No. 23-1275

In the Supreme Court of the United States

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

v.

PLANNED PARENTHOOD SOUTH ATLANTIC, ET AL.

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

BRIEF OF FORMER SENIOR OFFICIALS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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INTEREST OF *AMICI CURIAE*[1]

Amici curiae are former senior officials of the United States Department of Health and Human Services ("HHS" or "Department") or its predecessor, the Department of Health, Education, and Welfare ("HEW"), who served during the administrations of President Bill Clinton, President George W. Bush, President Barack Obama, and President Joseph Biden.[2] Each of the *amici* either exercised direct control over the administration of Medicaid or advised the Secretary of HHS or HEW on Medicaid law and policy. They are:

Hon. Xavier Becerra, Secretary, HHS (2021-25)

Donald M. Berwick, M.D., Administrator, Centers for Medicare and Medicaid Services ("CMS") (2010-11)

Nancy-Ann DeParle, Administrator, CMS (1997-2000)

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[1] No counsel for any party authored this brief in whole or in part, and no such counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amici curiae* or their counsel made a monetary contribution to the preparation or submission of this brief.

[2] HEW was bifurcated into the Department of Education and HHS in 1979. The Centers for Medicare and Medicaid Services ("CMS")—the HHS agency that administers the Medicaid program—was known as the Health Care Financing Administration ("HCFA") from its inception in 1977 until July 2001.

Margaret M. Dotzel, Deputy General Counsel, HHS (2011-16); Acting General Counsel (2016-17).

Renée M. Landers, Acting Deputy General Counsel, HHS (1996); Deputy General Counsel, HHS (1996-97)

Cindy Mann, Deputy Administrator, CMS and Director, Center for Medicaid and CHIP Services (2009-15)

William Schultz, Acting General Counsel, HHS (2011-13); General Counsel, HHS (2013-2016)

Hon. Kathleen Sebelius, Secretary, HHS (2009-14)

Hon. Donna E. Shalala, Secretary, HHS (1993-2001)

Bruce C. Vladeck, Administrator, Health Care Financing Administration ("HCFA") (1993-97)

Although *amici* hold different views about various aspects of Medicaid policy, they file this brief in support of Respondents' argument that the free-choice-of-provider provision of the Medicaid Act, 42 U.S.C. § 1396a(a)(23)(A), unambiguously confers a right that is privately enforceable under Section 1983. Their experience in overseeing the program's administrative enforcement tools also confirms that

there is no "comprehensive alternative scheme" intended to preclude Section 1983 enforcement of this critical right.

In addition, *amici* file this brief in response to the brief filed in support of Petitioner by the United States as *amicus curiae* that reverses the long-time position of HHS about the private enforceability of the right (*see* Br. of United States 4 and n.1) and instead suggests that the administrative enforcement mechanisms that are available are sufficient to protect Medicaid patients' right to obtain care from any qualified willing provider. They are not.

Amici's collective experience administering the Medicaid program leads to their conclusion that private enforcement of the free-choice-of-provider right under Section 1983 has been critical to ensuring that Medicaid patients are able to vindicate it. This is why the government has never previously argued that this right is not individually enforceable. The arguments advanced by Petitioner and the United States as *amici* in this case are at odds with the individual, mandatory, rights-creating language of the free-choice-of-provider provision and with HHS's longstanding administrative practice. If they are adopted, they would seriously undermine enforcement of one of the most important rights of this nation's most vulnerable individuals.

SUMMARY OF ARGUMENT

Since its inception in 1965, the central purpose of the Medicaid program has been to provide access to "mainstream" health care for those who cannot afford to purchase private medical services. Critical to

serving that goal, and as the legislative history makes clear, the free-choice-of-provider right exists to ensure that Medicaid patients like Julie Edwards are able, like everyone else, to choose their own doctor. Congress has reiterated that Medicaid patients retain that right for the services at issue here, family planning services, *even* in States with mandatory managed care programs.

