounds. *See* 42 C.F.R. § 431.51(c)(2).

Putting all this together, § 1396a(p)(1) and the free-choice-of-provider provision operate in pleasant conjunction. The free-choice-of-provider provision confers an individual right on Medicaid recipients to select the willing and competent provider of their choice. Section 1396a(p)(1) clarifies that states retain discretionary authority to disqualify providers as professionally incompetent for nonmedical reasons such as fraud and for any number of unprofessional behaviors. But the emphasis in § 1396a(p)(1) upon professional malfeasance in no way deprives states of the latitude they possess, under the free-choice-of-provider provision itself, to judge a provider's medical qualifications. Indeed, the language that begins the free-choice-of-provider provision—"A State plan for medical assistance must—provide," 42 U.S.C. § 1396a(a)(23)(A)—presupposes the existence of discretionary authority in the states as it relates to provider qualifications. Nevertheless, the fact that the statute's language and structure suggest the deference due states on the matter of professional and medical qualifications in no way confers a blank check. Here, it bears repeating, no one disputes PPSAT's medical qualifications to perform the family-planning services required, nor is any professional

wrongdoing on the part of PPSAT even alleged. So it follows that South Carolina cannot arbitrarily disqualify PPSAT upon the generalized assertion of inapposite state interests without running afoul of the free-choice-of-provider provision.

South Carolina attempts to disrupt the congruence between these two provisions by reading the savings clause "for more than it's worth." *Planned Parenthood of Ind.*, 699 F.3d at 979. The state argues that the phrase "[i]n addition to any other authority" in § 1396a(p)(1) means it can exclude a provider on any state-law grounds—and for any reason. *See* Appellant's Opening Brief at 32 ("South Carolina's authority, under Section 1396a(p)(1), to determine whether a provider is qualified does not depend on the state interest the disqualification seeks to protect.").

The district court rejected this interpretation, concluding that reading the savings clause this way would render the right conferred by the free-choice-of-provider provision meaningless. *Baker*, 326 F. Supp. 3d at 47-48. We agree. If Congress had in fact harbored the sweeping intent that South Carolina gleans from § 1396a(p)(1), there would be no reason to bother with the free-choice-of-provider provision, as any state-law ground could serve as the basis to eliminate a patient's choice. To say that this would warp the law enacted by Congress is an understatement.

Moreover, South Carolina's interpretation also finds no support in the four corners of § 1396a(p)(1). For one thing, the phrase "[i]n addition to any other authority" serves a specific purpose. It lists what "is a non-exclusive list of specific grounds upon which states may bar providers from participating in

Medicaid." *Planned Parenthood of Ind.*, 699 F.3d at 979. The grounds identified—spanning everything from financial fraud to medical malpractice—relate generally to professional malfeasance. In contrast, the type of "qualification" the state argues for under § 1396a(p)(1) is different in kind. South Carolina's exclusion of PPSAT from its Medicaid network has nothing to do with professional misconduct or for that matter with PPSAT's ability to safely and professionally perform plaintiff's required family-planning services. PPSAT, after all, continues to deliver these services to thousands of South Carolinians each year—to which the state has no objection. *See* J.A. 91.

What we are left with, ironically, is the state's attempt to eliminate almost the entirety of § 1396a(p)(1). For if the phrase "[i]n addition to any other authority" authorizes any and all state interests to serve as a basis for termination, there would be no need to list the specific grounds identified in § 1396a(p)(1). Congress sometimes employs the broad version of the phrase. *See*, *e.g.*, 7 U.S.C. § 2279(c)(4)(B) ("The authority to carry out this section shall be *in addition to any other authority* provided in this or any other Act.") (emphasis added). But it did not do so here, and the foregoing discussion makes clear that this was not through inadvertence.

Consider also the cases cited by the state to support its broad reading of the savings clause. In *Guzman v. Shewry*, 552 F.3d 941 (9th Cir. 2009), the Ninth Circuit did not hold that § 1396a(p)(1) grants states plenary exclusion authority over healthcare providers. Rather, that court expressly recognized that states may exclude providers "for reasons bearing on the individual's or entity's professional competence, professional performance, or financial

integrity." *Id.* at 949 (citing 42 U.S.C. § 1320a-7(b)(5)). In any event, the provider in *Guzman* was deemed "unqualified" based on a state law guarding against professional malfeasance—as were the providers in all cases interpreting § 1396a(p)(1) that South Carolina cites. *See id.* at 946-47 (fraud or abuse); *First Med. Health Plan v. Vega-Ramos*, 479 F.3d 46, 49-50 (1st Cir. 2007) (financial self-dealing); *Triant v. Perales*, 491 N.Y.S.2d 486, 488 (App. Div. 1985) (shoddy record-keeping).

In the end, to read § 1396a(p)(1) as imposing such severe limits on the scope of the right conferred by the free-choice-of-provider provision would eviscerate the Medicaid Act's cooperative scheme and turn the congressional judgment on its head. Congress, aware of the deep national divide on a topic so sensitive as abortion, sought to strike a balance in the Medicaid Act. Starting in 1976, Congress has prohibited federal funds from being used to finance abortions, excepting instances of rape, incest, or to save the life of the mother. *Harris v. McRae*, 448 U.S. 297, 302 (1980) (describing the Hyde Amendment). On the other hand, Congress provided extra protections for beneficiaries' freedom of choice among family-planning providers, something it accomplished while amending the free-choice-of-provider provision to accommodate Medicaid managed care plans.[5] The Secretary, to wit, may waive the free-choice-of-

[5] Medicaid managed care plans allow a state to contract with a limited selection of healthcare providers. Through this arrangement, states can lower their Medicaid expenses and streamline their delivery of health care. There is no contention that any waiver of the free-choice-of-provider provision took place here.

provider provision when a state implements a Medicaid managed care plan. But with an important caveat: An individual's right to seek out non-abortion services from a qualified family-planning provider of her choice cannot be waived. 42 U.S.C. §§ 1396a(a)(23)(B), 1396d(a)(4)(C); *see also Betlach*, 727 F.3d at 972 ("Even if a state otherwise exercises its option to implement a managed-care system, § 1396a(a)(23)(B) makes clear that as to family planning services, state Medicaid plans must afford recipients the full range of free choice of provider."). This implicit bargain agreed to by the political branches is one that we are bound to respect.

VII.

Because the individual plaintiff has a private right of action to challenge South Carolina's denial of her right to the qualified and willing family-planning provider of her choice, we agree with the district court that she has demonstrated a substantial likelihood of success on her free-choice-of-provider claim. We also hold that the district court did not abuse its discretion in enjoining South Carolina from terminating PPSAT's provider agreement.

It is clear that the plaintiff would suffer irreparable harm in the absence of a preliminary injunction. Denial of her statutory right to select a qualified provider visits a tangible harm: diminished access to high-quality health care suited to the individual plaintiff's needs. *See* Appellees' Brief at 39. That PPSAT may be one of many providers available to the individual plaintiff through South Carolina's Medicaid network is not dispositive; the free-choice-of-provider provision, as we have noted, guarantees a patient's access to her *preferred* provider, save on

matters of professional integrity and competency. South Carolina has a legitimate interest in ensuring that state dollars do not subsidize abortion. But we are not prepared to disrupt the district court's finding that the state's reimbursement of PPSAT on a fee-for-service basis guards against the indirect subsidization of abortion. Finally, an injunction would serve the public interest by preserving the individual plaintiff's statutory right under the free-choice-of-provider provision and ensuring "affordable access to competent health care by some of South Carolina's neediest citizens," *Baker*, 326 F. Supp. 3d at 50, whose health challenges are every bit as real as those of citizens of greater means.

