No. 23-1275

IN THE
Supreme Court of the United States

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

v.

PLANNED PARENTHOOD SOUTH ATLANTIC, ET AL.,
Respondents.

On Writs of Certiorari to the United States Courts of Appeals for the Fourth Circuit

BRIEF OF 7 SOUTH CAROLINA HEALTHCARE POLICY EXPERTS, ADVOCATES, AND PROVIDERS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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STATEMENT OF INTEREST[1]

Amici are South Carolina healthcare policy experts, advocates, and providers who share a commitment to ensuring that Medicaid recipients can receive timely, quality care from the providers they trust. *Amici* understand that access to healthcare providers is essential for Medicaid to fulfill its promise of equitable, comprehensive care. This brief unites providers who witness firsthand the harm caused by barriers to access, researchers who document the systemic consequences, and advocates who work to uphold policies that protect patient rights. Together, they demonstrate that maintaining provider access is not only a legal and policy imperative but a fundamental necessity for public health and equity.

The **Women's Rights and Empowerment Network (WREN)** is a nonpartisan, non-profit, gender justice advocacy organization dedicated to advancing the human rights and economic wellbeing of women and girls throughout South Carolina. WREN advocates for a society where everyone can thrive and make informed life choices through its legislative activities, public policy efforts, and amicus brief participation. WREN is committed to protecting women's right to access the provider of their choice for all of their medical care.

South Carolina Appleseed Legal Justice Center is a non-profit law office that fights on behalf of low-income South Carolinians for social, legal and

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

economic justice. For more than forty years, the program's attorneys have worked to ensure that quality and affordable healthcare is available for all individuals in our state. A strong, fully funded Medicaid program that allows for choice of services and providers has been a priority for our program. It provide this representation for Medicaid beneficiaries before the state agency, in the legislature and the courts.

Columbia NOW is the Columbia, SC chapter of the National Organization for Women (NOW), founded in 1966. Through advocacy, education, and coalition-building, Columbia NOW strives to dismantle systemic barriers to equality and create a more inclusive and just society for all women. Columbia NOW is part of the largest grassroots feminist organization in the United States, and it creates a community where women can come together to advocate for gender equality and women's rights. Columbia NOW joins this amicus brief because the ability of Medicaid enrollees in South Carolina to choose a willing and qualified provider is of critical importance to women across the Palmetto State and vital to improving health outcomes for the women who live here.

Deborah Billings, Ph.D., is a public health researcher who, for over a decade, has focused on understanding the impact of policies, programs, and practices that support and facilitate access to maternity care for low-income pregnant, birthing, and postpartum populations throughout South Carolina. She is an Adjunct Associate professor at the Arnold School of Public Health and Faculty Affiliate in Women's and Gender Studies, as well as the Institute for Families in Society, University of South Carolina, where she has studied the experience of pregnant women

covered by South Carolina's Medicaid program; Adjunct Associate Professor, Gillings School of Global Public Health, The University of North Carolina at Chapel Hill; and Senior Advisor to Group Care Global. She served as a Research Associate with Ipas for 15 years, documenting legislation's impact on the health and lives of women globally and collaborating with health systems. She regularly consults with agencies and organizations, including the World Health Organization, Pan American Health Organization, World Bank, and UN Trust Fund to End Violence against Women.

Jessica Tarleton, M.D., M.P.H., is a board-certified OB-GYN and Complex Family Planning specialist. She is licensed to practice medicine in South Carolina. Dr. Tarleton provides hospital-based emergency gynecologic, prenatal, labor, and delivery care at a regional medical center in Florence to patients from throughout the state, and she treats a disproportionate number of underserved patients, high-risk patients, and patients experiencing emergencies. Dr. Tarleton is the current Vice-Chair of the South Carolina Section of the American College of Obstetricians and Gynecologists (ACOG) and has focused her career on women's health, including devoting research and services to underserved populations and to the high rate of maternal mortality in the United States.

Dr. Dawn Bingham, M.D., is a board-certified obstetrician-gynecologist, Fellow of The American College of Obstetricians and Gynecologists (FACOG), and a prominent advocate for women's health in South Carolina. With over two decades of clinical experience, Dr. Bingham specializes in maternal health and has been a vocal proponent of improving women's

access to healthcare. She serves on various boards and committees dedicated to public health and equity, including her role as a leader in the South Carolina chapter of ACOG. Dr. Bingham's advocacy extends beyond her clinical practice as she works to shape policy that promotes health equity.

