No. 18-2133

# United States Court of Appeals
## for the
# Fourth Circuit

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.*

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA AT COLUMBIA
AT CASE NO. 3:18-cv-02078-MGL
MARY GEIGER LEWIS, U.S. DISTRICT COURT JUDGE

## BRIEF FOR PLAINTIFFS-APPELLEES

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# TABLE OF CONTENTS

# TABLE OF AUTHORITIES

## Cases

**Statutes**

**Other Authorities**



**Regulations**

## PRELIMINARY STATEMENT

For four decades, Plaintiff Planned Parenthood South Atlantic (PPSAT) and its predecessor organization have been a trusted Medicaid provider for thousands of South Carolinians, providing a broad range of reproductive and preventative health care.

At the direction of Governor McMaster, Defendant Joshua Baker abruptly terminated PPSAT from South Carolina's Medicaid Program—not for any reason related to its qualifications as a provider but solely because its non-Medicaid services include safe, legal abortion. In so doing, Defendant immediately cut off Plaintiff Julie Edwards and PPSAT's other Medicaid patients from their chosen, qualified provider, in violation of the Medicaid Act. PPSAT and Ms. Edwards brought suit to challenge that decision and moved for a preliminary injunction which the district court issued. Defendant has appealed that interlocutory decision.

The district court correctly concluded that § 1396a(a)(23) of the Medicaid Act ("Free Choice Provision") affords Ms. Edwards a right to freely choose her own willing, qualified Medicaid Provider, and authorizes her to bring a federal suit challenging state actions violating that right. Five out of the six courts of appeals to have considered this question have reached the same conclusion. *Planned Parenthood of Kan. & Mid-Mo. v. Andersen*, 882 F.3d 1205 (10th Cir. 2018), *cert. denied*, 2018 WL 1456394 (U.S. Dec. 10, 2018) (No. 17-1340); *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); *but see Does v. Gillespie*, 867 F.3d 1034 (8th Cir. 2017).

Moreover, *every* court to reach the issue has concluded that similar state efforts to exclude Planned Parenthood affiliates from the Medicaid program violates or likely violates the Medicaid Act's Free Choice Provision, and has granted injunctive relief on that basis. *See Andersen*, 882 F.3d 1205; *Gee,* 862 F.3d 445; *Betlach*, 727 F.3d 960; *Comm'r of Ind.*, 699 F.3d 962; *Planned Parenthood Se., Inc. v. Bentley*, 141 F. Supp. 3d 1207 (M.D. Ala. 2015); *Planned Parenthood of Greater Tex. Family Planning & Preventative Health Servs., Inc. v. Smith*, 236 F. Supp. 3d 974 (W.D. Tex. 2017), *appeal docketed*, No. 17-50282 (5th Cir. Apr. 7, 2017); *Planned Parenthood Se., Inc. v. Dzielak*, No. 3:16cv454-DPJ-FKB, 2016 WL 6127980 (S.D. Miss. Oct. 20, 2016), *appeal docketed*, No. 16-60773 (5th Cir. Nov. 21, 2016); *see also Planned Parenthood Ark. & E. Okla. v. Gillespie*, No. 4:15-cv-00566, 2016 WL 8928315 (E.D. Ark. Sept. 29, 2016), *rev'd on other grounds sub nom. Does v. Gillespie*, 867 F.3d 1034 (8th Cir. 2017).

Here, too, the district court correctly found that Defendant's actions likely violate the Medicaid Act and that an injunction was warranted to halt the irreparable harm Defendant was causing. Its decision should be affirmed.

## STATEMENT OF ISSUES

1. Did the district court correctly hold that 42 U.S.C. § 1396a(a)(23) affords Medicaid-insured patients a private right of action to challenge state actions depriving them of their choice of qualified provider?

2. Did the district court correctly hold that Ms. Edwards could bring her claims in federal court without first exhausting state remedies?

3. Did the district court correctly hold that Defendant likely violated the Free Choice Provision of the Medicaid Act by terminating PPSAT from the Medicaid program for providing abortion services outside of that program?

4. Did the district court abuse its discretion in holding that Defendant's actions threatened irreparable harm and that the balance of equities favored preliminary relief?

## STATEMENT OF THE CASE

This interlocutory appeal concerns an order of the U.S. District Court for the District of South Carolina preliminarily enjoining Defendant Joshua Baker from terminating PPSAT's Medicaid provider agreements, which Defendant sought to do not based on any concerns about PPSAT's qualifications but solely based on a directive from Governor McMaster to exclude all abortion providers from all public health programs. The district court's order ensures that Plaintiff Julie Edwards, along with hundreds of other Medicaid patients who rely on PPSAT, can continue to obtain

critically needed family planning and other preventive health services from their provider of choice while Plaintiffs' challenge proceeds.

## I. PPSAT's Participation in the Medicaid Program and Role in Providing Critical Services in South Carolina

PPSAT offers Medicaid patients a range of family planning and other reproductive health services, and other preventive care, at two health centers in South Carolina: in Charleston and Columbia. This care includes well-woman exams; contraception and contraceptive counseling; hormonal counseling; screening for breast cancer; screening and treatment for cervical cancer; screening, vaccination and treatment for sexually transmitted infections ("STIs"); pregnancy testing and counseling; physical exams; and screening for conditions such as diabetes, depression, anemia, cholesterol, thyroid disorders and high blood pressure. App. 46. In 2017, PPSAT served over three hundred South Carolina women, men and teens insured through Medicaid. App. 47. While PPSAT provides abortions, Medicaid does not pay for that service except under very narrow circumstances *required* by federal law (if women's lives are in danger or if they are a victim of rape or incest). App. 46.

Patients insured through Medicaid choose PPSAT based on a number of advantages. With its specialization in family planning, evidence-based practices, and up-to-date technology, PPSAT is known as a provider of high-quality medical care. App. 47; *see* App. 77. PPSAT is also known as a provider of nonjudgmental,

culturally-sensitive care related to reproductive health issues, which involve topics that can be sensitive for patients. App. 47; App. 77. PPSAT devotes substantial time and resources to patient education, particularly about how to use contraception effectively and how to avoid, detect, and treat STIs. App. 47. Many individuals specifically go to Planned Parenthood for their reproductive health care because they are concerned about their privacy and fear (and/or have experienced) being judged by other providers. *Id.*; *see* App. 77.

In addition, PPSAT has designed its services to serve patients with low incomes, who often face numerous barriers to accessing basic health care services. App. 47–48; *see* App. 76–77. To ensure that these patients have access to family planning services, PPSAT offers evening hours; same-day or walk-in appointments, flexible scheduling, and short wait-times; and same-day contraceptive services, including for long-acting reversible contraceptives (LARCs), so that patients only need to make one trip to the health center. App. 48; *see* App. 78. PPSAT also has bilingual interpreting services available at all times. App. 48.

Plaintiff Julie Edwards is a PPSAT patient who is insured through Medicaid. She wishes to continue receiving reproductive health care from PPSAT because she finds that care accessible and high-quality and because "they treated me respectfully and kindly, which has not always been my experience at other doctors' offices." App. 78.

## II. Defendant's Efforts to Exclude PPSAT from Medicaid

Since taking office in 2017, Governor McMaster has sought to exclude PPSAT and other abortion providers from participating in public health programs that have nothing to do with abortion because outside of those programs, PPSAT provides safe, legal abortion. App. 48. On August 24, 2017, the Governor directed the South Carolina Department of Health and Human Services (SCDHHS):

> 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.