We do not doubt that South Carolina's termination of PPSAT's provider agreement was intended "to further [its] own legitimate interests in protecting prenatal life." *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 853 (1992). Reasonable people can disagree with how Congress chose to balance state flexibility on the one hand, and enforcement of federal entitlements on the other. But in all events federal courts are ill-suited to second-guess this act of political judgment in the Medicaid Act. An injury so concrete and a right so clear is something that the courts must respect, else we forsake natural and straightforward readings of statutory text in favor of spinning ever-finer webs of circumvention that lead to our desired outcomes. To subscribe to this portentous course is to abandon the very source of our authority and the mandate that alone makes the Third Branch a distinctive organ of our government. The judgment of the district court is affirmed.

AFFIRMED

RICHARDSON, Circuit Judge, concurring:

I join in affirming the grant of the preliminary injunction. The Majority correctly recognizes that applying existing Supreme Court precedents requires that we find § 1396a(a)(23) to unambiguously create a right privately enforceable under § 1983 to challenge a State's determination of whether a Medicaid provider is "qualified." Six Circuits now recognize that § 1396a(a)(23) creates this enforceable right.[1] One Circuit does not.[2]

As lower court judges, we are bound to do our level best to apply the law as it is, not how it may become. We have done so here. But when binding precedents present us with a bit of "a mess of the issue," *Gee v. Planned Parenthood of Gulf Coast, Inc.*, 139 S. Ct.

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[1] *See Planned Parenthood S. Atlantic & Julie Edwards v. Baker*, No. 18-2133 (4th Cir. 2019); *Planned Parenthood of Kan. & Mid-Mo. v. Andersen*, 882 F.3d 1205 (10th Cir. 2018), *cert. denied*, 139 S. Ct. 638 (2018); *Planned Parenthood of Gulf Coast, Inc. v. Gee*, 862 F.3d 445 (5th Cir. 2017), *cert. denied*, 139 S. Ct. 408 (2018); *Planned Parenthood Ariz. Inc. v. Betlach*, 727 F.3d 960 (9th Cir. 2013), *cert. denied*, 571 U.S. 1198 (2014); *Planned Parenthood of Ind., Inc. v. Comm'r of Ind. State Dep't of Health*, 699 F.3d 962 (7th Cir. 2012), *cert. denied*, 569 U.S. 1004 (2013); *Harris v. Olszewski*, 442 F.3d 456 (6th Cir. 2006).

[2] *See Does v. Gillespie*, 867 F.3d 1034 (8th Cir. 2017). And in the last two years, other judges have raised questions about recognizing the right of action. *See Planned Parenthood of Greater Tex. Family Planning and Preventative Health Servs., Inc. v. Smith*, 913 F.3d 551, 569–73 (5th Cir. 2019) (Jones, J., concurring); *Gee*, 862 F.3d at 473–86 (Owen, J., dissenting); *Andersen*, 882 F.3d at 1238–49 (Bacharach, J., concurring in part and dissenting in part).

408, 409 (2018) (Thomas, J., dissenting from denial of certiorari), our job becomes particularly challenging.

The challenge here derives from a broader question lurking in the background. What is the proper framework for determining whether a given statute creates a right that is privately enforceable under § 1983? And specifically, has *Wilder v. Virginia Hospital Ass'n*, 496 U.S. 498 (1990), a case relied on in other Circuits' decisions and in our own, been repudiated (or even effectively overruled)? There are indications that it has. *See Armstrong v. Exceptional Child Ctr., Inc.*, 135 S. Ct. 1378, 1386 n.* (2015). But we do not lightly conclude that the Supreme Court has overruled its prior cases—that job is for the Supreme Court alone. *See Hohn v. United States*, 524 U.S. 236, 252–53 (1998) ("Our decisions remain binding precedent until we see fit to reconsider them, regardless of whether subsequent cases have raised doubts about their continuing vitality.").

Like this case, *Wilder* involved a question of whether a subsection of § 1396a(a) of the Medicaid Act created a private right of action under § 1983. The particular provision at issue required a State's plan for medical assistance to "provide . . . for payment" of certain medical services "through the use of rates (determined in accordance with methods and standards developed by the State . . .) *which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities*. . . ." 496 U.S. at 502–03 (quoting 42 U.S.C. § 1396a(a)(13)(A)) (alterations

and emphasis in original).[3]

The *Wilder* Court found that service providers had an enforceable right under § 1983 to reimbursement at "reasonable and adequate" rates. 496 U.S. at 512. It reached this conclusion after looking to three "factors." First, the Court had "little doubt that health care providers are the intended beneficiaries" of the provision. *Id.* at 510. Then the Court observed that the statutory language imposed a binding obligation on States that participate in the Medicaid program because the relevant statutory provision was "cast in mandatory rather than precatory terms," given its use of the word "*must*." *Id.* Finally, the Court found that the provision's obligation was not "too 'vague and amorphous' to be judicially enforceable," applying what would become the second of the three "factors" to find clarity in the statutory directive for payment of "rates . . . which the State finds . . . are reasonable and adequate." *Id.* at 503; *see id.* at 519.[4]

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[3] In 1997, Congress replaced the provision at issue in *Wilder*. *See Long Term Care Pharmacy All. v. Ferguson*, 362 F.3d 50, 58 (1st Cir. 2004).

[4] In finding that this statutory right was "judicially enforceable," the Court rejected the argument that the language in the Medicaid Act giving States the authority to set rates "which the State finds . . . reasonable and adequate," granted "a State flexibility to adopt *any* rates it finds are reasonable and adequate." *Wilder*, 496 U.S. at 503, 519 (emphasis added). Though acknowledging that the Act provided States "substantial discretion in choosing among reasonable methods of calculating rates," the Court held that it was "well within the competence of the Judiciary" to identify which rates were "outside that range

Seven years later in *Blessing*, the Supreme Court instructed courts to apply these "three principal factors" to determine whether a statutory provision creates an enforceable right under § 1983. *Blessing v. Freestone*, 520 U.S. 329, 338 (1997). The Court applied the multifactor test from *Wilder* to determine whether § 1983 established a private right of action under Title IV–D of the Social Security Act. *See Blessing*, 520 U.S. at 338, 340–41.

When the Supreme Court again revisited privately enforcing a statutory right under § 1983 in *Gonzaga*, it seemed to consider this multifactor test problematic, to say the least. "[C]onfusion" on how to apply the *Blessing* factors improperly "led some courts to interpret *Blessing* as allowing plaintiffs to enforce a statute under § 1983 so long as the plaintiff falls within the general zone of interest that the statute is intended to protect." *Gonzaga Univ. v. Doe*, 536 U.S. 273, 283 (2002); *see id.* (noting the "uncertainty"). *Gonzaga* also questioned "how relations between the branches are served by having courts apply a *multifactor balancing test* to pick and choose which federal requirements may be enforced by § 1983 and which may not." *Id.* at 286 (emphasis added).