Despite the Court of Appeals' ruling on three separate occasions over the course of this case that this right is individually enforceable, Petitioner and the United States (in a switch of position) contend that private enforcement of this right is inconsistent with the statutory scheme, suggesting that Congress intended for the provision to be enforced exclusively by HHS or by any state rights given to the excluded providers.

In *amici*'s experiences as senior officials at HHS, individual suits to vindicate this right are not just useful for proper enforcement of the free-choice-of-provider provision; they are essential. Put simply, HHS lacks the ability to meaningfully remedy individual violations of this right. Congress has had this understanding throughout the history of the Medicaid Act, and it has been the prevailing view of those charged with administering the program.

Perhaps no right is more individual or personal than a patient's choice of their own qualified doctor. Individual private enforcement of the free-choice-of-provider right is what Congress has long intended to ensure that individuals like Ms. Edwards can obtain care from the doctor of their choosing.

ARGUMENT

I. HHS Cannot Adequately Remedy All Violations of the Medicaid Act

"Medicaid is a cooperative federal-state program through which the Federal Government provides financial assistance to States so that they may furnish medical care to needy individuals." *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 502 (1990). "The Medicaid statute . . . is designed to advance cooperative federalism," and operates within a cooperative spending statutory scheme. *Wis. Dep't of Health & Fam. Servs. v. Blumer*, 534 U.S. 473, 495 (2002) (citing *Harris v. McRae,* 448 U.S. 297, 308 (1980)); *see also* Abbe R. Gluck, *Federalism from Federal Statutes: Health Reform, Medicaid, and the Old-Fashioned Federalists' Gambl*e, 81 Fordham L. Rev. 1749, 1761–67 (2013) (reviewing legislative history of Medicaid's enactment and noting the centrality of "cooperative federalism" principles).

While Congress has given HHS the authority to administer the program and to enforce its requirements when States fail to comply "substantially" with federal statutory program requirements, 42 U.S.C. § 1396c, its enforcement authority is not designed to, nor does it typically operate to, vindicate important individual rights provided by the Medicaid Act, such as the free-choice-of-provider right.

A. Medicaid is a Cooperative Federal-State Program, and Enforcement of Program Requirements Against States Is Cumbersome and Rarely Used

Codified as Title XIX of the Social Security Act, Medicaid is a cooperative program under which the federal government authorizes federal grants to states to provide health services to a diverse low-income population, including children, pregnant women, adults, the elderly, individuals with disabilities, and individuals requiring long term services and supports. *See* 42 U.S.C. § 1396a(a)(10)(A)(i) (identifying Medicaid-eligible populations); *see also* 42 C.F.R. § 430.0 (describing purpose of the Medicaid program). The program is "jointly financed by the Federal and State governments and administered by States." *Id*. As a "grant-in-aid" program, Medicaid operates through the provision of federal funds (known as "FFP" or "Federal financial participation," 42 C.F.R. § 400.203) to the States in exchange for the States' agreement to spend those funds consistent with the requirements of the Medicaid Act. 42 U.S.C. § 1396b; *Alexander v. Choate*, 469 U.S. 287, 289 n.1 (1985) (explaining that states must agree to comply with federal Medicaid law to receive funds). The bulk of the funding for Medicaid comes from the federal government.[3] The Medicaid

[3] As relevant to this case, the federal government provides a 90 percent match for state expenditures attributable to the offering, arranging, and furnishing of family planning services and supplies. *Federal Match Rate Exceptions*, MACPAC, https://perma.cc/DH8A-LL84 (last visited Mar. 9, 2025). Medicaid does not cover abortion except in life-threatening

Act requires States to operate their programs consistent with "state plans" that comply with the requirements of the Act and are submitted for federal approval. 42 U.S.C. § 1396a; *Id.* § 1396-1.