App. 56–58. On July 5, 2018, "to prevent taxpayer dollars from directly or indirectly subsidizing abortion providers like Planned Parenthood," the Governor vetoed over fifteen million dollars in family planning funds, none of it directed to abortion (and most of it going to providers other than Planned Parenthood). App. 60–68.

A week later, on July 13, he issued Executive Order 2018-21, which directed Defendant to divert other funds to continue the Family Planning program whose funding he had just cut. However, in this same order, the Governor also directed Defendant to "deem" all abortion clinics and any affiliated physicians "unqualified," and to "immediately terminate them upon due notice and deny any future such

provider enrollment applications for the same." App. 70–71.[1] On that same day, Defendant notified PPSAT that "[t]he Governor's actions result in Planned Parenthood no longer being qualified to provide services to Medicaid beneficiaries" and that he was terminating PPSAT effective immediately. App. 73.

## III. The Impact of Defendant's Action on the Provider Plaintiff and Its Patients

Because Defendant terminated PPSAT's Medicaid contract effective immediately, PPSAT had to turn away patients for weeks before it and Ms. Edwards' motion for a preliminary injunction could be heard and granted. The injunction has prevented further harm for the more than three hundred South Carolina Medicaid patients who receive care from PPSAT each year, including Ms. Edwards.

Medicaid patients already face severely restricted options and barriers to care. South Carolina has some of the tightest eligibility requirements in the country. To be eligible for Medicaid-covered family planning services, an individual must make under $24,000 a year if living alone or $32,000 a year if supporting a dependent. App. 50. Enrollees have limited resources to search extensively for providers or travel far for care. South Carolina also has a relatively large Medicaid patient population, as well as a relatively low rate of spending per beneficiary. App. 51. Its

[1] Under South Carolina law, the term "abortion clinic" refers to any "[f]acility in which any second trimester or five or more first trimester abortions are performed in a month." S.C. Code Ann. § 44-41-75.

population also has higher rates of key health problems, as compared to the national population. *Id*.

The need for publicly-supported family planning services, in particular, is great in South Carolina. In 2010, fifty percent of pregnancies in South Carolina were unintended. *Id*. South Carolina's unintended pregnancy rate in 2010 was forty-six per 1,000 women aged fifteen to forty-four, and forty-eight per 1,000 women aged fifteen to nineteen in 2013. Moreover, South Carolina faces high, and rising, rates, particularly among teenagers, for various STIs including syphilis and HIV/AIDS. *Id*.

PPSAT is an important piece of the provider network striving to meet these needs. App. 52. As explained above, PPSAT's model is designed to reduce barriers to care for patients with limited resources—for example, by emphasizing nonjudgmental communication and by offering care on a same-day basis, over extended hours, and with interpreting services available. *Id*. More generally, having specialized sexual health care providers is important because many patients are uncomfortable discussing sexual health issues with their primary care providers. *Id*.

Moreover, both of PPSAT's health centers in South Carolina are located in high-population areas with formally-recognized provider shortages. Thirty percent of the population of South Carolina lives in U.S. Department of Health and Human Services (HHS)-designated Primary Care Health Professional Shortage Areas

(HPSAs)—areas in which primary care professionals are practically inaccessible. *Id*. Both the Columbia health center and the Charleston health center provide care in population-based HPSAs. The low-income populations of both Richland County (where the Columbia health center is located) and Charleston County (where the Charleston health center is located) are designated as HPSA population groups, indicating a shortage of providers specifically for that population. *Id*.

Women and men who are unable to obtain family planning care, or encounter delays in obtaining it, can face devastating consequences, including undetected cancers and diseases. App. 53. Delays in obtaining contraception will result in unintended pregnancies, which will either result in increased abortions or increased Medicaid births, at great expense to the state. *Id*. Thus, Defendant's efforts to terminate to PPSAT not only are illegal but would further strain resources and impose barriers to care for patients who are already underserved.

## IV. District Court Proceedings

On July 27, 2018, Plaintiffs filed this case challenging Defendant's termination as violating the Free Choice Provision of the federal Medicaid Act, 42 U.S.C. § 1396a(a)(23), and the Equal Protection and Due Process Clauses of the U.S. Constitution. App. 7–14. Plaintiff PPSAT brought these claims on their own and their patients' behalf, and Plaintiff Julie Edwards, a PPSAT patient, brought these claims on her own behalf. App. 9–10. On July 30, 2018, Plaintiffs sought temporary

and preliminary injunctive relief based on their Medicaid Act claims, which the district court set for an immediate hearing. App. 21–23.

On August 23, 2018, the district court heard Plaintiffs' motion, App. 173–203, and on August 28, 2018, it granted a preliminary injunction, allowing Plaintiff Edwards and hundreds of other Medicaid patients to continue receiving Medicaid services at their provider of choice. App. 204–21.

In granting the preliminary injunction, the district court "agree[d] with the well-reasoned analysis of the Fifth, Sixth, Seventh, Ninth, and Tenth Circuit Courts of Appeals and [held] § 1396a(a)(23)(A) confers a private right of action on Medicaid beneficiaries such as Ms. Edwards." App. 209–10. The district court also rejected Defendant's argument that Ms. Edwards could not bring this federal suit without first exhausting state administrative remedies. App. 212–13. The district court did not reach whether PPSAT also had a right of action to assert its patients' claims, or whether Defendant could require PPSAT to exhaust state administrative remedies before bringing such an action.

Next, considering the substance of § 1396a(a)(23)(A), the court, like all other courts to consider that question, held that "Defendant's termination of PPSAT from South Carolina's Medicaid program violates [that requirement]." App. 216. Finally, the court held that Ms. Edwards met the other factors for injunctive relief because: 1) she and other patients were being irreparably harmed by Defendant's unlawful

action; 2) an injunction would not harm Defendant; and 3) "[i]njunctive relief further serves the public interest by helping to ensure affordable access to competent health care by some of South Carolina's neediest citizens." App. 216–20.

This appeal followed.

## SUMMARY OF ARGUMENT

The district court properly issued a preliminary injunction against Defendant.

Ms. Edwards has an enforceable right under the Free Choice Provision because that provision meets the standard laid out by the Supreme Court in *Blessing v. Freestone*, 520 U.S. 329 (1997) and *Gonzaga University v. Doe*, 536 U.S. 273 (2002): its language is clear, mandatory and individually focused on the intended beneficiaries. Ms. Edwards properly brought federal suit to enforce that right without first pursuing any state administrative remedies. Although she signed a Medicaid enrollment form that gave her the *option* to administratively appeal agency decisions not to cover certain *services*, the form did not waive her right to bring claims in a federal forum, nor did it contemplate the type of claim she brought here: that Defendant is unlawfully restricting her choice of *provider*. Nor was there any other requirement that she exhaust state remedies; exhaustion is not generally required for § 1983 actions, and could not be required here, where it would be futile.

On the substance, Plaintiffs demonstrated that it is extremely likely that Defendant's actions violated the Free Choice Provision. That provision states that

the state plan "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) (emphasis added). This mandate prohibits Defendant's current effort to exclude PPSAT solely because PPSAT provides safe and constitutionally-protected abortion services outside of the Medicaid program. Court after court—indeed, every court to address the issue—has concluded that similar state efforts to exclude Planned Parenthood affiliates from the Medicaid program violates or likely violates the Free Choice Provision. *See Andersen*, 882 F.3d 1205; *Gee,* 862 F.3d 445; *Betlach*, 727 F.3d 960; *Comm'r of Ind.*, 699 F.3d 962; *Bentley*, 141 F. Supp. 3d 1207; *Smith*, 236 F. Supp. 3d 974; *Dzielak*, 2016 WL 6127980; *Gillespie*, 2016 WL 8928315.