The multifactor test is not the only aspect of *Wilder* that has been questioned. *Wilder* had noted

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that no State could ever find to be reasonable and adequate." *Id.* at 519–20.

In this way, *Wilder* seems to foreclose the argument that § 1396a(a)(23) grants South Carolina the flexibility to adopt qualifications based on its interests beyond professional integrity and competency. *See* Majority Op. at 17, 27–29. And on this record, South Carolina has not explained how its actions fall within its broad discretion to identify professional qualifications.

that its analysis was "a different inquiry than that involved in determining whether a private right of action can be implied from a particular statute." 496 U.S. at 508 n.9. On this point, the Court in *Gonzaga* would later "reject the notion" that "*Wilder* appears to support" that "our implied private right of action cases have no bearing on the standards for discerning whether a statute creates rights enforceable by § 1983." 536 U.S. at 283. To the contrary, "our implied right of action cases should guide the determination of whether a statute confers rights enforceable under § 1983." *Id.*

So are *Wilder*, specifically, and the *Blessing* factors, generally, still good law? On the one hand, we look to the three factors from *Blessing*. 520 U.S. at 338, 340–41. But on the other hand, we must find a bright-line: nothing "short of an unambiguously conferred right." *Gonzaga*, 536 U.S. at 283.

But *Gonzaga* did not explicitly overrule *Blessing*'s three-factor approach. Nor did it plainly discard *Wilder*'s application of the factors. *See Gonzaga*, 536 U.S. at 289–90 (distinguishing *Wilder* on its facts). More recently, the Court has more directly questioned *Wilder*'s reasoning and validity. *Armstrong*, 135 S. Ct. at 1386 n.* ("Respondents do not claim that *Wilder* establishes precedent for a private cause of action in this case. They do not assert a § 1983 action, since our later opinions *plainly repudiate* the ready implication of a § 1983 action that *Wilder* exemplified." (emphasis added)). Yet, at least in our Circuit, *Wilder* and *Blessing* remain controlling. *See*, *e.g.*, *Doe v. Kidd*, 501 F.3d 348, 356 (4th Cir. 2007) (relying on *Wilder* and *Blessing* to find § 1396a(a)(8) confers an individual right).

Despite the "confusion" and "uncertainty," we must apply the law as we find it. Today, our opinion is "guide[d]" by the three factors from *Blessing*. Majority Op. at 14. Following their guide requires that we find a private right of action under § 1983 to challenge a State's determination of whether a Medicaid provider is "qualified" under 42 U.S.C. § 1396a(a)(23). And so I do. But I do so with hope that clarity will be provided.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
COLUMBIA DIVISION

PLANNED PARENTHOOD SOUTH ATLANTIC and JULIE EDWARDS, on her behalf and on behalf of all others similarly situated,	§	
Plaintiffs,	§	Civil Action No.: 3:18-2078-MGL
vs.	§	
JOSHUA BAKER, in his official capacity as Director, South Carolina Department of Health and Human Services,	§	
Defendant.	§	

MEMORANDUM OPINION AND ORDER GRANTING PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

I. INTRODUCTION

This is an action for violation of 42 U.S.C. § 1396a(a)(23)(A), a provision of the Medicaid Act, and related constitutional claims. The Court has jurisdiction over this matter under 28 U.S.C. § 1331.

Pending before the Court is Plaintiffs' Motion for Temporary Restraining Order and Preliminary Injunction. ECF No. 5. Having carefully considered Plaintiffs' Motion, the response, the reply, the record, and the applicable law, it is the judgment of the Court Plaintiffs' Motion will be granted, and Plaintiffs' requested preliminary injunction will be issued.

II. FACTUAL AND PROCEDURAL HISTORY

This action arises out of the South Carolina Department of Health and Human Services' (SCDHHS) termination of Plaintiff Planned Parenthood South Atlantic (PPSAT) from South Carolina's Medicaid program. SCDHHS is the state agency that administers South Carolina's Medicaid program, and Defendant is the director of SCDHHS. ECF No. 1 ¶ 16.

PSSAT operates two health centers in South Carolina—one in Charleston and one in Columbia. *Id.* ¶ 14. Prior to SCDHSS' termination of PPSAT from South Carolina's Medicaid program, PPSAT treated patients insured through Medicaid at both of its South Carolina locations. ECF No. 5-2 at 3. PPSAT offers its patients, including but not limited to those insured through Medicaid, a range of family planning, reproductive health, and preventive care services at its Charleston and Columbia health centers. ECF No. 1 ¶ 14. PPSAT performs abortions at its South

Carolina health centers, but South Carolina Medicaid does not cover abortions except under limited circumstances required by federal law. ECF No. 5-2 at 3. Plaintiff Julie Edwards (Ms. Edwards) is a South Carolina resident insured through Medicaid who has been treated at the Columbia location of PPSAT. ECF No. 5-3 ¶¶ 1-2, 11-13.

On August 24, 2017, South Carolina Governor Henry McMaster issued Executive Order No. 2017-15 directing all State agencies to "take any and all necessary actions . . . to cease providing State or local funds . . . to any physician or professional medical practice affiliated with an abortion clinic and operating concurrently with and in the same physical, geographic location or footprint as an abortion clinic." ECF No. 5-2 at 14. On July 13, 2018, Governor McMaster issued Executive Order No. 2018-21 instructing SCDHHS to "deem abortion clinics . . . and any affiliated physicians or professional medical practices . . . enrolled in the Medicaid program as unqualified to provide family planning services and, therefore, to immediately terminate them upon due notice and deny any future such provider enrollment applications for the same." *Id.* at 28. That same day, SCDHHS notified PPSAT it was no longer qualified to provide services to Medicaid beneficiaries, and SCDHHS was therefore terminating PPSAT's Medicaid enrollment agreements effectively immediately. *Id.* at 30.

PPSAT and Ms. Edwards filed their complaint in this matter on July 27, 2018. ECF No. 1. Ms. Edwards has brought suit on her own behalf and as representative of a purported class of South Carolina Medicaid beneficiaries who have obtained or seek to obtain covered healthcare services from PPSAT. *See id.* ¶¶

15, 41-46. In their complaint, Plaintiffs allege Defendant's actions in terminating PPSAT from South Carolina's Medicaid program violate 42 U.S.C. § 1396a(a)(23), a provision of the Medicaid Act, as well as the Fourteenth Amendment of the United States Constitution. Plaintiffs seek declaratory and injunctive relief.

Plaintiffs filed their Motion for Temporary Restraining Order and Preliminary Injunction on July 30, 2018. ECF No. 5. Defendants filed a response in opposition on August 13, 2018, ECF No. 16, to which Plaintiffs replied on August 20, 2018, ECF No. 24. On August 23, 2018, the Court held a hearing on Plaintiffs' Motion at which counsel for Plaintiffs and Defendant were present. The Court, having been fully briefed on the relevant issues, is now prepared to discuss the merits of Plaintiffs' Motion for Temporary Restraining Order and Preliminary Injunction.

The Court notes there are two additional motions pending. ECF Nos. 6, 25. In the interest of expeditiously ruling on Plaintiffs' Motion for Temporary Restraining Order and Preliminary Injunction, however, the Court will address the other pending motions at a later date.