Congress granted HHS the authority to administer the Medicaid program and to oversee the state plans. HHS runs the program through the Centers for Medicare & Medicaid Services (CMS). The Medicaid Act provides HHS a tool for enforcing State compliance with federal requirements. HHS may, after "reasonable notice and opportunity for hearing," withhold Federal financial assistance from States in two instances: (1) where the state plan "has been so changed" that it no longer complies with federal statutory conditions or (2) where the State, in administering the plan, fails "to comply substantially" with federal requirements. 42 U.S.C. § 1396c; *see also* 42 C.F.R. § 430.35; Jon Donenberg, Note, *Medicaid and Beneficiary Enforcement: Maintaining State Compliance with Federal Availability Requirements*, 117 Yale L.J. 1498, 1501 (2008) ("[T]he intended mechanism for keeping states accountable for their obligations under Medicaid is found in 42 U.S.C. § 1396c, which allows the Secretary of HHS, upon a sufficient finding of noncompliance, to withhold some or all of the federal government's grant payments.").

HHS's enforcement authority is therefore largely limited to "wield[ing] only the blunt and politically dangerous club of withholding federal funding." *See* Sasha Samberg-Champion, Note, *How to Read* Gonzaga*: Laying the Seeds of a Coherent Section 1983 Jurisprudence*, 103 Colum. L. Rev. 1838, 1858–59

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situations or in cases of rape or incest. Further Consolidated Appropriations Act of 2024, Pub. L. No. 118-47, 138 Stat. 703.

(2003). Notably, the tool is a financial penalty only. The Secretary "can withhold payment or he can negotiate with a State. He cannot compel compliance." *Arthur C. Logan Mem. Hosp. v. Toia*, 441 F. Supp. 26, 27 (S.D.N.Y. 1977); *see also* Katherine Moran Meeks, Case Note, *Private Enforcement of Spending Conditions After* Douglas, 161 U. Pa. L. Rev. Online 56, 59 (2012) ("CMS has only one tool to cudgel compliance . . . [i]f the agency determines that a state's management of its Medicaid program has failed 'to comply substantially' with federal conditions, it may cease making all or part of the payments" to the state's program. (quoting 42 C.F.R. § 430.35(a))); Samberg-Champion, *supra*, at 1858 ("Getting tough would be hazardous, because the agencies have no power to require a condition to be followed.").

Withholding some, or all, of a State's federal financial assistance is necessarily a drastic and cumbersome remedy. As an initial matter, CMS might not even be aware that a State is failing to comply with its statutory obligations. If and when CMS becomes aware that a State appears to be out of compliance with the Medicaid Act and is considering an enforcement action, CMS first asks the State for its position and attempts to secure voluntary compliance with the federal requirement or requirements at issue. 42 C.F.R. § 430.35(a) ("Hearings . . . are generally not called until a reasonable effort has been made to resolve the issues through conferences and discussions."). If the process of engaging the state does not resolve the compliance issue, CMS *may* in its discretion take the step of initiating a compliance action against a State that it believes to be out of "substantial" compliance.

If CMS chooses to take this step, CMS mails the State a notice of hearing or opportunity for hearing, 42 C.F.R. § 430.70, and must follow additional detailed hearing requirements governing the timing of the hearing, discovery, hearing procedures including the rules of evidence, briefing, and participation of impacted parties, among other requirements. 42 C.F.R. §§ 430.60–430.104. If the "presiding officer" is the CMS Administrator, he or she issues the hearing decision within 60 days after the expiration of the period for submission of posthearing briefs. 42 C.F.R. § 430.102(a). If the presiding officer is a designee of the Administrator, the presiding officer will certify "the entire record, including his or her recommended findings and proposed decision, to the Administrator." 42 C.F.R. § 430.102(b)(1). The parties may file "exceptions" to those recommended findings within 20 days, and the Administrator issues his or her own decision within 60 days of the proposed decision. 42 C.F.R. § 430.102(b)(2) & (3).