Finally, the district court was correct in concluding that Defendant's violation of Ms. Edward's rights and interference in her medical care constituted irreparable harm, and that the balance of equities favored an injunction that preserved statutory rights as well as access to critical healthcare.

## ARGUMENT

### I. Standard of Review

Defendant's statement of the standard of review is incomplete. While Defendant is correct that a preliminary injunction is an extraordinary remedy, a

district court's conclusion that such a remedy is warranted "is committed to the sound discretion of the trial court. That decision will not be disturbed on appeal unless the record shows an abuse of that discretion, regardless of whether the appellate court would, in the first instance, have decided the matter differently." *Centro Tepeyac v. Montgomery Cty.*, 722 F.3d 184, 188 (4th Cir. 2013) (quoting *Quince Orchard Valley Citizens Ass'n v. Hodel*, 872 F.2d 75, 78 (4th Cir. 1989)). In other words, a preliminary injunction warrants deference unless the district court "'appl[ied] an incorrect preliminary injunction standard,' 'rest[ed] its decision on a clearly erroneous finding of a material fact,' or 'misapprehend[ed] the law with respect to underlying issues in litigation.'" *Centro Tepeyac,* 722 F.3d at 188 (alteration in original) (quoting *Quince Orchard Valley*, 872 F.2d at 78). None of those circumstances exist here.

## II. The District Court Correctly Held that Ms. Edwards Was Likely To Succeed on the Merits of Her Medicaid Act Claim

### A. The Medicaid Act provides a private right of action enforceable through § 1983

The Free Choice Provision is clear: state Medicaid plans "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).

The district court—like the Fifth, Sixth, Seventh, Ninth, and Tenth Circuits—correctly recognized that Medicaid recipients have a private right of action to enforce this requirement under § 1983. *See Gee*, 862 F.3d at 457; *Harris*, 442 F.3d at 461–62; *Comm'r of Ind.*, 699 F.3d at 974–75; *Betlach*, 727 F.3d at 966–68; *Andersen*, 882 F.3d at 1224. This is because, as the district court properly found and as these near-unanimous cases set forth in detail, the Free Choice Provision satisfies the three-part standard for creating an enforceable right. App. 210–12; *see generally Gonzaga*, 536 U.S. 273; *Blessing*, 520 U.S. 329.

First, the requirement that the state provide "any *individual* eligible for medical assistance" with assistance from any qualified provider, 42 U.S.C. § 1396a(a)(23)(A) (emphasis added), "confer[s] rights on a particular class of persons" and contains sufficient "rights-creating language" to support a cause of action under § 1983, *Gonzaga*, 536 U.S. at 285, 287 (quoting *California v. Sierra Club*, 451 U.S. 287, 294 (1981)). *Comm'r of Ind.*, 699 F.3d at 974 (finding that the Free Choice Provision satisfies this requirement); *accord Betlach*, 727 F.3d at 966–67 (same); *Harris*, 442 F.3d at 461 (same). As the Seventh Circuit explained, this focus on the individual is significant because:

> Medicaid patients are the obvious intended beneficiaries of the statute; it states that *any* Medicaid-eligible person may obtain medical

> assistance from *any* institution, agency, or person qualified to perform that service . . . . This language does not simply set an aggregate plan requirement, but instead establishes a personal right to which all Medicaid patients are entitled.

*Comm'r of Ind.*, 699 F.3d at 974. The district court agreed, finding that "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." App. 210.

Second, the requirement "is not so 'vague and amorphous' that its enforcement would strain judicial competence," *Blessing*, 520 U.S. at 340–41 (citation omitted), because determining whether a provider is "qualified to perform the service or services required," "falls comfortably within the judiciary's core interpretive competence," *Comm'r of Ind.*, 699 F.3d at 974. As the Ninth Circuit explained, the Free Choice Provision

> [S]pecifies that any individual Medicaid recipient is free to choose any provider so long as two criteria are met: (1) the provider is "qualified to perform the service or services required," and (2) the provider "undertakes to provide [the recipient] such services." 42 U.S.C. § 1396a(23)(A). These are objective criteria, well within judicial competence to apply. The second criterion raises a simple factual question no different from those courts decide every day.

*Betlach*, 727 F.3d at 967 (alteration in original); *see also Andersen*, 882 F.3d at 1226–27; *Gee*, 862 F.3d at 459; *Harris*, 442 F.3d at 462; *Bentley*, 141 F. Supp. 3d at 1214.

And third, the requirement is "couched in mandatory terms," App. 211, rather than precatory terms, i.e. that "[a] State plan for medical assistance *must* . . . provide.

. . .” this free choice of qualified provider. 42 U.S.C. § 1396a(a) (emphasis added). *See Comm’r of Ind.*, 699 F.3d at 974; *Harris*, 442 F.3d at 462; *Betlach*, 727 F.3d at 967; *see also Andersen,* 882 F.3d at 1227–28*; Gee*, 862 F.3d at 459–60.

While barely engaging with the *Gonzaga/Blessing* factors, Defendant argues that this Court should disregard this near-unanimous and well-reasoned persuasive precedent because the Free Choice Provision is contained in a list of requirements imposed on state plans for which the U.S. Department of Health and Human Services (“HHS”) may withhold funds for violations of the Act. Br. for Def.-Appellant (“Def.’s Br.”) at 23, Doc. No. 16. Defendant argues that this administrative enforcement mechanism forecloses a private right of action. But the Supreme Court long ago rejected this argument. *See Wilder v. Va. Hosp. Ass’n*, 496 U.S. 498, 521–22 (1990). This Court has too. *See Doe v. Kidd*, 501 F.3d 348, 355–57 (4th Cir. 2007) (citing *Wilder*, *Gonzaga*, and *Blessing*; rejecting argument that Medicaid plan requirements are not enforceable; and finding a right of action to enforce a requirement that state plans include a procedure for informing applicants of their eligibility for Medicaid services with “reasonable promptness”).

Defendant asserts that Go*nzaga* limited *Wilder* to monetary entitlements. Def.’s Br. at 29–30. As multiple courts have recognized, including this Court in *Kidd*, nothing in *Gonzaga*’s language or reasoning indicates such a limitation. In distinguishing *Wilder*, *Gonzaga* focused not on the monetary nature of the statutory

provision *Wilder* enforced, but rather on the "objective" standard set forth in that provision as well as on the inadequacy of alternative remedies. *Gonzaga*, 536 U.S. at 280–81. As in *Wilder*, the Free Choice Provision sets an objective standard, requiring absolute free choice of all providers "qualified *to perform the service or services required*." 42 U.S.C. § 1396a(a) (emphasis added); *see Betlach*, 727 F.3d at 967–68 (quoting 42 U.S.C. § 1396a(a)(23)(A) "the statutory term here, 'qualified,' is tethered to an *objective* benchmark" of competence (emphasis added)); *Andersen*, 882 F.3d at 1227 (quoting this *Betlach* analysis); *Gee*, 862 F.3d at 459 (same).