III. STANDARD OF REVIEW

"A plaintiff seeking a preliminary injunction must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest." *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008) (citations omitted). "A preliminary injunction is an extraordinary remedy intended to protect the status quo and prevent

irreparable harm during the pendency of a lawsuit." *Di Biase v. SPX Corp.*, 872 F.3d 224, 230 (4th Cir. 2017) (citation omitted).

IV. DISCUSSION AND ANALYSIS

As an initial matter, the Court notes Plaintiffs are moving for injunctive relief on their Medicaid Act claim only. ECF No. 5-1 at 14. Therefore, the Court will confine its analysis to that claim. The Court will first consider whether Ms. Edwards has made the requisite showing for injunctive relief on her Medicaid Act claim.

A. Likelihood of Success on the Merits

1. Contentions of the Parties

Ms. Edwards argues she is likely to succeed on her Medicaid Act claim because Defendant's termination of PPSAT from South Carolina's Medicaid program violates 42 U.S.C. § 1396a(a)(23)(A), which provides "any individual eligible for medical assistance . . . 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 . . . ." Ms. Edwards asserts it is uncontested PPSAT is a medically and professionally qualified provider, and § 1396a(a)(23)(A) therefore guarantees her the right to choose PPSAT as her provider. She explains § 1396a(a)(23)(A) prohibits Defendant from excluding PPSAT from South Carolina's Medicaid program merely because PPSAT provides abortions outside the Medicaid program. Ms. Edwards further maintains § 1396a(a)(23)(A) creates a private right of action for Medicaid beneficiaries enforceable through 42 U.S.C. § 1983.

In support of her contentions, Ms. Edwards notes the overwhelming majority of courts that have considered these issues, including the Fifth, Sixth, Seventh, Ninth, and Tenth Circuit Courts of Appeals, have held § 1396a(a)(23)(A) creates a private right of action and prohibits a State from terminating qualified providers from its Medicaid program for reasons unrelated to professional competency to perform the services at issue.

Defendant responds Ms. Edwards is unlikely to succeed on her Medicaid Act claim because § 1396a(a)(23)(A) fails to create a private right of action enforceable through § 1983. Defendant posits § 1396a(a)(23)(A), when read in context of § 1396a(a) as a whole, is meant to protect patients in the aggregate, not to confer an unambiguous right upon individuals such as Ms. Edwards. Accordingly, Defendant asserts the remedy for a violation of § 1396a(a)(23)(A) is the termination of federal funding to an offending State's Medicaid program as opposed to a private action. Defendant acknowledges the majority of courts to consider this issue have held § 1396a(a)(23)(A) does confer a private right of action upon patients, but Defendant relies upon *Does v. Gillespie*, 867 F.3d 1034 (8th Cir. 2017), in support of his position. Defendant further avers Ms. Edwards' interpretation of § 1396a(a)(23)(A) is overly broad, and, under *O'Bannon v. Town Court Nursing Center*, 447 U.S. 774 (1980), the right outlined in § 1396a(a)(23)(A) is the right to choose among the pool of providers determined to be qualified by a State, not the right to have a particular provider deemed qualified. Defendant also claims Ms. Edwards is unable to maintain her Medicaid Act cause of action because she has failed to exhaust state administrative

remedies available to her.

Defendant insists that, even if Ms. Edwards were able to maintain her Medicaid Act claim, the claim lacks merit. Defendant posits § 1396a(a)(23)(A) does not define the term "qualified," and § 1396a(p)(1) permits a State to exclude providers from its Medicaid program for any reason established by State law. Defendant argues it may therefore terminate PPSAT from South Carolina's Medicaid program because PPSAT performs abortions, and S.C. Code Ann. § 43-5-1185 mandates "States funds appropriated for family planning must not be used to pay for an abortion."

2. Analysis

a) Private Right of Action

The Court must first determine the threshold issue of whether § 1396a(a)(23)(A) creates a private right of action enforceable through § 1983 such that Ms. Edwards may pursue her Medicaid Act claim. Although there is no controlling precedent on this issue, the Fifth, Sixth, Seventh, Eighth, Ninth, and Tenth Circuit Courts of Appeals have considered this question, and all of those courts except the Eighth Circuit have held § 1396a(a)(23)(A) does confer a private right of action. *Planned Parenthood of Kan. v. Andersen*, 882 F.3d 1205, 1224-29 (10th Cir. 2018) (holding § 1396a(a)(23) creates a private right of action); *Planned Parenthood of Gulf Coast, Inc. v. Gee*, 862 F.3d 445, 457-62 (5th Cir. 2017) (same); *Planned Parenthood Ariz. Inc. v. Betlach*, 727 F.3d 960, 965-68 (9th Cir. 2013) (same); *Planned Parenthood of Ind., Inc. v. Comm'r of Ind. State Dep't of Health*, 699 F.3d 962, 972-77 (7th Cir. 2012) (same); *Harris v. Olszewski*, 442 F.3d 456, 460-65 (6th Cir. 2006)

(same). *Contra Does v. Gillespie*, 867 F.3d 1034, 1039-45 (8th Cir. 2017) (holding § 1396a(a)(23)(A) does not create a private cause of action). The Court agrees with the well-reasoned analysis of the Fifth, Sixth, Seventh, Ninth, and Tenth Circuit Courts of Appeals and holds § 1396a(a)(23)(A) confers a private right of action on Medicaid beneficiaries such as Ms. Edwards.

To create a private cause of action enforceable through § 1983, a federal statute must unambiguously confer a federal right, not simply a benefit or interest. *Gonzaga Univ. v. Doe*, 536 U.S. 273, 283 (2002). To determine whether this requirement has been met, a court must examine whether Congress intended the statute to benefit the plaintiff, whether the right is "so 'vague and amorphous' that its enforcement would strain judicial competence," and whether the obligation created by the statute is mandatory. *Blessing v. Freestone*, 520 U.S. 329, 340-41 (1997). "Once a plaintiff demonstrates that a statute confers an individual right, the right is presumptively enforceable by § 1983." *Gonzaga*, 536 U.S. at 284.

Section 1396a(a)(23)(A) provides "any individual eligible for medical assistance . . . 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." The Court holds this language unambiguously confers a right upon Medicaid-eligible patients, such as Ms. Edwards. *See*, *e.g.*, *Andersen*, 882 F.3d at 1225 ("[W]e have no trouble concluding that Congress unambiguously intended to confer an individual right on Medicaid-eligible patients." (citation omitted)). Contrary to Defendant's argu-

ment, the clear language of this provision reveals it is meant to confer a right upon "any individual eligible for medical assistance," not simply patients in the aggregate. *See Comm'r of Ind.*, 699 F.3d at 974 ("This language does not simply set an aggregate plan requirement, but instead establishes a personal right to which all Medicaid patients are entitled." (citation omitted)). Thus, individual patients like Ms. Edwards are indeed the intended beneficiaries of the right conferred.