If CMS, after the hearing process, finds that the State is out of compliance with a provision of the Medicaid Act, CMS may then notify the State that "no further payments will be made to the State (or that payments will be made only for those portions or aspects of the program that are not affected by the noncompliance)" and that the "total or partial withholding will continue until the Administrator is satisfied that the State's plan and practice are, and will continue to be, in compliance with the Federal requirements." 42 U.S.C. § 1396c; 42 C.F.R. § 430.35(d)(1)(i)-(ii). A State that is dissatisfied with CMS's final determination may file a petition for judicial review with the U.S. Court of Appeals for the

circuit in which the State is located, and judicial review will occur. 42 C.F.R. § 430.38(a)-(b).

B. HHS Enforcement Cannot Adequately Remedy Violations of Individual Rights.

HHS's role in administering Medicaid is neither structurally designed to protect—nor functionally capable of protecting—the free-choice-of-provider right in the absence of private enforcement. Every aspect of the Department's administration of the Medicaid program—from the structure and design of the program to the annual budget—is premised on the understanding that its cooperative relationship with the States is insufficient to vindicate individual rights, and private parties will shoulder much of the enforcement burden.

1. Medicaid's structure of cooperative federalism creates practical and political constraints on HHS's ability to respond to violations of individual beneficiaries' statutory rights, and a "general reluctance" in agency officials to utilize existing cumbersome enforcement mechanisms. Brian J. Dunne, Comment, *Enforcement of the Medicaid Act Under 42 USC § 1983 after* Gonzaga University v. Doe: *The "Dispassionate Lens" Examined*, 74 U. Chi. L. Rev. 991, 994–95 (2007); *see also* Edward A. Tomlinson & Jerry L. Mashaw, *The Enforcement of Federal Standards in Grant-in-Aid Programs: Suggestions for Beneficiary Involvement*, 58 Va. L. Rev. 600, 619–20 (1972) (explaining that grant-in-aid programs are "meant to be cooperative efforts" and federal agencies are not "enforcement oriented").

HHS is understandably hesitant to commence enforcement proceedings, given that its only remedy is to withhold program funding. Withholding Federal financial assistance risks imposing further harm on Medicaid patients by weakening or suspending the State programs on which beneficiaries rely for their medical care and services. See *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 52 (1981) (White, J., dissenting) (characterizing withholding funds as "a drastic remedy with injurious consequences to the supposed beneficiaries" of spending clause programs). The limitation and severity of withholding Federal financial assistance from State programs account, in part, for the reality that "agency action following state noncompliance is a rarity." Samberg-Champion, *supra*, at 1859; *see also* Meeks, *supra*, at 59 (CMS's ability to withhold payments "is both exceedingly harsh and rarely, if ever, used . . . because withholding funds would inevitably harm the vulnerable populations . . . for whom Medicaid provides a critical safety net."). To *amici*'s knowledge, CMS has never fully withheld Federal financial assistance, and has only withheld partial amounts in a small number of instances.

In addition to supplying an inadequate remedy that in fact may imperil rather than benefit beneficiaries, exacting these harsh penalties on States risks harming other important program priorities, including fraud prevention.

2. From a budgetary perspective, HHS faces significant challenges in securing adequate administrative resources for effective oversight and enforcement. HHS's statutory mandate is enormous. HHS supervises 56 individual state and territorial Medicaid programs which in 2023 accounted for

nearly $900 billion in federal and state Medicaid expenditures. *See* Medicaid.gov, *Medicaid and CHIP Expenditures by Service Category*, https://tinyurl.com/mr3nce2w (last visited Mar. 9, 2025). As of October 2024, Medicaid covers more than 72 million people, over one-fifth of the United States population. *See* Medicaid.gov, *October 2024 Medicaid & CHIP Enrollment Data Highlights*, https://tinyurl.com/bdkjtj5 (last visited Mar. 9, 2025).

