No. 03-10777

In the Supreme Court of the United States

HEIDI SENGER, PERSONAL REPRESENTATIVE OF THE ESTATE OF ALTHEA M. KEUP, PETITIONER

v.

WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE WISCONSIN SUPREME COURT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

PAUL D. CLEMENT
Acting Solicitor General
Counsel of Record

PETER D. KEISLER
Assistant Attorney General

EDWIN S. KNEEDLER
Deputy Solicitor General

PATRICIA A. MILLETT
Assistant to the Solicitor General

SCOTT R. MCINTOSH
TARA LEIGH GROVE
Attorneys

Department of Justice
Washington, D.C. 20530-0001
(202) 514–2217

ALEX M. AZAR II
General Counsel

ROBERT P. JAYE
Acting Associate General Counsel

MARK D. POLSTON
Acting Deputy Associate General Counsel for Litigation

H. ANTONY LIM
Attorney
U.S. Department of Health and Human Services
Washington, D.C. 20201

QUESTION PRESENTED

Whether provisions of the federal Medicaid law, 42 U.S.C. 1396 *et seq.*, which require participating nursing care facilities to accept Medicaid reimbursement as payment in full for any medical services provided to Medicaid beneficiaries, create individual rights that beneficiaries may enforce in an action brought under 42 U.S.C. 1983.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases:

Cases—Continued: Page

Constitution, statutes, regulations and rule:

Miscellaneous—Continued: Page

In the Supreme Court of the United States

No. 03-10777

HEIDI SENGER, PERSONAL REPRESENTATIVE OF THE ESTATE OF ALTHEA M. KEUP, PETITIONER

v.

WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE WISCONSIN SUPREME COURT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

INTRODUCTION

This brief is submitted in response to the order of this Court inviting the Acting Solicitor General to express the views of the United States. In the view of the United States, although the analysis reflected in the decision below is flawed, the decision reaches the correct result and does not merit plenary review by this Court.

STATEMENT

1. The federal Medicaid program, 42 U.S.C. 1396 *et seq.*, is a cooperative federal-state program under which the federal government provides funding to state programs that provide medical assistance to individuals "whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. 1396. States that choose to participate in the Medicaid program must submit a plan for medical assistance that conforms to the requirements of the

Medicaid Act. See 42 U.S.C. 1396a (2000 & Supp. I 2002); 42 C.F.R. 430.10. Among other requirements, the state program must make medical assistance available on a uniform basis to similarly situated individuals. See 42 U.S.C. 1396a(a)(10)(B) ("[T]he medical assistance made available to any individual * * * shall not be less in amount, duration, or scope than the medical assistance made available to" any other similarly situated individual.). The State also must make such assistance available on a retroactive basis for qualifying individuals. See 42 U.S.C. 1396a(a)(34) ("A State plan for medical assistance must * * * provide that * * * such assistance will be made available * * * for [covered] care and services * * * furnished in or after the third month before the month in which he made application * * * for such assistance.").

In addition, States must limit participation in their Medicaid programs to health care providers that agree to accept "as payment in full" the medical assistance provided by the State plus any statutorily established contribution amount by the beneficiary. See 42 C.F.R. 447.15 ("A State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayment required by the plan to be paid by the individual.").[1] Congress statutorily underscored the application of that full-payment requirement to nursing homes. See 42 U.S.C. 1396r(c)(5)(A)(iii) ("[A] nursing facility must * * * not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under [an approved] State plan * * *, any gift, money, donation, or other consideration as a precondition of admitting (or expediting the admission of) the individual to

[1] See also 42 U.S.C. 1320a-7b(d)(2) (making it a felony for health care providers to "knowingly and willfully" charge an individual more than her statutorily established payment "as a precondition" of admission or "as a requirement" for her continued stay at a facility).

the facility or as a requirement for the individual's continued stay in the facility.").

If a State fails to comply substantially with the requirements of the Medicaid Act, the Secretary of Health and Human Services may withhold federal funding in part or in full. See 42 U.S.C. 1396c; see also 42 C.F.R. 430.35(c).

2. Wisconsin participates in the Medicaid program. In accordance with federal law, the Wisconsin Medicaid program (known as "Medical Assistance") generally requires providers to accept as "payment in full" the amount of compensation for medical services established by the State's Medical Assistance program and paid by the State, plus any copayment or pre-established contribution amount owed by the beneficiary. See Wis. Stat. Ann. § 49.49(3m) (West 2003 & Supp. 2004) ("No provider may knowingly impose upon a recipient charges in addition to payments received for services under §§ 49.45 to 49.47.").

A separate provision of Wisconsin law creates an exception to the general payment-in-full rule. Under Wisconsin's plan, an individual who qualifies for Medicaid benefits at any time during a month is entitled to benefits for medical services received during the entire month, even the portion of the month that preceded the beneficiary's application, as long as the beneficiary was eligible for benefits during that earlier period. See *Wisconsin State Plan Under Title XIX of the Social Security Act*, <http://www.cms.hhs.gov/medicaid/stateplans/State_Data/WI/2.6/Attachments /A/A_005.pdf>.[2] If the individual pre-paid for medical services that were later found to be eligible for Medicaid coverage, the provider may collect payment at the applicable Medicaid rate from the state agency, but then must make a refund to the beneficiary. See 42 U.S.C. 1396r(c)(5)(A) (iii); 42 C.F.R.