Moreover, the right conferred—the right to obtain assistance from any qualified and willing provider—is neither vague nor amorphous. *See Comm'r of Ind.*, 699 F.3d at 974 ("[T]he right is administrable and falls comfortably within the judiciary's core interpretive competence."). Additionally, the right is plainly expressed in mandatory terms, as the statute states: "A State plan for medical assistance must . . . provide that (A) any individual eligible for medical assistance . . . may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service . . . who undertakes to provide him such services . . . ." § 1396a(a)(23)(A); *see also Comm'r of Ind.*, 699 F.3d at 974 ("Finally, § 1396a(a)(23) is plainly couched in mandatory terms.").

The Court rejects Defendant's suggestion there is no private right of action under § 1396a(a)(23)(A) because the appropriate remedy for violation of the provision, according to Defendant, is the termination of federal funding to an offending State's Medicaid program. The ability to withhold federal funding does not constitute a comprehensive enforcement scheme revealing an intent of Congress to foreclose private enforcement, and "private enforcement of

§ 1396a(a)(23) in suits under § 1983 in no way interferes with the Secretary's prerogative to enforce compliance using [his] administrative authority." *Comm'r of Ind.*, 699 F.3d at 975; *see also Olszewski*, 442 F.3d at 462-63.

The Court likewise rejects Defendant's contention that a beneficiary's ability to challenge the termination of a provider deemed unqualified by a State from the State's Medicaid program has been foreclosed by the Supreme Court's decision in *O'Bannon v. Town Court Nursing Center*, 447 U.S. 773 (1980). In *O'Bannon*, the Supreme Court considered whether Medicaid beneficiaries had procedural due process rights prior to the termination of a nursing home's Medicaid provider agreement, and it was uncontested the nursing home was unqualified to provide the services at issue. *O'Bannon*, 447 U.S. at 775-90. In contrast, this case involves a claim Ms. Edwards' substantive rights have been violated, and, as discussed in more detail below, there is no suggestion PPSAT is professionally incompetent or unable to perform family planning services. Thus, *O'Bannon* is inapposite and has no bearing on this case. *See Andersen*, 882 F.3d at 1231-32; *Comm'r of Ind.*, 699 F.3d at 977.

Accordingly, the Court holds, in accordance with the Fifth, Sixth, Seventh, Ninth, and Tenth Circuit Courts of Appeals, that § 1396a(a)(23)(A) confers a private right of action enforceable through § 1983 on Medicaid patients such as Ms. Edwards.

b) Exhaustion of Administrative Remedies

The Court must next consider Defendant's assertion Ms. Edwards is unable to maintain her

Medicaid Act claim because she has failed to exhaust available state administrative remedies. Defendant argues Ms. Edwards' application for Medicaid, ECF No. 25-4, and the SCDHHS Medicaid Member Handbook, ECF No. 25-5, require her to pursue an administrative appeal. The provision Defendant relies upon in Ms. Edwards' Medicaid application states: "If I think SCDHHS . . . has made an error I can appeal its decision. To appeal means to tell someone at SCDHHS that I think the action is wrong, and ask for a fair hearing." ECF No. 25-4 at 16. The relevant portion of the SCDHHS Medicaid Member Handbook provides: "You can ask for an appeal if your Medicaid coverage has changed, ended, or been denied. You can also ask for an appeal if a medical service you need has been denied or delayed." ECF No. 25-5 at 21.

"[A]s a general rule, a plaintiff bringing a suit pursuant to 42 U.S.C. § 1983 does not have to exhaust state administrative remedies before filing suit in federal court." *Talbot v. Lucy Corr Nursing Home*, 118 F.3d 215, 218 (4th Cir. 1997) (citing *Patsy v. Bd. of Regents of State of Fla.*, 457 U.S. 496 (1983)). Exceptions to this general rule have been recognized for circumstances in which Congress has explicitly provided state administrative remedies must be exhausted prior to bringing suit under § 1983 or implicitly indicated such in a statutory scheme. *Id.* at 219.

The Medicaid Act contains no provision explicitly requiring the exhaustion of state administrative remedies prior to bringing a § 1983 suit for violation of the Act. *Id.* Likewise, the Court does not interpret the Medicaid Act as implicitly requiring exhaustion of administrative remedies. Although there is a state

administrative appeal process available to Ms. Edwards, the "mere provision of state administrative remedies . . . is not enough to demonstrate an implicit Congressional intent to impose an exhaustion requirement on a plaintiff seeking to bring a § 1983 action." *Id.* (citations omitted). Further, the relevant provisions of Ms. Edwards' Medicaid application and the SCDHHS Medicaid Member Handbook speak in optional rather than mandatory terms; they provide Ms. Edwards "can" appeal, not that she must.

Accordingly, the Court holds Ms. Edwards was not required to exhaust state administrative remedies prior to bringing this action. *See id.* at 220 (holding the "existence of state administrative review procedures does not suffice to evidence Congress' intent to implicitly create an exhaustion requirement" for claims under a different provision of the Medicaid Act given "the strong presumption against requiring the exhaustion of state administrative remedies in § 1983 suits.").

The Court further holds, even if there were a requirement for Ms. Edwards to exhaust state administrative remedies, her failure to do so would be excused under the circumstances because the pursuit of an administrative appeal before SCDHHS would be futile given the clear directive in Governor McMaster's Executive Order No. 2018-21 for SCDHHS to deem abortion clinics unqualified to provide family planning services and to terminate them from South Carolina's Medicaid program. *See Shalala v. Ill. Council on Long Term Care, Inc.*, 529 U.S. 1, 13 (2000) (explaining there is a futility exception to the doctrine of exhaustion of administrative remedies).

c) Violation of 42 U.S.C. § 1396a(a)(23)(A)

The Court will now turn to the question of whether Defendant's termination of PPSAT from South Carolina's Medicaid program violates § 1396a(a)(23)(A). The Court notes the Fifth, Seventh, Ninth, and Tenth Circuit Courts of Appeals have held, in well-reasoned and persuasive opinions, that similar terminations of PPSAT affiliates from the Medicaid programs of other states violated § 1396a(a)(23)(A). *Andersen*, 882 F.3d at 1229-36; *Gee*, 862 F.3d at 462-68; *Betlach*, 727 F.3d at 968-74; *Comm'r of Ind.*, 699 F.3d at 977-80.

As set forth above, § 1396a(a)(23)(A) provides "any individual eligible for medical assistance . . . 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 . . . ." The Medicaid Act does not define the term "qualified." In § 1396a(a)(23)(A), however, the term "qualified" is modified by the phrase "to perform the service or services required." *See Betlach*, 727 F.3d at 969. Thus, the relevant qualification to which the provision refers is a provider's qualification to perform the medical services at issue. *See id.* The Court agrees with the Seventh Circuit that "[r]ead in context, the term 'qualified' as used in § 1396a(a)(23) unambiguously relates to a provider's fitness to perform the medical services the patient requires." *Comm'r of Ind.*, 699 F.3d at 978. Therefore, for purposes of § 1396a(a)(23)(A), "qualified" means "capable of performing the needed medical services in a professionally competent, safe, legal, and ethical manner." *Id.*

It is undisputed PPSAT is professionally competent and is capable of performing family planning services for Medicaid patients. Defendant claims, however, it may exclude PPSAT from South Carolina's Medicaid program for any reason established by State law pursuant to § 1396a(p)(1). Defendant reasons it may therefore terminate PPSAT from the Medicaid program because PPSAT performs abortions, and S.C. Code Ann. § 43-5-1185 mandates "State funds appropriated for family planning must not be used to pay for an abortion." The Court disagrees.