Under budgetary rules, Medicaid administrative expenses are classified as "discretionary" spending, which must be appropriated on an annual basis. *See* D. Andrew Austin, Cong. Rsch. Serv., R44641, Trends in Mandatory Spending: In Brief 2 (Updated 2018), https://perma.cc/G46V-A3VR ("Administrative costs of federal benefits programs are generally supported by discretionary funding, even if the benefits are paid out of mandatory funds."). During the budget process, CMS must compete for a limited pool of discretionary funds with the Centers for Disease Control and Prevention, the National Institutes of Health, the Food and Drug Administration, and other HHS components with compelling and often urgent priorities. This process renders the resources necessary for meaningful oversight of Medicaid vulnerable to political and budgetary fluctuations.

Funding constraints for oversight and enforcement are considerable. As overall federal Medicaid spending has doubled over the last ten years, from $304 billion in FY 2014 to $608 billion in FY 2024, the amount allocated to CMS for administrative oversight of that spending has failed to keep up the pace, rising just $30 million from $156 million in 2014 to $186 million in 2024. Compare Ctrs. for Medicare & Medicaid Servs., Financial Report: Fiscal Year 2014,

at 60 (2014), https://perma.cc/QDB7-7JKW, with Ctrs. for Medicare & Medicaid Servs., Financial Report: Fiscal Year 2024, at 37 (2024), https://perma.cc/Q9XM-Z8GV. The expansion of federal Medicaid spending without a comparable increase of funds to administer this sprawling program has exacerbated CMS's enforcement limitations.

Beyond budgetary constraints, CMS does not have the operational capacity to fill the void if the private enforcement mechanisms on which the agency has come to rely were stripped away. CMS has only a few hundred employees supervising Medicaid programs, *see* Meeks, *supra*, at 60. Out of necessity, then, most of CMS's Medicaid-focused employees are tasked with bookkeeping and management of Medicaid funds.

3. The other potential administrative remedies for violation of the right to free choice of provider are also insufficient. The Department of Justice gestures towards (Br. of United States 30) HHS's ability to reject proposed State plan amendments ("SPAs"). 42 U.S.C. § 1316; 42 C.F.R. § 430.18. A State must submit a SPA to CMS whenever there is a "material change" in "State law, organization, or policy, on in the State's operation of the Medicaid program." 42 C.F.R. § 430.12(c)(ii). While CMS has the authority to deny a SPA and has done so in the past when States have sought to remove certain providers from their Medicaid programs,[4] this remedy is unsuited to a

[4] For example, in 2012, CMS disapproved Indiana State Plan Amendment (SPA) 11-011, which proposed to limit the participation of providers that perform abortions or maintain or operate facilities where abortions are performed, for violating the

situation where, as here, the State has not submitted a request for amendment in the first place.

While an excluded provider may pursue state administrative appeals, as the Fourth Circuit observed,[5] beneficiaries lack even that limited path to relief. Pet. App. 32a. A Medicaid patient who has lost access to a preferred provider does not have any administrative right to challenge the loss of the provider; rather, the Medicaid Act provides that a State must permit her an appeal only when "a claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness." 42 U.S.C. § 1396a(a)(3). A patient who cannot obtain care from a provider unable to participate in the Medicaid program will never have a "claim" submitted, and Petitioner has never claimed that Ms. Edwards could invoke that administrative remedy here. This glaring omission is far from the kind of comprehensive enforcement scheme that this Court has held is incompatible with individual enforcement under Section 1983. *Cf. Blessing v. Freestone*, 520 U.S. 329, 346–48 (1997) (discussing cases in which this Court found remedial schemes sufficiently comprehensive to supplant Section 1983 enforcement).

4. In contrast to the limitations inherent in the structure, requirements, and practicalities of the Medicaid Act, private beneficiaries bringing Section 1983 actions can pursue injunctive relief, using an individualized scalpel far superior to the Secretary's

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free-choice-of-provider right. *See* The Disapproval of the Indiana State Plan Amendment, SPA 11-011 (June 20, 2012), https://perma.cc/AN48-WSTF.