Palmetto State Abortion Fund (PSAF) is dedicated to ensuring women have access to healthcare. It recognizes the critical role Medicaid plays in the health and well-being of South Carolinians, and its vital tool in the effort to advance equity in healthcare access across the state. Restricting Medicaid patients' ability to choose their providers for routine check-ups and preventive care does the opposite—it deepens existing barriers and exacerbates the already limited accessibility of healthcare in South Carolina.

Amici submit this brief to share their perspective on the question presented, which is based on their on-the-ground experience caring for and advocating on behalf of South Carolina's Medicaid enrollees. *Amici* urge the Court to affirm the judgment of the Fourth Circuit.

SUMMARY OF ARGUMENT

Medicaid operates, in effect, as a nationwide system of public health insurance for those who cannot afford medical care on their own. Congress enacted Medicaid in 1965 to incentivize states to extend health coverage to their most vulnerable citizens: "The Federal Government shares the costs of Medicaid with States that elect to participate," but in exchange, states are required "to comply with requirements imposed by the Act and by the Secretary of Health and Human Services." *Atkins* v. *Rivera*, 477 U.S. 154, 156-157 (1986).

One such binding requirement is the free-choice-of-provider provision, which guarantees patients the right to receive needed services from any "qualified" provider willing to offer such services. 42 U.S.C. § 1396a(a)(23). South Carolina defied that requirement when it terminated a willing and qualified healthcare provider from its Medicaid network as retribution for services that PPSAT offers outside of South Carolina's Medicaid program.[2]

South Carolinians who seek medical care through Medicaid faced a severe shortage of qualified doctors willing and able to provide that care to them, even before South Carolina cut off their right to access care through PPSAT's clinics in Charleston and Columbia. For South Carolinians enrolled in Medicaid and in need of screenings for breast or cervical cancer, diabetes, hypertension, and depression, or prenatal or postpartum services, or in need of vaccinations, screening and testing for sexually transmitted infections or HIV, among other care and services, PPSAT's clinics are a

[2] There is no dispute as to South Carolina's motivation for prohibiting Medicaid enrollees from obtaining care covered by South Carolina's Medicaid program from PPSAT. Some South Carolina elected officials are politically opposed to the abortion care that PPSAT offers *outside of Medicaid* to South Carolinians who are legally entitled to receive that care under South Carolina law and that it offers *outside of South Carolina* consistent with the laws of other states in which PPSAT operates. *See, e.g.,* Tim Smith, *Gov. Henry McMaster Says He Would Reject $34 Million in Federal Aid to Stop Abortion*, Greenville News, May 29, 2018, https://www.greenvilleonline.com/story/news/local/south-carolina/2018/05/29/gov-henrymcmaster-says-he-would-reject-federal-aid-stop-abortion/651245002/.

crucial provider option for high-quality care.[3] *Amici* submit this brief to provide the Court with the perspective of how challenging it is in South Carolina to find willing and qualified providers for Medicaid services, as well as to emphasize the real-life consequences that would flow from this Court holding that states can exclude willing and qualified providers from Medicaid networks for political reasons. Medicaid enrollees should be able to seek care from willing and qualified providers of their choice.

Understanding these real-world consequences starts with understanding the broader health and healthcare landscape in South Carolina. At baseline, South Carolinians are in the bottom quintile across a range of measures of infant, child, and adult health and health outcomes.[4] Because South Carolina has restricted its Medicaid plan to only the most vulnerable categories of its population, the residents who are eligible for full Medicaid coverage in South Carolina are sicker and poorer than the general low-income population, with a correspondingly greater need for

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[3] Planned Parenthood, *Columbia Health Center of Columbia, SC*, https://perma.cc/XTU4-7ENT.

