Supreme Court's Medina decision limits options for Medicaid enforcement actions

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The Supreme Court's June 2025 decision in *Medina v. Planned Parenthood South Atlantic* (https://bit.ly/45gAHl2) significantly narrows when plaintiffs can sue states for alleged violations of the Medicaid Act. The ruling directly impacts Medicaid providers and enrollees who have traditionally relied on civil rights litigation under 42 U.S.C. Section 1983 ("Section 1983," https://bit.ly/3lHZmpW) to obtain relief from states that contravened the Medicaid Act's requirements.

In *Medina*, the Court made clear that only "atypical" statutes that clearly contain explicit "rights-creating language" confer a "private right of action" to litigate under Section 1983. The Court held that the statutory provision at issue — the Medicaid Act's "any qualified provider" provision — did not meet this high bar.

Without a private right of action, the plaintiffs in *Medina* had no case against South Carolina for excluding Planned Parenthood as a provider in the state's Medicaid program. While *Medina* is consistent with the Supreme Court's most recent decisions that have narrowed private enforcement rights under Section 1983, it represents a departure from the earliest Supreme Court precedent finding private rights of action.

Following *Medina*, Medicaid providers and enrollees will have few practical options for challenging state decisions about Medicaid funding and benefits. *Medina* is especially relevant to reproductive health services providers, and individuals seeking reproductive health care. Medicaid is the largest single payer of reproductive and maternal health services in the United States. According to the Center for Medicare & Medicaid Services, it covers nearly 41% of all births nationwide (https://bit.ly/44UXqBP), and the National Partnership for Women & Families states nearly 24 million women (https://bit.ly/3lEJ15s) receive health insurance through the program. Post *Medina*, states may pursue policies to limit Medicaid spending on reproductive health care services.

The court's opinion

In a 6-3 decision, the majority in *Medina* held that the Medicaid Act's any qualified provider provision does not confer a private right of action under Section 1983. The any qualified provider provision (https://bit.ly/4f3i07S) states that a state's Medicaid program 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 ... who undertakes to provide him such services." 42 U.S.C. § 1902(a)(23).

Justice Neil Gorsuch, writing for the majority, reasoned that the language in the any qualified provider provision could not establish a private right of action because it does not "clearly and unambiguously" use "rights-creating terms." 606 U. S. at 19 (2025).

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To illustrate this, the Court explained that the any qualified provider provision "looks nothing like" other provisions of the Medicaid Act that do create a private right of action. *Id.* at 4. The Court pointed to the Federal Nursing Home Reform Amendments Act ("FNHRA"), which is part of the Medicaid Act, that was at issue in its 2023 decision in *Health and Hospital Corporation of Marion County v. Talevski*.

In *Talevski*, the Court explained that although spending clause legislation like the Medicaid Act does not create enforceable rights "as a matter of course," the FNHRA met the "demanding bar" because of its use of the word "right" throughout. *Id.* at 13. To the contrary, the word "right" is not present in the any qualified provider provision.

According to the Court, absent such language, states have no notice that agreeing to participate in a spending clause program — like the ones the Medicaid Act creates — establishes potential liability for states.

Justice Ketanji Brown Jackson, writing for the dissent, noted that the Court's prior cases emphasized that no "magic words" were needed to create a private right of action. *Id.* at 16 (Jackson, J., dissenting). Justice Jackson further argued that if "actual notice were the touchstone, this would be an easy case" since prior precedent had construed the any qualified provider provision as establishing a private right of action. *Id.*

The future of enforcing the Medicaid Act

Although *Medina* specifically concerned the any qualified provider provision of the Medicaid Act, its reach likely will be far wider. That is because the any qualified provider provision, like most other requirements in the Medicaid Act, is written as a directive to states, not like the unique rights-conferring text in *Talevski*. As such, it will be difficult for plaintiffs to meet the high bar for demonstrating "rights-creating terms" the Court solidified in *Medina*.

Without Section 1983 litigation to enforce the Medicaid Act, there are few alternatives. The majority in *Medina* assumed that the federal government would hold states accountable under spending clause legislation like the Medicaid Act. That is, the federal government would apply the "typical remedy" of terminating federal funds to the state when a state violated the federal law. However, in practice, the federal government rarely does so. At oral argument in *Medina* (https://bit.ly/46nF8M4), no party could cite an example of the federal government withholding Medicaid funding.

Access to reproductive health services in Medicaid following *Medina*

The immediate implication of the Court's ruling is reversal of a 4th U.S. Circuit Court of Appeals decision that blocked the state of South Carolina from excluding Planned Parenthood from its Medicaid program. Following *Medina*, states now have greater discretion to exclude providers from their Medicaid programs, even if those providers meet federal qualifications.

If other states follow South Carolina in excluding providers of reproductive health services, the result may be a patchwork of state policies that limit access to care. Reproductive health and abortion providers are often the primary or sole source of preventive reproductive health services in underserved areas. Exclusion from Medicaid funding can lead to clinic closures or service reductions, especially in rural or medically underserved communities.

Medina's impact is amplified by other legislative changes. The One Big Beautiful Bill Act ("OBBBA," https://bit.ly/3lAyaJT), signed into law on July 4, prohibits federal Medicaid payments to certain nonprofit organizations that provide reproductive health services, including abortions (outside of the Hyde Rule (https://bit.ly/4f5SGyb), which prevents federal Medicaid dollars from paying for abortions unless the pregnancy is the result of rape or incest, or the abortion is "necessary to save the life of the woman").

The OBBBA prohibition extends to not only organizations that provide abortions but also their affiliates, subsidiaries, successors, and clinics. As a result, states that continue to contract with these entities risk losing federal Medicaid matching funds for services provided by these providers. Many providers that offer abortion care often also offer a wide range of other healthcare services (https://bit.ly/4maRw6F), including contraception, STI testing, cancer screening, and prenatal care. In rural areas with few providers, exclusion of providers that offer abortion care could lead to reduced service availability.

It remains to be seen what states, if any, exercise the discretion *Medina* appears to afford them in excluding providers from their Medicaid programs. While unlikely, it also remains to be seen whether the federal government will step in to prevent states from eliminating providers that otherwise meet federal qualifications from state Medicaid programs.

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