Further, as in *Wilder*, HHS's option of withholding *all* Medicaid funding is not a feasible or adequate "remedy" for individuals deprived of their free choice of providers. *See Comm'r of Ind.*, 699 F.3d at 974–75 (rejecting argument that availability of federal enforcement forecloses private right of action and noting that "private enforcement of [Free Choice Provision] in suits under §1983 in no way interferes with the Secretary's prerogative to enforce compliance using her administrative authority"); *Andersen*, 882 F.3d at 1229 ("[the Medicaid Act's] administrative scheme cannot be considered sufficiently comprehensive to demonstrate a congressional intent to withdraw the private remedy of § 1983 . . . '[G]eneralized powers' . . . to audit and cut off federal funds [are] insufficient to foreclose reliance on § 1983 to vindicate federal rights." (alterations in original) (quoting *Wilder*, 496 U.S. at 522)); *Harris*, 442 F.3d at 463 ("that the Federal

Government may withhold federal funds to non-complying States is not inconsistent with private enforcement"); *cf. Kidd,* 501 F.3d at 356 (in context of considering a different state plan requirement, holding that "the Act does not contain a '*comprehensive* enforcement scheme that is *incompatible* with individual enforcement under § 1983'" (quoting *Blessing*, 520 U.S. at 341))).

For these reasons, all but one of the courts considering § 1396a(a)(23)(A) claims since *Gonzaga* have applied *Wilder* to find an enforceable right of action. *See Andersen,* 882 F.3d at 1229 (applying *Wilder* as binding precedent to Free Choice Provision); *Comm'r of Ind.*, 699 F.3d at 975–76 (same); *Harris*, 442 F.3d at 463 (same); *Gee,* 862 F.3d at 460 n.49 (citing *Wilder*); *cf. Betlach*, 727 F.3d at 965–68 (without citing *Wilder*, finding § 1396a(a)(23)(A) enforceable under *Gonzaga*); *but see Does*, 867 F.3d 1034.[2]

[2] Congress, moreover, has reinforced that Medicaid Act provisions can support a private right of action even when they are part of a state plan and subject to HHS enforcement. 42 U.S.C. § 1320a-2 ("In an action brought to enforce a provision of this chapter, such provision is not to be deemed unenforceable because of its inclusion in a section of this chapter requiring a State plan or specifying the required contents of a State plan."). The House Report to this provision (known as the Suter Amendment) explains Congress's "intent . . . is to assure that individuals who have been injured by a State's failure to comply with the Federal mandates of the State plan titles of the Social Security Act are able to seek redress in the federal courts" regardless of whether the right they seek to enforce is part of a state plan requirement. H.R. CONF. REP. No. 103-761 (1994), reprinted in 1994 U.S.C.C.A.N. 2901, 3257 (emphasis added). These statements of legislative intent reinforce that Congress has more than met the *Gonzaga* standard for creating a right of action to enforce the Free Choice Provision.

Thus, contrary to Defendant's argument, the Free Choice Provision plainly meets the *Gonzaga* standard for rights-creating language.[3]

**B. Ms. Edwards is entitled to bring her claims in federal court**

Faced with this near-unanimous and persuasive precedent, Defendant next tries to evade Ms. Edwards' claims by contending she waived her right to a federal forum and/or was required to exhaust administrative remedies before bringing this action because she signed a Medicaid enrollment form that set forth certain limited administrative appeal rights. The district court correctly rejected these arguments.[4]

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[3] Defendant also argues that the Free Choice Provision is not rights-creating because states retain broad authority to set provider qualifications. Def.'s Br. at 23–24. Defendant does not explain how this assertion relates to the *Gonzaga* test, but at any rate as set forth below in Section II.C., *infra*, the district court correctly found that, under the Medicaid Act, state "qualifications" must be related to a providers "ability to perform the service or services required." App. 214 (quoting 42 U.S.C. § 1396a(a)(23)(A)).

[4] Defendant devotes much of his discussion of waiver to *PPSAT*, contending it waived its right to seek relief in federal court because the Medicaid provider agreement it signed provides that administrative appeals are a provider's "sole and exclusive remedy" for "any dispute arising under this agreement." Def.'s Br. at 6 n.2 (citing language at App. 115). But that argument is irrelevant to the central question here, which is whether the district court properly found that *patient plaintiff* Julie Edwards could bring federal suit without first bringing an administrative appeal. Were this Court to reach Defendant's argument anyway, that argument fails for at least three reasons. *First,* (unlike in *Pee Dee Health Care, P.A. v. Sanford,* 509 F.3d 204 (4th Cir. 2007), on which Defendant relies) PPSAT's federal claims "arise[] under" the Free Choice Provision and the Constitution, not the provider agreement. *Second*, an administrative appeal would have been futile given the Governor's directive, *see supra* Argument, Section II.B.; *Rohr Indus., Inc. v. Washington Metro. Area Transit Auth.*, 720 F.2d 1319, 1323 (D.C. Cir. 1983) ("[I]it is now settled that the [dispute] clause extends only to controversies" that are "capable of complete

As an initial matter, it does not appear Ms. Edwards actually had any administrative appeal available to her, as would be required for either Defendant's waiver or exhaustion arguments to apply. In contending such an appeal is available, Defendant relies solely on an enrollment form signed by Medicaid beneficiaries that 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," App. 212, and the SCDHHS Medicaid Member Handbook, which provides that: "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." *Id*. On its face, this language does not address the type of claim at issue here: Ms. Edward's Free Choice claim is not that she is being denied "coverage," or a specific "service," but that her choice of *provider* for covered services is being illegally restricted.[5] Thus, it does not appear that Ms. Edwards

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resolution by a procedure specified in the contract" (quoting *Bethlehem Steel Corp. v. Grace Line, Inc.*, 416 F.2d 1096, 1101 (D.C. Cir. 1969))); *cf. Washington Metro. Area Transit Auth. v. Buchart-Horn, Inc.*, 886 F.2d 733, 735 (4th Cir. 1989) (citing *United States v. Utah Constr. & Mining Co.*, 384 U.S. 394 (1965)) ("[A]dministrative resolution of a given claim is only authorized if some other provision of the contract establishes an administrative remedy sufficient to afford full relief for thethat claim."). And *third*, public policy militates against allowing Defendant to evade the Free Choice Provision, the Constitution, and § 1983 by foreclosing a federal remedy for wrongfully terminated providers suing on behalf of their patients. *See also* Pls.' Opp'n to Def.'s Mot. to Dismiss, ECF No. 31.

[5] Since Ms. Edward's claim is not one that falls within SCDHHS's stated purview, it strains credulity that Defendant would claim that Plaintiffs' claims are "the type

*could* seek administrative relief from Defendant's unlawful termination of PPSAT. *Cf. Andersen*, 882 F.3d at 1218, 1236 (finding that patients had no administrative avenue to enforce their free choice right); *Gee*, 862 F.3d at 455 (same).

But even if the enrollment form and handbook did provide an administrative remedy for denial of a chosen provider, her signature on the form could not constitute a waiver of remedies because the form and handbook "speak in optional rather than mandatory terms; they provide Ms. Edwards 'can' appeal, not that she must." App. 213. A mandatory clause requires litigation to occur in a specified forum; a permissive clause permits litigation to occur in a specified forum but does not bar litigation elsewhere. *See Albemarle Corp. v. AstraZeneca UK Ltd.*, 628 F.3d 643, 650–51 (4th Cir. 2010). "A permissive forum selection clause" like the one here, which "permits litigation to occur in a specified forum but does not bar litigation elsewhere . . . does not justify dismissal on the grounds that the plaintiff filed suit in a forum other than the one specified in the clause," *BAE Sys. Tech. Sol. & Servs., Inc. v. Republic of Korea's Def. Acquisition Program Admin.*, 884 F.3d 463, 470 (4th Cir. 2018).