[4] *See, e.g.,* Lauren Lennon, *South Carolina's Healthcare Crisis: Life Expectancy, Infant Mortality, Mental Health*, ABC4 News South Carolina, Mar. 1, 2024, https://abcnews4.com/news/local/south-carolinas-healthcare-crisis-life-expectancy-infant-mortality-mental-health-news-musc-abc-wciv-news-4-2024; Scott Morgan, *South Carolina (Again) Ranks Among The Worst States For Child Well-Being*, Children's Trust of South Carolina, June 10, 2024, https://perma.cc/QA7Z-FFQX.

access to medical services—yet the state spends *less* per Medicaid enrollee than the national average.[5]

The shortage of medical providers in South Carolina generally—especially primary care and women's health providers—is stark. An alarming 41 of the states' 46 counties are Health Professional Shortage Areas (HPSA)—areas federally designated as having too few primary care providers given anticipated needs per capita—and Medicaid participants are disproportionately likely to live in medically underserved areas. On top of that, Medicaid's notoriously low reimbursement rates and administrative headaches discourage the scarce available providers from participating.[6]

In this context, PPSAT is an essential provider of high-quality preventative services and family planning in the State. Thousands of Medicaid enrollees across the State have relied on PPSAT over the course of many years for critical care and services. PPSAT

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[5] Kaiser Family Found. (KFF), *Medicaid Spending per Enrollee (Full or Partial Benefit) by Enrollment Group* (2021) ("SC Medicaid Spending"), https://perma.cc/9KFS-FKQN.

[6] *See, e.g.,* Stephen Zuckerman et al., *Medicaid Physician Fees Remained Substantially Below Fees Paid By Medicare In 2019*, 40 HEALTH AFF. 2 (2021) (explaining that "private insurance physician fees greatly exceed those in Medicare, whereas Medicaid physician fees have historically been far below those in Medicare" "limit[ing] physician participation in" Medicaid); National Bureau of Economic Research, *Administrative Burdens Lead Some Doctors to Avoid Medicaid Patients*, Dec. 1, 2021, https://perma.cc/NKB8-RWAM ("Low reimbursement rates are not the only reason many providers decline to accept Medicaid," but also that "physicians are substantially less likely to be paid by Medicaid" "los[ing] 17 percent of Medicaid reimbursements to billing problems.").

delivers its high-quality care in clinics designed to lower access barriers faced by vulnerable patient populations, and it fills pressing gaps in South Carolina's primary care provider network. Denying Medicaid enrollees the right to access care by this willing and medically qualified provider will force vulnerable patients to bear the cost of the State's political disagreement with care lawfully provided by PPSAT outside of South Carlina's Medicaid program.

Finally, the harms to Medicaid enrollees risk stretching far beyond the loss of PPSAT. The State seeks the power to remove Medicaid providers for reasons wholly unrelated to their medical competency; granting that power would leave patients unprotected, should their trusted provider or needed medical services fall into political disfavor next. To make matters worse, the risk of state targeting adds a further disincentive to provider participation in Medicaid, thus deepening enrollees' struggles to find qualified and willing providers to access needed medical care.

ARGUMENT

I. MEDICAID PATIENTS IN SOUTH CAROLINA ALREADY STRUGGLE TO ACCESS NEEDED CARE.

A. South Carolinians have poor health outcomes across their lifetimes.

South Carolina faces a persistent public health crisis. The state ranks 43rd on its overall health outcomes, solidly in the bottom quintile of the nation.[7]

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[7] America's Health Rankings, *2024 Annual Report: State Summaries* (2024) (AHR General), https://perma.cc/3A3T-MPFF.

Six in ten South Carolinian adults suffer from a chronic disease, and four in ten suffer from multiple chronic diseases,[8] one of the highest rates in the country.[9] These are not simply on-paper diagnoses—South Carolinians report some of the highest rates of frequent physical distress in the country, highlighting how these conditions take a real toll on daily life.[10] The State also has one of the highest rates of premature mortality—26% higher than the national average.[11] And within each of these measures, South Carolinians of color fare worse, with higher rates of chronic conditions[12] and higher rates of premature mortality.[13]

These health deficits reproduce across generations, creating a cycle of poor health outcomes. The State has one of the highest rates of low birth weight infants, a key indicator both reflecting poor maternal health during pregnancy and predicting poorer future health for the child.[14] Here too, women and children of color bear the largest burden, as South Carolina has one of the largest racial disparities in low birth weight

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[8] South Carolina Department of Public Health, *Disparities in Health Outcomes Data: Chronic Diseases*, https://perma.cc/4LH4-JRYL.

[9] AHR General, *supra* note 7.