First, S.C. Code Ann. § 43-5-1185 provides no basis for terminating PPSAT from South Carolina's Medicaid program because, except in narrow circumstances required by federal law, the State's Medicaid program does not cover abortions. ECF No. 5-2 at 3. PPSAT is reimbursed through the Medicaid program on a fee-for-service basis for covered services, and the Medicaid reimbursement rates in South Carolina do not even fully cover the cost of the Medicaid services PPSAT provides. ECF No. 24-1 ¶¶ 2-3. Thus, PPSAT's inclusion in South Carolina's Medicaid program results in neither the direct nor indirect use of State funds to pay for abortions.

Moreover, the Court rejects Defendant's implication § 1396a(p)(1) permits a State to terminate a provider from its Medicaid program for any reason whatsoever as long as the reason is bolstered by State law. Section 1396a(p)(1) provides a State may exclude a provider from its Medicaid program for any reason the Secretary of the United States Department of Health and Human Services may exclude a provider, "[i]n addition to any other authority." Although § 1396a(p)(1) gives States broad authority to exclude

providers from their Medicaid programs, *see*, *e.g.*, *Andersen*, 882 F.3d at 1230, it does not provide States with "unlimited authority to exclude providers for any reason whatsoever," *Comm'r of Ind.*, 699 F.3d at 979. Notably, a State's ability to exclude a provider is limited by § 1396a(a)(23)(A) and its requirement that Medicaid patients be afforded the freedom to choose any qualified and willing provider. *See Gee*, 862 F.3d at 465.

Thus, contrary to Defendant's suggestion, § 1396a(p)(1) does not permit a State to pass a law deeming a provider unqualified for reasons unrelated to professional competence to perform the services at issue and then to exclude the provider from its Medicaid program on the basis of that law. *See Comm'r of Ind.*, 699 F.3d at 979-80. To hold otherwise would render the right conferred in § 1396a(a)(23)(A) meaningless.

As explained above, Defendant's termination of PPSAT from South Carolina's Medicaid program was not based on any alleged incompetence or inability of PPSAT to perform the medical services at issue. Rather, it was based on the fact that PPSAT performs abortions outside the Medicaid program. Because it is undisputed PPSAT is professionally competent to perform family planning services, Defendant's termination of PPSAT from South Carolina's Medicaid program violates § 1396a(a)(23)(A). Accordingly, the Court holds Ms. Edwards is likely to succeed on the merits of her Medicaid Act claim.

B. Irreparable Harm

Ms. Edwards asserts she will suffer irreparable harm in the absence of preliminary relief because she is being deprived of her statutory right under

§ 1396a(a)(23)(A) to have the qualified and willing provider of her choice. She avers she is also suffering irreparable harm in the form of disruption of and reduced access to health care.

Defendant claims Ms. Edwards will suffer no harm without a preliminary injunction because she has no right to receive Medicaid services from a provider deemed unqualified by the State, such as PPSAT. Defendant reiterates its contention Ms. Edwards is unable to maintain a cause of action challenging Defendant's determination PPSAT is unqualified to provide Medicaid services. Defendant further suggests Ms. Edwards will suffer no harm because she can still obtain Medicaid services from PPSAT's physicians as long as they bill for such services outside of PPSAT.

The Court has no trouble concluding Ms. Edwards would suffer irreparable harm in the absence of a preliminary injunction because she would be deprived of her statutory right to select the qualified and willing provider of her choice. Ms. Edwards is insured through Medicaid, ECF No. 5-3 ¶ 2, and she wants to continue receiving care from PPSAT, ECF No. 5-3 ¶ 17. Defendant's termination of PPSAT from South Carolina's Medicaid program is depriving Ms. Edwards of her statutory right to choose PPSAT as her provider, and deprivation of this right constitutes irreparable harm.

Defendant's arguments regarding Ms. Edwards' alleged lack of irreparable harm are without merit. As set forth above, the Court holds § 1396a(a)(23)(A) provides Medicaid patients such as Ms. Edwards a private right of action enforceable under § 1983, and Defendant's termination of PPSAT from South

Carolina's Medicaid program violates § 1396a(a)(23)(A). Thus, the Court rejects Defendant's contention Ms. Edwards will suffer no irreparable harm because she has no right to receive Medicaid services from PPSAT and no ability to challenge Defendant's termination of PPSAT from the State's Medicaid program.

Defendant's claim Ms. Edwards may still obtain services from PPSAT's physicians as long as they bill for her services outside of PPSAT is likewise lacking in merit. Section 1396a(a)(23)(A) affords Ms. Edwards the right to obtain services from any qualified "institution, agency, community pharmacy, or person." Thus, Ms. Edwards has the right to choose PPSAT, not just its physicians, as her provider, and Defendant's termination of PPSAT from the State's Medicaid program deprives her of that right.

Accordingly, the Court holds Ms. Edwards has demonstrated she is likely to suffer irreparable harm in the absence of preliminary relief.

C. Balancing of the Equities

Ms. Edwards insists the balance of the equities tips in her favor because she will suffer irreparable harm in the absence of a preliminary injunction, and Defendant would suffer no injury if the Court were to issue a preliminary injunction. She explains Defendant would suffer no injury because the State would simply continue to reimburse PPSAT for Medicaid services as it has done for years.

Defendant disagrees the balance of the equities tips in Ms. Edwards' favor. Defendant claims Ms. Edwards and other PPSAT Medicaid patients can seek health care services elsewhere in the absence of

injunctive relief. Furthermore, Defendant maintains he would in fact suffer an injury if injunctive relief were granted because, as revealed by Governor McMaster's Executive Order No. 2017-15 and S.C. Code Ann. § 43-5-1185, the State has a compelling interest in ensuring no State funds are used to pay for abortions or are provided to physicians or medical practices affiliated with abortion clinics. Defendant claims States funds would be used to subsidize abortions at PPSAT if Plaintiffs' requested injunction were issued, and, as evidence of this, Defendant cites to the testimony of PPSAT's CEO that PPSAT might have to reduce services and hours at its health centers without Medicaid reimbursements.

The Court holds the balance of the equities tips in Ms. Edwards' favor. As stated above, Ms. Edwards, as well as other PPSAT patients insured through Medicaid, will suffer irreparable harm in the absence of an injunction because they will be deprived of their statutory right to the qualified provider of their choice. This harm is significant and can have substantial negative effects, including a potential lack of access to health care. Contrary to Defendant's suggestion, it is immaterial whether Ms. Edwards can seek health care from another provider because she is entitled to the qualified provider of her choice under § 1396a(a)(23)(A).

The Court agrees with Ms. Edwards the State would suffer no harm if injunctive relief were granted. As Ms. Edwards points out, the State would simply have to continue to reimburse PPSAT for Medicaid services as it has done previously. Defendant's argument injunctive relief would force it to subsidize abortions is without merit. As explained above, South Carolina's Medicaid program does not cover abortions

except in narrow circumstances required by law, and PPSAT is reimbursed for Medicaid services on a fee-for-service basis. ECF No. 24-1 ¶¶ 2-3. Thus, PPSAT's inclusion in South Carolina's Medicaid program does not cause the State to subsidize abortions, and the fact PPSAT might have to reduce services and hours if it loses Medicaid patients fails to prove otherwise. Moreover, Defendant can have no legitimate interest in perpetuating circumstances contrary to law, and Defendant's termination of PPSAT from the Medicaid program violates § 1396a(a)(23)(A).