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of issues that the SCDHHS Division of Appeals and Hearings was specifically designed and created to rule upon." Def.'s Br. at 41. In fact, SCDHHS has no expertise in deciding the pure legal issue of whether Defendant has violated the Free Choice Provision by terminating Ms. Edward's chosen provider, PPSAT, from the Medicaid program solely because PPSAT provides abortion services outside the context of that program violates.

Nor can these documents require Ms. Edwards to exhaust administrative remedies before bringing any federal claim, as Defendant appears to suggest. Def.'s Br. at 40–42. Even if an administrative appeal was available (which it does not appear to be), it is well settled that plaintiffs are not required to exhaust administrative remedies before filing a § 1983 action. *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 (1982)); *see also Andersen*, 882 F.3d at 1222–23; *Bentley*, 141 F. Supp. 3d at 1215. As the district court noted, 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." App. 213 (citations omitted and emphasis added).

Additionally, Ms. Edwards is not required to exhaust the claims she brings here because, as the district court recognized, doing so would be futile. App. 213 (citing *Shalala v. Ill. Council on Long Term Care, Inc.*, 529 U.S. 1, 13 (2000)); *see also Mullins Coal Co. v. Clark*, 759 F.2d 1142, 1146 (4th Cir. 1985) ("A litigant need not exhaust administrative remedies where their pursuit would be a futile gesture."). Here, exhaustion would be futile because 1) her Free Choice claim is not that she is being denied "coverage," or a specific "service," but that her choice of *provider* is being illegally restricted and such claims are not expressly included in the enrollment form or Handbook, *Cf. Kunda v. C.R. Bard, Inc.*, 671 F.3d 464, 472

(4th Cir. 2011) (noting that where a "suit is directed to the legality of a plan, not to a mere interpretation of it, exhaustion of the plan's administrative remedies would be futile" (quoting *Durand v. Hanover Ins. Group, Inc.,* 560 F.3d 436, 439–40 (6th Cir. 2009))); and 2) Defendant's position is that PPSAT is per se "unqualified" as a result of Executive Order 2018-21, and therefore, that there can be one possible outcome of any administrative appeal. Def.'s Br. at 32–33.[6]

For these reasons, Ms. Edwards neither waived her right to bring suit in federal court nor was required to exhaust state remedies before filing such a suit.

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[6] *See* App. 183–184, 186 (acknowledging futility of any administrative appeal); *Dameron v. Sinai Hosp. of Balt., Inc.*, 626 F. Supp. 1012, 1015 (D. Md. 1986), *aff'd in part, rev'd in part on other grounds,* 815 F.2d 975 (4th Cir. 1987) (plaintiffs were not required "to undertake a futile administrative challenge to the Plan's method of calculating benefits," given clear evidence that Plan administrators had a fixed position adverse to the plaintiffs); *cf. Perry v. Blackledge*, 453 F.2d 856, 857 (4th Cir. 1971) (following established rule that state prisoners seeking post-conviction relief need not exhaust state remedies if their claims would be foreclosed by state judicial precedent); *Dunkley v. Hamidullah*, No. 6:06-2139-JFA-WMC, 2007 WL 2572256, at *2 (D.S.C. Aug. 31, 2007) ("[E]xhaustion would be futile in this instance 'because the BOP has adopted a clear and inflexible policy regarding its interpretation of 18 U.S.C. § 3624(c).'" (quoting *Fagiolo v. Smith*, 326 F. Supp. 2d 589, 590 (M.D. Pa. 2004))); *Bentley*, 141 F. Supp. 3d at 1215 (applying futility exception where termination decision was dictated by the Governor and therefore "impervious to evidentiary rebuttal"); *Morgan v. Laborers Pension Tr. Fund for N. Cal.*, 433 F. Supp. 518, 529 (N.D. Cal. 1977) (where "[t]he Board [of Trustees] has already determined [the] question . . . [and] there is no reason to believe that it will change its position," exhaustion would be futile).

### C. Defendant's actions violated Medicaid beneficiaries right to their choice of provider

Defendant's attempt to terminate PPSAT from Medicaid violates the Free Choice Provision, which guarantees a Medicaid enrollee's right to receive care from the qualified provider of her choice. South Carolina is not the first state to attempt to exclude a Planned Parenthood affiliate from its Medicaid program; similar efforts by Louisiana, Indiana, Arizona, Kansas, Texas, Alabama, and Mississippi have been rejected as violations of the Free Choice Provision, including by the Fifth, Seventh, Ninth, and Tenth Circuits. *See Gee*, 862 F.3d 445 (affirming preliminary injunction enjoining termination); *Comm'r of Ind.*, 699 F.3d 962 (same); *Betlach*, 727 F.3d 960 (same); *Andersen*, 882 F.3d 1205 (same); *Smith*, 236 F. Supp. 3d 974 (granting preliminary injunction enjoining termination); *Bentley*, 141 F. Supp. 3d 1207 (same); *Dzielak*, 2016 WL 6127980 (granting summary judgment and enjoining termination).[7]

The Free Choice Provision states that the state plan "must provide" that "any individual eligible for medical assistance . . . may obtain such assistance from any

[7] The Eighth Circuit did not reach the legality of a similar effort in Arkansas, because unlike every other Circuit Court to have considered these claims, that court found that patients do not have a private right of action to enforce the Free Choice Provision. *Does v. Gillespie*, 867 F.3d 1034 (8th Cir. 2017). The Arkansas district court did reach this issue and found, consistent with every other court to reach the issue, that Arkansas's attempt to terminate the Planned Parenthood affiliate there from its Medicaid program violated its patients' Free Choice Provision rights. *Gillespie*, 2016 WL 8928315.

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); 42 C.F.R. § 431.51(a)(1) (recipients "may obtain services from any qualified Medicaid provider that undertakes to provide the services to them"); *see also* 42 C.F.R. § 431.51(b).

In addition to enacting this provision, Congress has singled out family planning services for other special protections. First, Congress provided ninety percent federal funding for these services, 42 U.S.C. § 1396b(a)(5), a higher percentage than many other services. Second, although HHS is generally permitted to waive § 1396a(a)(23)(A) when allowing states to implement a primary care case-management system, *see* 42 U.S.C. § 1396n(b)(1), it may not do so for family planning services. 42 U.S.C. § 1396a(a)(23)(B) (mandating that in such a system patients still be permitted to access family planning care from their provider of choice) (emphasis added). As the Ninth Circuit explained, "[s]ection 1396a(a)(23)(B) . . . carves out and insulates family planning services from limits that may otherwise apply under approved state Medicaid plans, assuring covered patients an unfettered choice of provider for family planning services." *Betlach*, 727 F.3d at 964; *see also Bentley*, 141 F. Supp. 3d at 1217 (noting that, because family planning is an area where providers may particularly vary in the range of options they are willing to provide, "Congress saw fit to identify family planning as the area

of medical care with respect to which a recipient's free choice of provider was most critical").

As the U.S. Supreme Court has explained, the Free Choice Provision gives beneficiaries "an absolute right" to choose any qualified provider "without government interference." *O'Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773, 785 (1980). And as the four federal courts of appeals to reach the issue have uniformly found, that right is "subject only to two limitations: (1) the provider is 'qualified to perform the service or services required' and (2) the provider 'undertakes to provide [the patient] such services.'" *Betlach*, 727 F.3d at 969 (alteration in original) (quoting 42 U.S.C. § 1396a(a)(23)); *accord Andersen*, 882 F.3d at 1225; *Gee*, 862 F.3d at 459–60; *Comm'r of Ind.*, 699 F.3d at 978; *Bentley*, 141 F. Supp. 3d at 1217; 42 C.F.R. § 431.51(b)(1); H.R. Rep. No. 90-544, S. Rep. No. 90-744, reprinted in 1967 U.S.C.C.A.N. 2834, 3021 (explaining that the term "qualified" was included to enable states to "set certain standards for the provision of care").