[10] *Id.*

[11] *Id.*

[12] South Carolina Department of Public Health, *supra* note 8.

[13] AHR General, *supra* note 7.

[14] America's Health Rankings, *2024 Health of Women and Children Report: State Summaries* (2024) (AHR Women), https://perma.cc/5F5V-XJVS.

infants, falling 45th out of the states.[15] Further, the state has some of the highest rates of maternal, infant, and neonatal mortality in the country, ranking 38th, 41st, and 45th, respectively.[16]

B. South Carolina restricts Medicaid eligibility to its most vulnerable residents.

In the Affordable Care Act, Congress extended a new invitation to states: expand Medicaid coverage to *all* low-income Americans, up to 138% of the Federal Poverty Line (FPL), and the federal government will cover 90% of the new enrollee cost.[17] In the states that accepted this invitation, Medicaid is now a universal safety net program for low-income residents, rather than a targeted intervention for only the most severely vulnerable.

South Carolina is one of ten states that declined to expand its Medicaid program.[18] As a result, in non-expansion states like South Carolina, full Medicaid coverage remains available only to especially vulnerable categories of low-income residents—resulting in Medicaid participants that are poorer and sicker as a result.[19] Some low-income South Carolinians are eligible due to special health vulnerabilities, like elderly and disabled South Carolinians who depend on

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[15] *Id.*

[16] *Id.*

[17] Robin Rudowitz et al., *Medicaid 101*, KFF, May 28, 2024, at 5, https://perma.cc/Q693-3C5L.

[18] KFF, *Status of State Medicaid Expansion Decisions*, Feb. 12, 2025, https://bit.ly/3X67BR0.

[19] Madeline Guth et al., *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*, KFF, Mar. 2020, at 16, https://perma.cc/6L8D-W6VQ.

Medicaid's coverage of their needed long-term services and supports, ranging from in-home assistance to nursing facility care. This care, and these categories of participants, are also the most expensive: while only a fifth of South Carolina's Medicaid population, they account for more than half of its Medicaid expenditures.[20] The handful of other South Carolinians eligible for full Medicaid have particular social vulnerabilities: children, pregnant women and their infants,[21] and parents living below two-thirds of the poverty line.[22] Outside of these categories, most low-income South Carolinians qualify solely for a limited Family Planning benefit to cover certain preventative screenings, but not full Medicaid coverage for all their chronic and acute healthcare needs.[23]

Despite the high needs of South Carolina's Medicaid enrollee pool—the direct consequence of its stringent eligibility criteria—the State falls to the bottom of states by Medicaid spending per full coverage enrollee: 47th and 42nd on spending per elderly and disabled enrollee, respectively.[24] Indeed, such low state

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[20] KFF, *Medicaid in South Carolina*, Aug. 2024, at 2 ("SC Medicaid Factsheet"), https://perma.cc/AB5Q-H9RK.

[21] In *amici*'s experience, most pregnant women who qualify for Medicaid were ineligible *before* their pregnancy and had difficulty accessing care, resulting in more medical complications both pre- and post-partum.

[22] *Id.*; Healthy Connections Medicaid, *Program Eligibility and Income Limits*, https://perma.cc/2LJ5-GWU7. As of the latest income eligibility update on March 1, 2025, a mother with two children must make less than $16,523 annually to qualify for full Medicaid.

[23] *Id*.

[24] SC Medicaid Spending, *supra* note 5.

spending levels reflect both sparse benefits coverage and limited accessibility of Medicaid providers, rather than enrollee medical need.[25]

C. The State faces a pressing shortage of medically qualified and willing providers to care for these needy patients.

Even without expansion, Medicaid covers one in five South Carolinians—and almost half of all births—creating an immense need for services from providers willing to participate in the program.[26] Yet South Carolina already faces shortages of medical providers, with a physician-to-patient ratio 23% worse than the national average.[27] Narrow the scope to primary care physicians, and the shortage grows even more dire. South Carolina falls into the bottom quartile of states, ranking 38th in active primary care physicians per capita.[28] And these scarce physicians are not distributed evenly across the state, but are concentrated in select areas—with the result that 41 of the state's 46 counties qualify as Primary Care Health Professional Shortage Areas (HPSA) under federal regulations,[29]

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[25] Rhiannon Euhus and Priya Chidambaram, *A Look at Variation in Medicaid Spending Per Enrollee by Group and Across States*, KFF, Aug. 16, 2024, https://www.kff.org/medicaid/issue-brief/a-look-at-variation-in-medicaid-spending-per-enrollee-by-group-and-across-states/.