D. The Public Interest

Ms. Edwards argues a preliminary injunction would serve the public interest of ensuring continued access to crucial health services for Medicaid patients. Defendant claims injunctive relief would be adverse to the public interest because it would require the State to subsidize abortions in violation of S.C. Code Ann. § 43-5-1185.

The Court has already rejected Defendant's claim a preliminary injunction would require the State to subsidize abortions, and the Court therefore rejects Defendant's argument injunctive relief is adverse to the public interest. The Court holds Plaintiffs' requested preliminary injunction would serve the public interest by preserving the statutory right of Ms. Edwards and other PPSAT patients insured through Medicaid to have the qualified provider of their choice. Injunctive relief further serves the public interest by helping to ensure affordable access to competent health care by some of South Carolina's neediest citizens.

In accordance with the above discussion, the Court holds Ms. Edwards has demonstrated she is

likely to succeed on the merits of her Medicaid Act claim, she is likely to suffer irreparable harm in the absence of preliminary injunctive relief, the balance of equities tips in her favor, and her requested injunction is in the public interest. The Court will therefore issue a preliminary injunction enjoining Defendant from terminating the Medicaid enrollment agreement of PPSAT during the pendency of this litigation.

Because the Court holds preliminary injunctive relief is appropriate and warranted for Ms. Edwards' Medicaid Act claim, the Court declines to analyze whether preliminary injunctive relief is appropriate for PPSAT's claim. The Court likewise declines to address the remaining arguments of the parties, as the Court's holdings articulated above are dispositive of Plaintiffs' Motion for Temporary Restraining Order and Preliminary Injunction. *See Karsten v. Kaiser Found. Health Plan of Mid-Atl. States, Inc.*, 36 F.3d 8, 11 (4th Cir. 1994) ("If the first reason given is independently sufficient, then all those that follow are surplusage; thus, the strength of the first makes all the rest *dicta*.").

V. CONCLUSION

Wherefore, based on the foregoing discussion and analysis, it is the judgment of the Court Plaintiffs' Motion for Temporary Restraining Order and Preliminary Injunction is **GRANTED**. Defendant and his employees, agents, successors in office, and all others acting in concert with him in his official capacity as Director of the South Carolina Department of Health and Human Services are hereby enjoined from terminating the Medicaid enrollment agreement of Planned Parenthood South

Atlantic during the pendency of this action. Plaintiffs are directed to post security in the amount of $1,000 with the Clerk of Court for the District of South Carolina by Tuesday, September 4, 2018.

IT IS SO ORDERED.

Signed this 28th day of August 2018 in Columbia, South Carolina.

s/ Mary Geiger Lewis
MARY GEIGER LEWIS
UNITED STATES DISTRICT JUDGE

42 U.S.C. 1396a(a)(23); 1396a(b)
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 . . . .

* * * * *

(b) Approval by Secretary

The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) . . . .

* * * * *

42 U.S.C. 1396c
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—

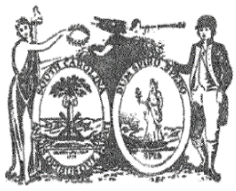
(1) that the plan has been so changed that it no longer complies with the provisions of section 1396a of this title; or

(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).

State of South Carolina

Executive Department



FILED

AUG 24 2017

Mark Hammond
SECRETARY OF STATE

Office of the Governor

EXECUTIVE ORDER NO. 2017-15

WHEREAS, the State of South Carolina has a strong culture and longstanding tradition of protecting and defending the life and liberty of the unborn; and

WHEREAS, the General Assembly has expressed, in section 43-5-1185 of the South Carolina Code of Laws, as amended, that "State funds appropriated for family planning must not be used to pay for an abortion"; and

WHEREAS, on June 5, 20l7, the undersigned requested that the South Carolina Board of Health and Environmental Control ("DHEC Board") "publicly reaffirm" the South Carolina Department of Health and Environmental Control's ("DHEC") "policy prohibiting the distribution of Title X grant funding to any local health care provider that performs abortion services"; and

WHEREAS, on July 12, 2017, in response to the undersigned's June 5, 2017 letter, the chairman of the

DHEC Board confirmed that "no abortion services or activities are provided or paid for by the Department" and that "the Department will continue its practice of not providing Title X grant funding to abortion clinics"; and

WHEREAS, abortion providers often focus primarily on abortion-related services and procedures; however, abortion providers may be subsidized by State or local funds intended for other women's health or family planning services, whether such non-abortion services are rendered directly by abortion providers or by affiliated physicians or professional medical practices; and

WHEREAS, a variety of governmental agencies and non-governmental entities offer important women's health and family planning services without resulting in the State directly or indirectly subsidizing abortion providers; and

WHEREAS, for the foregoing reasons, the State of South Carolina need not contract with abortion clinics, as defined by section 44-41-75 of the South Carolina Code of Laws, as amended, or any of coincident or affiliated physicians or professional medical practices, via the Medicaid program or provider network, in order to ensure the health and well-being of the people of South Carolina or to secure appropriate access to women's health and non-abortion family planning services.

NOW, THEREFORE, by virtue of the authority vested in me as Governor of the State of South Carolina and pursuant to the Constitution and Laws of this State and the powers conferred upon me therein, I hereby direct all State agencies to take any and all necessary actions, as detailed herein and to

the extent permitted by law, to cease providing State or local funds, whether via grant, contract, state-administered federal funds, or any other form, to any physician or professional medical practice affiliated with an abortion clinic and operating concurrently with and in the same physical, geographic location or footprint as an abortion clinic.

FURTHER, I hereby Order that the Executive Budget Office ("EBO") shall: (1) prepare, maintain, and make available on its website a comprehensive list of physicians or professional medical practices affiliated with an abortion clinic and operating concurrently with and in the same physical, geographic location or footprint as an abortion clinic; (2) conduct and make available on its website an annual audit or survey, the form of which shall be determined by EBO, of State agencies identifying or listing by agency and provider, any and all State or local funds, whether via grant, contract, state-administered federal funds, or any other form, provided to any physician or professional medical practice affiliated with an abortion clinic and operating concurrently with and in the same physical, geographic location or footprint as an abortion clinic.

FURTHER, I hereby direct the South Carolina Department of Health and Human Services ("DHHS") to take all necessary actions, to the extent permitted by law, to seek from the Centers for Medicare and Medicaid Services any and all appropriate waivers that may be required to comply with the provisions of this Order, including but not limited to all necessary actions, to the extent permitted by law, to exclude abortion clinics from the State of South Carolina's Medicaid provider network.

FURTHER, to ensure that the people of South Carolina are informed of and have appropriate access to women's health and family planning services, I hereby direct DHHS to coordinate with DHEC to prepare, produce, and make publicly available a user-friendly list of all qualified women's health and family planning providers operating within a twenty-five (25) mile radius of any abortion clinic identified as set forth herein and excluded from the State of South Carolina's Medicaid provider network.