As every court to address this issue has ruled, the Free Choice Provision means that a state cannot bar Medicaid recipients from obtaining care at their chosen provider for reasons unrelated to that provider's ability to perform Medicaid-covered services. This is so because "[i]n this context, 'qualified' means fit to provide the necessary medical services—that is, capable of performing the needed medical services in a professionally competent, safe, legal, and ethical manner." *Comm'r of*

*Ind.*, 699 F.3d at 968 (finding Planned Parenthood affiliate in that state was clearly "qualified" under that definition); *Betlach*, 727 F.3d at 969 (reading "qualified" as conveying its ordinary meaning, which is: 'having an officially recognized qualification to practice as a member of a particular profession; fit, competent.'") (quoting qualified, Oxford English Dictionary (3d ed. 2007)); *Gee*, 862 F.3d at 465 (quoting *Comm'r of Ind.*, 699 F.3d at 978); *Andersen*, 882 F.3d at 1230 (quoting *Gee*, 862 F.3d at 462 and *Comm'r of Ind.*, 699 F.3d at 978); *Bentley*, 141 F. Supp. 3d at 1221 (state is not authorized to terminate provider agreements "on grounds unrelated to medical competency *or* legal and ethical propriety." (quoting *Betlach*, 727 F.3d at 972)); *Smith*, 236 F. Supp. 3d at 996 (same); *Planned Parenthood Ark. & E. Okla. v. Selig*, No. 4:15-cv-00566-KGB, 2015 WL 13307030 at *9 (E.D. Ark. Sept. 18, 2015).

As the district court noted, there is no dispute that PPSAT is qualified in this sense. App. 214. Nor has Defendant claimed otherwise; Defendant raises no concern whatsoever about the quality of services PPSAT provides to its South Carolina Medicaid patients (or any other patients). To the contrary, Defendant has simply labeled PPSAT "unqualified" in an effort to carry out Governor McMaster's campaign promise to punish PPSAT and the patients who seek Medicaid services there for its provision of safe, legal, and constitutionally-protected abortion services. This is the paradigm example of what a state may not do under the Free Choice

Provision. *See, e.g., Comm'r of Ind.*, 699 F.3d at 978 (rejecting state's argument that it may deem providers unqualified because they provide abortions; "[i]f 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.'")[8]; *Betlach*, 727 F.3d at 963 (impermissible under Free Choice Provision to "preclud[e] Medicaid patients from using medical providers concededly qualified to perform family planning services to patients . . . solely on the basis that those providers separately perform privately funded, legal abortions.");[9] *Gee*, 862

[8] It is odd that Defendant would rely on a 2003 Seventh Circuit decision to support his claim that removing PPSAT from the Medicaid program because it provides abortions does not violate the Free Choice Provision. *See* Def.'s Br. at 36 (citing *Bruggeman ex rel. Bruggeman v. Blagojevich*, 324 F.3d 906 (7th Cir. 2003). In 2012, the Seventh Circuit ruled on the exact question presented here—whether removing a Planned Parenthood affiliate from the Medicaid program because it provides abortions violates patients' rights under the Free Choice Provision—and found it did. *Comm'r of Ind*., 699 F.3d 962.

[9] Indeed, Governor McMasters' directive, which Defendant concedes is the basis for his decision, *see* Def.'s Br. at 12–13, is even more clearly unlawful than the state action invalidated in *Betlach*; whereas Arizona expressly allowed Medicaid providers to perform abortions which federal law *requires* states to cover (i.e. those in cases of rape, incest, or threats to a woman's life), *see* App. 12, McMaster's directive does not. Thus, South Carolina is directly flouting federal requirements that it cover certain medically necessary abortions. *Cf. Hope Med. Grp. for Women v. Edwards*, 63 F.3d 418, 428 (5th Cir. 1995) (holding that federal law required Louisiana, as a condition of its participation in Medicaid, to cover abortions to rape and incest victims as well as women whose lives were in danger).

F.3d at 466 ("a state cannot 'determine for any reason that a provider is not qualified for Medicaid purposes, even if the provider *is* otherwise legally qualified, through training and licensure, to provide the requisite medical services within the state.'" (quoting *Betlach*, 727 F.3d at 970)); *Andersen*, 882 F.3d at 1236 (rejecting state attempt "to do exactly what [other circuits] warned against: 'simply labeling any exclusionary rule as a "qualification"' to evade the mandate of the free-choice-of-provider requirement") (alterations in original) (citations omitted).[10]

Defendant attempts, as other state defendants have unsuccessfully attempted, to avoid the plain and absolute terms of § 1396a(a)(23)(A) by relying on § 1396a(p)(1). Section 1396a(p)(1) authorizes states to terminate providers based on

[10] Even in cases where (unlike here) a state executive agency attempted to terminate specific providers from its Medicaid program because of claimed violations of state or federal Medicaid requirements, courts, including the Fifth and Tenth Circuits, have not hesitated to reject these claimed bases for termination as unrelated to the providers' qualifications to provide medical services where they were factually and legally unsupported. *See Gee*, 862 F.3d at 457, 469–70 (challenge likely to succeed where claimed bases for termination are mere "accusation[s]," "devoid of any factual support or linkage," and therefore cannot "insulate [the state's] actions from a [Free Choice of Provider] challenge"); *Andersen*, 882 F.3d at 1232–37 (same; "allowing the state to terminate [provider]" based on unsupported claims would allow the state to "evade the mandate of the free-choice-of-provider requirement"); *Bentley*, 141 F. Supp. 3d at 1222–23 (same); *Smith*, 236 F. Supp. 3d at 998 (same where state lacked "even a scintilla of evidence" to support claims). All the more so here, where the sole basis for the termination is PPSAT's provision of legal and constitutionally-protected abortion services outside of the Medicaid program, the Free Choice Provision does not permit Defendant to terminate PPSAT from the Medicaid program.

specific categories of misconduct: crimes committed in the delivery of services, abuse or neglect of patients, submission of false claims or acceptance of kick-backs, or failure to comply with Medicaid regulations or corrective action requirements. In addition to laying out these specific categories, § 1396a(p)(1) includes a standard savings clause that these grounds are not exclusive but rather are "in addition to any other authority."[11] Defendant argues that this savings clause is a wholesale authorization to disqualify providers "for any reason established by state law." Def.'s Br. at 31.

As the Seventh Circuit held when faced with this argument, Defendants read § 1396a(p)(1)'s savings clause "for more than it's worth." *Comm'r of Ind.*, 699 F.3d at 979. "'[I]n addition to any other authority' signals only that what follows is a non-exclusive list of specific grounds upon which states may bar providers from participating in Medicaid. It does not imply that the states have an unlimited authority to exclude providers for any reason whatsoever." *Id.*

Section 1396a(p)(1) was enacted as part of the Medicare and Medicaid Patient and Program Protection Act of 1987, a statute that came about in response to a General Accounting Office report that providers who lost their licenses in one state were gaming the Medicaid system by reopening their practice elsewhere. *See* S. Rep.

[11] To exclude a provider under this provision, states must first give them notice and an opportunity to be heard *before* imposing the exclusion. 42 C.F.R. § 1002.213. Defendant failed to do so.