[26] SC Medicaid Factsheet, *supra* note 20, at 1-2.

[27] Cicero Institute, *South Carolina Physician Shortage Facts*, Jan. 2024, https://perma.cc/RKT6-MMQL.

[28] *Id.*

[29] Rural Health Information Hub, *Health Professional Shortage Areas: Primary Care, by County, October 2024 - South Carolina*, https://perma.cc/H63X-SF7S.

signaling that there are too few primary care providers to meet the basic health needs of those places. Indeed, every rural South Carolina county faces such a shortage.[30]

The shortage of women's healthcare providers is similarly dire.[31] Fourteen counties lack even a *single* practicing OB-GYN physician; five other counties have just one.[32] And Medicaid participants are disproportionately likely to live in these medically underserved areas, meaning that physician shortages disproportionately reduce their access to care.[33]

Then, Medicaid itself compounds the shortage: Its notoriously low reimbursement rates, combined with the administrative difficulty of securing reimbursement for care delivered, leaves many providers in the red on any care provided to a Medicaid enrollee.[34] Because physicians are ineligible for the supplemental payments that offset these losses for hospitals, Medicaid's payment structure acts as a profound

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[30] *Id.*

[31] AHR Women, *supra* note 14.

[32] Brandon Lockett, *Graphic: South Carolina's Shortage of OB-GYNs*, The Post and Courier, Aug. 21, 2022, https://www.postandcourier.com/graphic-south-carolinas-shortage-of-ob-gyns/html_5395306c-0d06-11ed-891d-8f2d1db6d0e9.html.

[33] Georgetown University McCourt School of Public Policy, *Medicaid Coverage in Metro and Small Town/Rural Counties, 2023*, https://ccf.georgetown.edu/2025/01/14/medicaid-coverage-in-metro-and-small-town-rural-counties-2023/.

[34] *See* Zuckerman, et al., *supra* note 6; National Bureau of Economic Research, *supra* note 6; American Hospital Association, *Underpayment by Medicare and Medicaid Fact Sheet*, Feb. 2022, https://perma.cc/T84E-D3BH.

disincentive to physician participation in the program.[35] As a result, in *amici*'s experience, even the South Carolinians who do qualify for Medicaid often struggle to find medically qualified and willing providers who accept their coverage.

The data bear this experience out. Take the elderly and disabled participants who depend on Medicaid for their long-term service and support needs: A recent national survey ranked South Carolina *second to last* among the states for accessibility and affordability of these services.[36]

II. IF THE STATE CAN REMOVE COMPETENT, WILLING MEDICAID PROVIDERS FOR PURELY POLITICAL REASONS, SOUTH CAROLINIANS IN NEED OF MEDICAL CARE WILL PAY THE PRICE.

A. PPSAT is a medically qualified provider that patients trust for crucial medical care covered by South Carolina's Medicaid program.

PPSAT is an essential safety net in this status quo: sick patient populations, immense need for Medicaid services, yet a scarcity of providers to meet the demand. PPSAT fills the gaps where South Carolina's providers are scarcest—women's health and

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[35] Cindy Mann and Adam Striar, *How Differences in Medicaid, Medicare, and Commercial Health Insurance Payment Rates Impact Access, Health Equity, and Cost*, Commonwealth Fund, Aug. 17, 2022, https://www.commonwealthfund.org/blog/2022/how-differences-medicaid-medicare-and-commercial-health-insurance-payment-rates-impact.