[5] For the reasons stated by Respondents, that remedy is also unsuited to vindicating Medicaid patient rights. Resp'ts' Br. 45.

state-wide sledgehammer. *See Mitchum v. Foster*, 407 U.S. 225, 242 (1972) (holding that "Congress plainly authorized federal courts to issue injunctions in §1983 actions" to carry out Section 1983's purpose of "interpos[ing] the federal courts between the States and the people, as guardians of the people's federal rights").

Permitting individual enforcement of the free-choice-of-provider right under Section 1983 does not amount to "steal[][ing] the discretion that Congress vested in the Secretary" and giving it to the courts, as Petitioners argue, Pet'rs' Br. 42; rather, private enforcement complements the Secretary's authority by providing a means of ensuring State compliance with individual Medicaid patient rights that is far less draconian, and more protective of Medicaid beneficiaries, than the remedies directly available to the Secretary. This understanding has been the cornerstone of HHS policy throughout the history of the Medicaid Act and has been the prevailing view of those charged with administering the program.

II. Congress and HHS Have Long Relied on the Availability of Private Enforcement to Ensure that Patients, like Ms. Edwards, Can Vindicate Certain Rights.

Respondents ably recount much of the relevant history of the Medicaid Act generally and the free-choice-of-provider right specifically. Resp'ts' Br. 3-5. As former senior HHS officials, *amici* here explain that Congress and HHS have always understood the free-choice-of-provider right to be individually enforceable through Section 1983. This has been a

necessary and valuable complement to *amici*'s work administering and overseeing the Medicaid program.

1. In enacting the Medicaid Act in 1965 and adding the free-choice-of-provider provision two years later, Congress did not include an express provision authorizing private enforcement actions because it knew that the courts would "provide such remedies as are necessary to make effective the congressional purpose." Jane Perkins, *Pin the Tail on the Donkey: Beneficiary Enforcement of the Medicaid Act over Time*, 9 St. Louis Univ. J. Health L. & Pol'y 207, 208 (2016) (quoting *J.I. Case Co. v. Borak*, 377 U.S. 426, 433 (1964)).

This rights-remedy presumption was baked into the free-choice-of-provider right's individualized language guaranteeing 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). Because "long-standing court precedent" at the time "recogniz[ed] the right of individuals to claim protection of the law and the duty of courts to accord an appropriate remedy[,] . . . the enacting Congress would not have thought it necessary to insert provisions about private enforcement." Perkins, *supra*, at 212–13.

Accordingly, and for decades, § 1983 has provided a private cause of action for beneficiaries like Julie Edwards to vindicate violations of the free-choice-of-provider right, and private enforcement has served a distinct role in effectuating the program's policy objectives. Since the enactment of the Medicaid Act, HHS's legal authority to administer Medicaid and

Congress's ongoing legislative reforms and amendments thereto developed against–and came to rely upon–the background availability of private enforcement. *See* Michael A. Platt, *Westside Mothers and Medicaid: Will This Mean the End of Private Enforcement of Federal Funding Conditions Using Section 1983?*, 51 Am. U.L. Rev. 273 (2001) (observing that Medicaid beneficiaries have been bringing Section 1983 suits since the early 1980s); Dunne, *supra*, at 1001 (noting that "lower courts throughout the early-to-mid-1990s generally allowed both providers and recipients to bring § 1983 suits" and listing cases). There is no question, then, that HHS has historically relied on private enforcement as a central means of ensuring compliance with various Medicaid provisions, including the free-choice-of-provider right.

2. Congress has had numerous opportunities to halt the use of Section 1983 actions to enforce individual rights in the Medicaid Act. But instead, Congress doubled down on protections for Medicaid patients' right to choose their provider in the context of family planning services by ensuring that the right is respected even in the managed care context. 42 U.S.C. § 1396a(a)(23)(B); 42 C.F.R. § 431.51(b)(1); 42 C.F.R. pt. 438.