100-109, reprinted in 1987 U.S.C.C.A.N. 682, 684. The stated purpose of the Act was to strengthen federal and state authority to "protect beneficiaries under the health care programs of [the] Act from unfit health care practitioners, and otherwise to improve the antifraud provisions relating to those programs." *See id.*, 1987 U.S.C.C.A.N. 682. Nowhere in the record did Congress contemplate that § 1396a(p)(1) might authorize the states to restrict patient choice except as necessary to protect patients and protect the Medicaid system from fraud.[12] For this reason, court after court has rejected Defendant's reading of § 1396a(p)(1). *Comm'r of Ind.*, 699 F.3d at 979; *Betlach*, 727 F.3d at 971–72; *Gee*, 862 F.3d at 466; *Andersen*, 882 F.3d at 1230–31; *Bentley*, 141 F. Supp. 3d at 1220–21.

The cases Defendant cites do not support his position that § 1396a(p)(1) grants states broad authority to exclude providers for reasons unrelated to fraud or incompetence, and have already been considered and distinguished by courts invalidating other efforts to deprive Medicaid beneficiaries of their right to receive services at Planned Parenthood. In *Guzman v. Shewry*, 552 F.3d 941 (9th Cir. 2009), the provider *was* terminated based on fraud and abuse allegations, specifically that he was importing "large quantities" of foreign, non-approved intrauterine devices,

[12] To the contrary, the same Congress that enacted § 1396a(p)(1) later enacted § 1396a(a)(23)(B), which as discussed above strengthened the right of family planning patients to freely choose their provider. *Compare* Pub L. No. 100-93, § 7 *with* Pub. L. No. 100-203, § 4113.

implanting them in patients, and fraudulently billing them to Medicaid as approved devices. *See Betlach*, 727 F.3d at 973 (limiting *Guzman* to "state laws providing for suspension of providers in cases of possible fraud or abuse, as well as for other reasons having to do with 'professional competence, professional performance, or financial integrity'" (citations omitted)).

*Triant v. Perales*, 491 N.Y.S.2d 486, 488 (N.Y. App. Div. 1985), also cited by Defendant, is a state case that does not even involve any Medicaid Act claim, in which a physician was barred from Medicaid in light of "monumental deficiencies" in record-keeping relating to prescriptions, ordered tests, and referrals to specialists. *See Betlach*, 727 F.3d at 974 n.9 ("*Triant* rested solely on New York state law and did not consider its interaction with the federal Medicaid Act."). Similarly, *First Medical Health Plan v. Vega-Ramos*, 479 F.3d 46 (1st Cir. 2007) concerned services provided in Puerto Rico, a jurisdiction in which the Free Choice Provision does not apply, and "thus cannot be understood to suggest that states may override the free-choice-of-provider requirement by creating 'qualifications' wholly unrelated to the competent delivery of medical services." *Comm'r of Ind.*, 699 F.3d at 979–80.

Defendant also cites *O'Bannon*, but that case is inapposite for multiple reasons: First, in *O'Bannon* there was no claim that state authorities had closed the home on an invalid ground not permitted by the Medicaid Act. Rather, the court took it as a given that the facility was unqualified, and determined that the residents had

no right to a pre-termination hearing on whether an unqualified facility should be closed. *Id*. at 785–88. *See Andersen*, 882 F.3d at 1231 ("*[O]'Bannon* addressed a different situation—one where no one contested that the nursing home was unqualified to perform the services."); *Gee*, 862 F.3d at 460–61 (*O'Bannon* "inapposite" where a terminated provider's competence not at issue). Second, the question in *O'Bannon* was whether residents of a nursing home had a procedural due process right to a hearing in front of state authorities before those authorities closed the home, *O'Bannon*, 447 U.S. at 775—not whether they could bring a § 1983 action in federal court.[13]

Defendant's citation to other specific federal grounds for excluding providers, Def.'s Br. at 32–33, is similarly irrelevant. That HHS allows for the exclusion from Medicaid of providers *who have met grounds for exclusion from* Medicare is

[13] Additionally, as courts have repeatedly explained in distinguishing *O'Bannon* from state efforts to terminate Planned Parenthood from Medicaid, that was a due process case that did not consider whether the Medicaid Act supports a substantive statutory right. *See Gee*, 862 F.3d at 460 ("[In *O'Bannon*], the patient-plaintiffs' injuries were alleged to stem from a deprivation of due process rights . . . . In contrast, the Individual Plaintiffs here assert the violation of a substantive right."); *Comm'r of Ind.*, 699 F.3d at 977 (distinguishing *O'Bannon* because "[t]his is not a due process case. Planned Parenthood and its patients are not suing for violation of their procedural rights; they are making a substantive claim that Indiana's defunding law violates § 1396a(a)(23)"). These courts have distinguished another case Defendant cites, *Kelly Kare, Ltd. v. O'Rourke*, 930 F.2d 170 (2d Cir. 1991), on the same basis. *See Betlach,* 727 F.3d at 974 n.9 (distinguishing *Kelly Kare* because "[h]ere, the question is not the procedures due patients but the substantive protections provided by the statute"); *Comm'r of Ind.*, 699 F.3d at 977; *Bentley*, 141 F. Supp. 3d at 1218 n.7.

unremarkable given that these grounds overlap closely. That Congress has allowed for the exclusion of providers who have defaulted on public loans, *id*. § 1320a–7(b), is similarly unsurprising as it relates to the provider's fiscal responsibility in the handling of government funds. Neither of these provisions alters the plain language and intent of the Free Choice Provision barring *states* from excluding providers for reasons *unrelated* to their professional competence or financial integrity. *See Comm'r of Ind.*, 699 F.3d at 979 ("[§ 1320a–7(b)] merely stipulates a *particular ground* for excluding a Medicaid provider; it does not imply that the states may establish *any* rule of exclusion and declare it a provider 'qualification' for purposes of § 1396a(a)(23)."") Contrary to Defendant's assertion, his effort to punish PPSAT for providing a safe, legal medical procedure is in no way "directly comparable" to these specific, limited federal grounds. Def.'s Br. at 33. To the contrary, it is the paradigm of what the Free Choice Provision forbids.

Thus, as numerous courts have recognized, Defendant's reading of the Medicaid Act fails because it would render the Free Choice Provision meaningless; there would be no point in affording patients an "absolute right" to choose any willing, qualified provider free from state interference, *O'Bannon*, 447 U.S. at 785, if states had complete discretion to deem providers "unqualified" for any reason whatsoever and then exclude them from the network on that basis. Indeed, Defendant's reading would also make *§ 1396a(p)(1)* meaningless as well; it would

make little sense for Congress to carefully enumerate proper grounds for excluding providers while, in the very same provision, authorizing states to exclude providers for any reason whatsoever. *Andersen*, 882 F.3d at 1243 ("If Congress had intended to allow unlimited authority, the listed provisions in § 1396a(p)(1) would have been superfluous."); *Betlach*, 727 F.3d at 972 (same).

Faced with this overwhelming precedent against him, Defendant attempts to couch his termination in terms of a state policy against "subsidizing" abortion. Def.'s Br. at 8–12. The district court correctly rejected this specious argument, finding that "PPSAT's inclusion in South Carolina's Medicaid program results in neither the direct nor indirect use of State funds to pay for abortions," including because South Carolina's Medicaid program does not cover abortion except in narrow circumstances *required* by federal law; Medicaid is a fee-for-service program, in which states (using mostly federal funds) provide low, standardized reimbursements to providers for specific services; and South Carolina's reimbursement rates "do not even fully cover the cost of the Medicaid services PPSAT provides." App. 215; App. 168–69;[14] *see also Planned Parenthood Ariz., Inc. v. Betlach*, 899 F. Supp. 2d 868,

[14] The district court properly rejected Defendant's assertion that PPSAT's Chief Executive Officer Ms. Black was acknowledging subsidization when she stated that, without Medicaid revenue, PPSAT might be forced to reduce hours and staffing. App. 218. At any rate, Ms. Black's statement was about PPSAT's continuing ability to provide the same level of *family planning* services, not abortion services. App. 169.