[36] AARP Foundation, *Long-Term Services and Supports State Scorecard 2023 Edition,* at 162, https://perma.cc/JTK3-C5QY.

preventative care—lessening the burden on other parts of the state's healthcare system. And its two clinics work in medically underserved areas of South Carolina[37] to offer patients a range of high-quality preventative services—breast and cervical cancer screenings; screenings for host of other illnesses, including diabetes, anemia, cholesterol, thyroid disorders, high blood pressure, and depression; prenatal and postpartum services; mental healthcare; wellness exams; and family planning and contraceptive services.[38]

In *amici*'s experience, South Carolina Medicaid enrollees choose PPSAT for their medical care precisely because its clinics are customized to their unique needs. By offering extended hours and flexible scheduling options, including options for walk-in care and same-day scheduling, PPSAT makes it easier for patients with less schedule flexibility to find a workable appointment time.[39] Indeed, this flexible scheduling approach is why Planned Parenthood clinics across the country offer appointments 2.5x more quickly on average than other publicly funded family planning clinics.[40] PPSAT clinics also offer on-sight interpreting services, removing the language barrier to care for

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[37] *See* J.A. 2; BIO at 3.

[38] Planned Parenthood, *supra* note 3.

[39] *See* J.A. 13; Elizabeth M. Allen et al., *Barriers to Care and Healthcare Utilization Among the Publicly Insured*, 55 Med. Care 207 (2017), https://doi.org/10.1097/MLR.0000000000000644.

[40] Mia R. Zolna and Jennifer J. Frost, *Publicly Funded Family Planning Clinics in 2015: Patterns and Trends in Service Delivery Practices and Protocols*, Guttmacher Institute, https://perma.cc/8GBU-B5VP.

residents with lower English proficiency.[41] Here too, PPSAT fills an essential role in ensuring access to healthcare for populations that would otherwise struggle to find accessible services. Indeed, these features are why Planned Parenthood clinics throughout the country can reach patients otherwise disconnected from the healthcare system—with more than 60% of their patients lacking a regular source of care.[42]

South Carolina Medicaid enrollees already struggle to find similarly accessible high-quality care from other providers—as the period before the district court's injunction, when PPSAT was forced to stop seeing Medicaid patients, made abundantly clear. During this time, there was a scramble to try to find other Medicaid providers who would accept new Medicaid patients and offer the same range of services. None were found who were willing to do so without a long lag time prior to the appointment—leaving hundreds of Medicaid patients in the lurch, with no access to timely care.

The State tries to dispute these real-world consequences by pointing to a map of 140 other health centers available throughout the entire state. State Br. 9. But if anything, this underscore the current scarcity of available Medicaid providers—with more than 750,000 adults enrolled in South Carolina Medicaid,[43]

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[41] *See* J.A. 13; Allen et al., *supra* note 39.

[42] Anna Newton-Levinson et al., *Influences on Women's Care Seeking at Planned Parenthood Health Centers in Two Southern States*, 31 Women's Health Issues 485, 485 (2021).

[43] Medicaid and CHIP Payment and Access Commission (MACPAC), *Medicaid Full-Year Equivalent Enrollment by State and Eligibility Group, FY 2022 (Thousands)*, Dec. 2024, https://perma.cc/WSZ2-NQ4N.

the resulting Medicaid-clinic-to-patient ratio is 1 to 5,357. And the State offers nothing to counter *amici*'s experience, which shows that this already-stretched provider network is not able handle the hundreds of Medicaid patients who receive care at PPSAT annually, nor that providers would offer the type of timely, accessible care that enrollees receive at PPSAT.

And Congress enacted the free-choice-of-provider provision to protect Medicaid patients' right to choose exactly this kind of care: not just competent, but designed to meet their particular needs. In the decision below, the Fourth Circuit rightly recognized that "[t]he ability to decide who treats us at our most vulnerable is a right that should not be lightly disregarded;" the free-choice-of-provider provision reflects "Congress's obvious and express desire to confer" that right to Medicaid patients. Pet. App. 33a. Although states have flexibility in Medicaid program design, Congress gave *patients* the right to choose any provider "qualified to perform the service" "required." 42 U.S.C. § 1396a(a)(23)(A). Congress shielded this "mo[st] personal," "mo[st] precious" choice from governmental interference. Pet. App. 33a.

For many South Carolina Medicaid enrollees in search of elusive preventative and primary care from providers willing to accept Medicaid patients, the ability to receive timely and quality care is of crucial importance. South Carolina's political disagreement with PPSAT's provision of *legal* abortion services *outside* the Medicaid context does not matter to a South Carolinian who needs timely breast cancer screening, on a date she has transportation, in a location she can get to. Further underscoring that South Carolina's decision here was motivated by politics—not medical

qualifications—without any consideration of the impact on Medicaid enrollees' ability to find willing, qualified providers, Governor McMaster bragged that his motive was to be "a threat" to PPSAT "until they are gone" entirely.[44] Indeed, even in its brief to this Court, the State confirms that it has conditioned participation in Medicaid on PPSAT agreeing to "stop" providing lawful medical care—without regard to the impact on South Carolinians' ability to access a willing and qualified Medicaid provider for Medicaid-covered services. State Br. 7.