After this Court's holding in *Wilder* that another requirement for Medicaid state plans was privately enforceable under Section 1983, Congress could have restricted the use of Section 1983 in this context. But rather than doing so, Congress moved in the opposite direction, clarifying that inclusion of an individual right in a state plan requirement does *not* render that right privately unenforceable.

The "*Suter* fix," as it came to be known, followed directly from this Court's decision in *Suter v. Artist M*, 503 U.S. 347 (1992). Interpreting another part of the Social Security Act (which also encompasses Medicaid), this Court held that a provision of the Adoption Assistance and Child Welfare Act did not create a privately actionable right under Section 1983, reasoning that the provision was included in a list of mandatory elements for state plans. *Id*. at 362–63; *see also* Perkins, *supra*, at 220.

Congress responded definitively and decisively to this holding by enacting 42 U.S.C. § 1320a-2, which provides that "[i]n an action brought to enforce a provision of [the Social Security Act], 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 language of the *Suter* fix makes clear that Congress did not intend to disturb the status quo, which unquestionably recognized the availability of private enforceability through Section 1983 of certain enforceable rights.

Legislators conferring over the *Suter* fix explained specifically that "[t]he intent of this provision is to assure that individuals who have been injured by the 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 federal courts to the extent they were able to prior to the decision in *Suter v. Artist M*." Perkins, *supra*, at 221 (citing H.R. Rep. No. 103-761 at 926 (1994) (Conf. Rep.), as reprinted in 1994 U.S.C.C.A.N. 2901, 3257). And the House Ways and Means Committee noted that prior to *Suter*, "Social Security Act Program beneficiaries, parents, and advocacy groups" had brought numerous successful

lawsuits, which in turn "increased [state] compliance with the mandates of the Federal statutes." *Id.* (citing Report of the Comm. on Ways & Means, H. R. Doc., No. 102-631, at 364 (2d Sess. 1992)).

In other words, private enforcement of certain Medicaid rights like the free-choice-of-provider right is a feature, not a bug, of the scheme's design. "So long as state agencies are faced with a credible threat of being held accountable through the § 1983 mechanism, they are likely to be discouraged from moving forward with changes that contravene federal requirements." Donenberg, *supra*, at 1502–03.

3. Eliminating private enforcement for the free-choice-of-provider right would thus destabilize the balance Congress designed, leaving Medicaid patients like Ms. Edwards more vulnerable to violations of their statutory rights. Individual enforcement actions are a necessary and effective tool to ensure State compliance with the free-choice-of-provider provision.

Just as this Court determined in *Wilder*, "it would make little sense" to include a right framed in individual terms if that right were not individually enforceable. 496 U.S. at 514. If the only options for an individual beneficiary barred from using their preferred provider are to passively sit by while that provider pursues a state administrative appeal or to hope that the federal government takes the drastic step of withholding Medicaid funds from the State writ large (which itself does not guarantee compliance), that effectively "would render [the free-choice-of-provider provision] a dead letter." *Id.*

The Fourth Circuit properly found the lack of another sufficient remedy crucial to its holding that the free-choice-of-provider provision is privately actionable, reiterating that "the Act lack[s] a remedy

for 'individual Medicaid recipients . . . to contest the disqualification of their preferred provider.'" Pet. App. 11a; *see also id.* at 32a ("[B]eneficiaries lack the ability to challenge provider disqualifications, such as through a judicial or administrative right of action."). And when beneficiaries cannot obtain care from providers they trust, they are less likely to seek out necessary medical attention, which can ultimately worsen health outcomes. Private enforcement through Section 1983 of the free-choice-of-provider right is consistent with congressional intent and HHS's longstanding administrative practice. Without it, enforcement of one of the most important rights of this nation's most vulnerable individuals will be undermined.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted,

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