886–87 (D. Ariz. 2012) (rejecting an identical state argument because "there is no excess funding that could be used to subsidize abortions").

While Defendant ignores these District Court findings, the record is clear that there is no potential state "subsidy" of Medicaid providers who also perform abortions by reimbursing them for non-abortion services, still less of "affiliated physicians," who also would be excluded from Medicaid under Executive Order 2018-21. App. 70–71. Defendant's position is akin to saying that South Carolina is "subsidizing" abortion when it pays for an enrollee's cancer treatment and she then uses the funds she would have used for that care to pay for an abortion. It is also contrary to federal law *requiring* that states "subsidize" certain medically necessary abortions, *see* n.9, *supra*.

Nor does *Rust v. Sullivan*, 500 U.S. 173 (1991), *see* Def.'s Br. at 34, support Defendant's "subsidization" argument. *Rust* involved a block grant (not a fee-for-service) program, Title X, which has no comparable free choice provision. More importantly, the Supreme Court made clear in *Rust* that the prohibition on abortion-related services *within* the Title X program survived only because providers were free to provide those services *outside* of the program. *See Rust*, 500 U.S. at 197 (the government may not "place[] a condition on the *recipient* of the subsidy rather than on a particular program or service, thus effectively prohibiting the recipient from engaging in the protected conduct outside the scope of the federally funded

program"); *see also Agency for Int'l Dev. v. All. for Open Soc'y Int'l, Inc.,* 570 U.S. 205, 214–15 (2013) ("[T]he relevant distinction . . . is between conditions that define the limits of the government spending program—those that specify the activities Congress wants to subsidize—and conditions that seek to leverage funding to regulate speech outside the contours of the program itself."). Here, South Carolina has fallen on the wrong side of this divide, penalizing PPSAT for conduct outside of the Medicaid program. Indeed, Executive Order 2018-21 goes even further, ordering Defendant to exclude even physicians "affiliated" with abortion providers. Given the terms of this Executive Order, Plaintiffs are baffled by Defendant's representation that "nothing prohibits PPSAT from operating separate and distinct entities to ensure abortion services are not provided by Medicaid providers," as well as his representation that patients could continue receiving care from PPSAT-employed physicians who have not yet been officially terminated. Def.'s Br. at 34, 45.[15]

[15] Defendant's reliance on *Harris v. McRae*, 448 U.S. 297 (1980), Def.'s Br. at 9–10, is similarly misplaced as there, the Court held only that the government is not required under the Due Process Clause to provide or to pay for abortions. *McRae*, 448 U.S. at 302. Indeed, the Court in *McRae* cautioned that government action might be unconstitutional if it imposed "broad disqualification from receipt of public benefits" as a price for the exercise of constitutionally-protected abortion rights. 448 U.S. at 317 n.19.

For these reasons, the district court was correct that the Free Choice Provision bars Defendant from excluding PPSAT solely because its services include safe, legal, constitutionally-protected abortion.

## III. The District Court Correctly Held that Ms. Edwards Met the Other Requirements for Injunctive Relief

The district court acted well within its discretion in concluding that the remaining preliminary injunction factors are met, as have numerous other courts in this same context. *Andersen*, 882 F.3d 1207; *Gee*, 862 F.3d 445; *Comm'r of Ind.*, 699 F.3d 962; *Bentley*, 141 F. Supp. 3d 1207; *Planned Parenthood of Ariz. v. Betlach*, 899 F. Supp. 2d 868; *Smith*, 236 F. Supp. 3d 974; *Gillespie*, 2016 WL 8928315 (incorporating findings from *Planned Parenthood Ark. & E. Okla. v. Selig*, No. 4:15-cv-00566-KGB, 2015 WL 13710046 (E.D. Ark. Oct. 5, 2015)).

*First*, Defendant's action was irreparably harming Ms. Edwards and PPSAT's other patients by depriving them of their statutory right to choose their own provider. As the district court recognized, "[t]his harm is significant and can have substantial negative effects, including a potential lack of access to health care." App. 218. Defendant dismisses this harm with the assertion that patients can simply seek care elsewhere, but as the district court found, "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)." *Id.*; *see Comm'r of Ind.*, 699 F.3d

at 981 ("That a range of qualified providers remains available is beside the point."); *Andersen*, 882 F.3d at 1237 (same).[16]

Not only is it immaterial whether other alternatives exist, but the undisputed record reflects that PPSAT health centers provide critical services in medically-underserved areas and that Ms. Edwards and hundreds of other South Carolina Medicaid patients choose PPSAT because it is known provider of accessible, high-quality, up-to-date, evidence-based, patient-centered, compassionate and judgment-free care. *See supra*, Statement of the Case, Sections I & II; *Andersen*, 882 F.3d at 1237 (citing evidence that some patients prefer Planned Parenthood for their "quality of care, lack of bias, and scheduling convenience"). Tellingly, Defendant notes that Ms. Edwards has sought care from other providers in the past, Def.'s Br. at 43, but omits that she switched to PPSAT because of negative experiences with other providers, App. 76–77.

[16] Moreover, Defendant's assertion that Ms. Edwards has plenty of adequate alternatives because 56,917 providers are enrolled in South Carolina's Medicaid program, Def.'s Br. at 13, is highly misleading, as a review of specialties listed on the Department's website reflects that this figure includes (among others) dental practitioners, ophthalmologists, and chiropractors. Such providers obviously are not options to provide the family planning and other reproductive healthcare PPSAT provides. This figure also encompasses providers outside of South Carolina entirely, in Georgia and North Carolina, as well as providers statewide, rather than only in Charleston or Columbia. Search for Providers, S.C. Healthy Connections Medicaid, http://www1.scdhhs.gov/search4aprovider/.

*Second*, the equities weigh in Plaintiffs' favor because the injunction does not harm Defendant: "the State would simply have to continue to reimburse PPSAT for Medicaid services as it has done previously," and "Defendant can have no legitimate interest in perpetuating circumstances contrary to law." App. 218–19. Defendant argues that he is harmed because the injunction requires him to "subsidize" abortion services, but this argument fails for the same reasons it failed as a justification for terminating PPSAT from Medicaid. *See supra* Argument, Section II.C.

*Third*, the public interest is served by an injunction "preserving the statutory right of Ms. Edwards and other PPSAT patients insured through Medicaid to have the qualified provider of their choice [and] . . . helping to ensure affordable access to competent health care by some of South Carolina's neediest citizens." App. 219; *see also Gee,* 862 F.3d at 472 (holding that "the public interest weighs in favor of preliminarily enforcing the Individual Plaintiffs' rights and thereby allowing some of the state's neediest citizens to continue receiving medical care from a medically qualified provider").

Thus, the district court's conclusion that Plaintiffs met the standard for injunctive relief was correct—and certainly well within its discretion—and should be affirmed.

## CONCLUSION

For these reasons, this Court should affirm the district court's decision.

Respectfully submitted,

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I certify that on January 14, 2019 the foregoing document was served on all parties or their counsel of record through the CM/ECF system if they are registered users or, if they are not, by serving a true and correct copy at the addresses listed below:

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