Tellingly, throughout this crusade, the State has never contested PPSAT's *medical* competence as a healthcare provider, nor contended that its clinics are unfit to perform any of the cancer screenings, chronic care screenings, wellness exams, or family planning they provide.[45] South Carolina may not deny Medicaid patients their right to choose PPSAT's high-quality, compassionate care for such covered services on any other ground.

B. The ripple effects of ruling for the State would harm Medicaid patients even more.

The immediate consequence of accepting South Carolina's position would be a sharp decrease in access to preventative care and family planning for the state's Medicaid patients. Diminishing an already scarce resource necessarily leads to greater difficulty in obtaining it. Here, removing a medically qualified and

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[44] Smith, *supra* note 2.

[45] *See* Pet. App. 33a ("There has never been any question during the long path of this litigation that Planned Parenthood is professionally qualified to provide the care" covered by Medicaid and "[t]he State has not contested this.").

willing Medicaid primary care provider in a state with shortages of exactly such providers raises significant new barriers to patients accessing care.[46]

And if the Court permits states to fight political battles via Medicaid provider networks, the harms to patients will compound. South Carolina asks for free license to remove medically qualified, willing providers from its Medicaid network solely because they provide—among many other services—certain politically disfavored *but legal* medical services. Permitting such provider targeting would "open a significant loophole for restricting patient choice, contradicting the broad access to medical care that" the free-choice-of-provider provision, § 1396a(a)(23), "is meant to preserve." *Planned Parenthood of Indiana, Inc.* v. *Comm'r of Indiana State Dep't of Health*, 699 F.3d 962, 978 (7th Cir. 2012).

The harms to patients of accepting South Carolina's position stretch still further. The risk of political targeting imposes a further disincentive to provider participation in the Medicaid program. Providers' participation calculus would have to account for a new risk: Do anything to curry the State's disfavor, and face public targeting for Medicaid removal. Critically, nothing in the State's position offers a limiting principle for this targeting power—so states could target providers for reasons wholly unrelated to their ability to provide competent, safe, and legal medical services,

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[46] *Accord* Br. of the American Academy of Family Physicians et al. as Amicus Curiae Supporting Plaintiff-Appellees at 18, *PPSAT* v. *Kerr*, 95 F.4th 152 (4th Cir. 2024) (No. 21-1043) (explaining that "[o]ther South Carolina health centers cannot fill the void in family planning care if PPSAT loses its status as a qualified Medicaid provider.")

or for no reason at all. So while today it is PPSAT that South Carolina views unfavorably, there is no way to predict what provider or what legal care might be in the crosshairs next, in South Carolina or any other state. For some providers, the inescapable nature of this risk, uncompensated by Medicaid's rock-bottom reimbursement rates, may tip the scales against accepting Medicaid in the first place. Any such chilling effect on provider participation will increase pressures on already-scarce Medicaid providers, further reducing patient access.

Indeed, Medicaid's low reimbursement rates heighten the irony of South Carolina's position. The State claims "money is fungible," and so reimbursing PPSAT for Medicaid-eligible services must be a "subsidy of abortion" care that its clinics provide outside of Medicaid. Pet. App. 157a–158a. Yet the reality of Medicaid's below-market reimbursements is that they do not even cover the costs of the cancer screenings, wellness exams, chronic illness screenings, and family planning services that PPSAT, a non-profit, does provide.[47] There is simply no surplus that could possibly subsidize the *legal* abortion care offered outside of Medicaid. The State seeks instead a symbolic but pyrrhic victory: sure to harm Medicaid patients, while *also* not realizing the States' purported interest. Indeed, if South Carolina can go forward to punish PPSAT, it is South Carolina's most vulnerable residents that will pay the steepest price.

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[47] *See* J.A. 45-46.

CONCLUSION

For the foregoing reasons, the judgments below should be affirmed.

Respectfully submitted,

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