This Order applies to all Cabinet agencies and all boards and commissions that are part of, comprised within, or under the jurisdiction of a Cabinet agency, including but not limited to DHHS and EBO. It is further advised that executive agencies not in the undersigned's Cabinet or otherwise subject to the undersigned's direct authority shall likewise act in accordance with this Order and the foregoing directives. This Order is effective immediately.

GIVEN UNDER MY HAND AND THE GREAT SEAL OF THE STATE OF SOUTH CAROLINA, THIS 24 DAY OF AUGUST, 2017.

HENRY MCMASTER
Governor

ATTEST:

MARK HAMMOND
Secretary of State

HENRY MCMASTER
GOVERNOR

July 5, 2018

Dear Mr. Speaker and Members of the General Assembly,

I am vetoing and returning without my approval certain line items in R293, H. 4950, the FY 20l8-19 General Appropriations Act.

South Carolina is winning. Since January 2017, we have announced nearly 21,000 jobs and over $6 billion in new capital investment. Our unemployment rate is at its lowest since 2000. And, with more and more companies moving here every month, starting and expanding, we continue to see record numbers of citizens who are gainfully employed and enjoying the new prosperity of the Palmetto State.

* * * * *

As stewards of the public trust, we must always be tireless advocates of government accountability and transparency. The vetoes below reflect these twin responsibilities and specify instances in which the legislature has acted unwisely and hastily with taxpayer dollars by directing public money to private

interests or earmarking funds for parochial projects which serve little or no public interest and should be considered locally.

I urge the General Assembly to thoughtfully consider each of these vetoes and promptly sustain them on behalf of the people of this state.

* * * * *

Preventing Taxpayers from Subsidizing Planned Parenthood

Veto 42 **Part 1A, Page 76, Section 33, Department of Health & Human Services, II. Program and Services, A. Health Services, 3. Medical Assistance Payments, Family Planning, Total Funds $15,779,259, General Funds $2,208,596**

Taxpayer dollars must not directly or indirectly subsidize abortion providers like Planned Parenthood. There are a variety of agencies, clinics, and medical entities in South Carolina that receive taxpayer funding to offer important women's health and family planning services without performing abortions.

That's why last year I directed state agencies to stop providing slate or local funds to abortion clinics. I also directed the Department of Health and Human Services to submit a waiver request to the federal government, making South Carolina one of only two states in the nation (along with Texas) to take this action. Until the waiver is acted upon by the federal government, I will veto this section of the SCDHHS budget to prevent taxpayer dollars from directly or

indirectly subsidizing abortion providers like Planned Parenthood.

For the foregoing reasons, I am vetoing and returning without my approval the above provisions in R293, H.4950, the FY 2018-19 General Appropriations Act.

Yours very truly,

Henry McMaster

State of South Carolina
Executive Department

FILED
JUL 13 2018
Mark Hammond
SECRETARY OF STATE

Office of the Governor

EXECUTIVE ORDER NO. 2018-21

WHEREAS, the preservation of life is the ultimate right to be protected and necessarily includes the life of unborn children; and

WHEREAS, the State of South Carolina has a strong culture and longstanding tradition of protecting and defending the life and liberty of unborn children; and

WHEREAS, the State also recognizes that the availability of women's health and family planning services is important in providing for healthy families and children; and

WHEREAS, the South Carolina Department of Health and Human Services ("DHHS") expends taxpayer dollars to pay for health care services, including family planning services; and

WHEREAS, the General Assembly has expressed, in section 43-5-1185 of the South Carolina Code of Laws, as amended, that "State funds appropriated for family planning must not be used to pay for an abortion"; and

WHEREAS, the payment of taxpayer funds to abortion clinics, for any purpose, results in the subsidy of abortion and the denial of the right to life; and

WHEREAS, abortion clinics' primary focus on denying the right to life is contrary to and conflicts with the State's obligation to protect and preserve that right; and

WHEREAS, on August 24, 2017, the undersigned issued Executive Order 2017-15 directing DHHS to pursue all available methods and to take all necessary actions to exclude abortion clinics from receiving taxpayer funds for any purpose, including but not limited to seeking any and all requisite waivers from the Centers for Medicare and Medicaid Services ("CMS"); and

WHEREAS, DHHS subsequently submitted and is negotiating with CMS regarding such a mandatory waiver: and

WHEREAS, on July 5, 2018, because CMS had not yet approved the requisite mandatory waiver, the undersigned issued Veto No. 42, which nullified the Family Planning appropriation in DHHS's budget; and

WHEREAS, although the State should not contract with abortion clinics for family planning services, the State also should not deny South Carolinians access to necessary medical care and important women's health and family planning services, which are provided by a variety of other non-governmental entities and governmental agencies; and

WHEREAS, Proviso 33.16 of the Fiscal Year 2018–19 General Appropriations Act grants DHHS broad authority to carry forward and expend funds for the purpose of operating the Medicaid program, to include family planning services.

NOW, THEREFORE, by virtue of the authority vested in me as Governor of the State of South Carolina and pursuant to the Constitution and Laws of this State and the powers conferred upon me therein, I hereby direct DHHS to exercise the authority granted in Proviso 33.16 of the Fiscal Year 2018–19 General Appropriations Act to expend such appropriated and carry-forward funds as necessary to continue the Family Planning program.

FURTHER, I hereby direct DHHS to deem abortion clinics, as defined by section 44-41-75 of the South Carolina Code of Laws, as amended, and any affiliated physicians or professional medical practices, as identified and defined by Executive Order 2017-15, that are enrolled in the Medicaid program as unqualified to provide family planning services and, therefore, to immediately terminate them upon due notice and deny any future such provider enrollment applications for the same.

This Order is effective immediately.

GIVEN UNDER MY HAND AND THE GREAT SEAL OF THE STATE OF SOUTH CAROLINA, THIS 13th DAY OF JULY, 2018.

HENRY MCMASTER
Governor

ATTEST:

MARK HAMMOND
Secretary of State

Henry McMaster GOVERNOR
Joshua D. Baker DIRECTOR
P.O. Box 8206 : Columbia, SC 29202
www.scdhhs.gov

July 13, 2018

Planned Parenthood South Atlantic
2712 Middleburg Drive, Suite 107
Columbia, SC 29204-2478

Re: Pharmacy MEDICAID ID#: 715572
NPI# 1497049555
Physician Group MEDICAID ID#: 143724
NPI# 1851438147

Dear Planned Parenthood South Atlantic:

On Friday, July 13, 2018, Governor Henry McMaster Issued Executive Order 2018-21 directing the South Carolina Department of Health and Human Services to deem abortion clinics unqualified to provide family planning services to beneficiaries in the South Carolina Medicaid Program. On July 5, 2018, Governor McMaster issued his vetoes to the FY 2018-2019 General Appropriations Act, among which was Veto 42, which prevents taxpayers from subsidizing abortion providers, including Planned Parenthood. Previously, Executive Order 2017-15

requires the South Carolina Department of Health and Human Services to take all necessary actions to cease payment of funds to any physician or professional medical practice affiliated with an abortion clinic.

The Governor's actions result in Planned Parenthood no longer being qualified to provide services to Medicaid beneficiaries; therefore, Planned Parenthood's enrollment agreements with the South Carolina Medicaid Program is terminated effective July 13, 2018.

Sincerely,

Amanda Q. Williams
Office of Health Programs