---

[2] In addition, under Medicaid's retroactivity provision, qualifying individuals are eligible to receive benefits for the three months that preceded the month in which application was made. 42 U.S.C. 1396a(a)(34).

447.15. Under Wisconsin law, however, the provider is not required to refund the prior payment in full. Instead, the provider need only reimburse the individual the amount paid by the State. See Wis. Stat. Ann. § 49.49(3m)(a)(2) (West 2003 & Supp. 2004) ("No provider may be required to reimburse the applicant * * * in excess of the amount reimbursed under § 49.45."). The provider is permitted to retain any additional amount previously paid by the individual, even if that sum exceeds the authorized Medicaid payment. *Ibid.*; Wis. Admin. Code § HFS 104.01(11) (2002) ("Upon the provider's receipt of the [Medicaid] payment, the provider shall reimburse the recipient for the lesser of the amount received from [Medicaid] or the amount paid by recipient * * * minus any relevant copayment.").

3. In late September 1999, Althea Keup entered the Mequon Care Center (Mequon), a private nursing home facility in Wisconsin. Pet. App. A5. Because Keup had not yet applied for Medicaid benefits, she paid Mequon $4540.38 in advance for the medical services that she would receive in October 1999. *Id.* at A6.

On October 21, 1999, Keup applied for Medicaid benefits and, eight days later, Wisconsin found her to be eligible for benefits as of October 1, 1999. Pet. App. A6. The state agency accordingly paid Mequon for the services provided to petitioner for the entire month of October at the applicable Medicaid rate of $3471.52. *Ibid.* Mequon then refunded Keup $3471.52, but retained the balance of her earlier payment ($1068.86) as additional compensation for her October care. *Ibid.*

Claiming that, under federal Medicaid law, she was entitled to have "MCC [Mequon] reimburse her the full amount she paid for October 1999 instead of the lesser amount that [Wisconsin Medical Assistance] paid," Pet. App. D2, Keup requested an administrative hearing. The Wisconsin Division of Hearings and Appeals ruled that it lacked jurisdiction over her claims. *Id.* at D3. The administrative law judge concluded that Keup was not "aggrieved by action

or inaction of" the Wisconsin Department of Health and Family Services, because her application for benefits was processed timely and in her favor, and the agency paid the full and proper amount of Medicaid benefits for her October care. *Id.* at D2-D3. The administrative law judge further explained that, "even if petitioner is correct and federal law requires full reimbursement to her, it is MCC [Mequon] that has failed to act, not the department." *Id.* at D3. "Any reimbursement due to petitioner," the administrative law judge concluded, "must come from [Mequon]," because "[i]n no case may the department reimburse petitioner directly." *Ibid.*

4. Petitioner filed suit in state court against the Wisconsin Department of Health and Family Services and its Secretary in her official capacity (collectively, Wisconsin), seeking both judicial review of the agency decision and independently asserting, under 42 U.S.C. 1983, claims for declaratory and injunctive relief based on the State law's alleged inconsistency with federal Medicaid law. Pet. App. A9. She argued, in particular, that Wisconsin law violated (i) 42 U.S.C. 1396a(a)(10)(B), which requires a State to provide similarly situated individuals with an equal amount of medical assistance (the uniformity requirement); (ii) 42 U.S.C. 1396a(a)(34), which directs a State to make benefits available to individuals on a retroactive basis (the retroactivity provision); and (iii) 42 U.S.C. 1396r(c)(5) and 42 C.F.R. 447.15, which require a State to limit participation in its state Medicaid program to providers that abide by the payment-in-full requirement of federal law (the payment-in-full requirement). See Complaint at 5-6.

The state court granted summary judgment for Wisconsin. Pet. App. C1-C2. The court first upheld the administrative law judge's determination that the state Department of Health and Family Services lacked jurisdiction over Keup's claims. *Id.* at C4. The court then held that state law did not violate the uniformity requirement of federal law, because Keup received "the same amount of benefits that

everyone else received," *ibid.*, or the retroactivity provision, because she received the retroactive benefits to which federal law entitled her, *id.* at C5. With respect to the payment-in-full requirement, the court explained that "Mequon Care Center is not a part of this," and that the court was "not sure that [respondents] have any responsibility to join them as a party." *Ibid.* The court continued: "I don't think it's appropriate to order them to change their policies, even if I would declare this [state] statute unconstitutional, to require Mequon Care Center to reimburse to Ms. Keup the difference * * *. I simply think it's beyond the scope of this Court's authority." *Id.* at C5-C6.

The Wisconsin court of appeals certified the case to the Wisconsin Supreme Court. See Pet. App. B1-B10.

b. The Wisconsin Supreme Court accepted the certification, Pet. App. B11-B12, and affirmed, *id.* at A1-A47. The court upheld the administrative law judge's jurisdictional decision under state law. *Id.* at A23-A27. With respect to Keup's claims for relief under 42 U.S.C. 1983, the supreme court held that none of the provisions of law on which Keup relied creates rights individually enforceable under Section 1983 in this context. In the court's view, the relevant federal Medicaid provisions do not "unambiguously impose a binding obligation on the state," Pet. App. A17, to ensure that "private pay patients" are "reimbursed for out-of-pocket amounts incurred prior to their application" for Medicaid benefits, *id.* at A20. With respect to the payment-in-full requirement in particular, the court concluded that federal law does not "unambiguously requir[e] that medical assistance providers reimburse a private pay patient the difference between the medical assistance benefits and the patient's original amount paid to the medical assistance provider." *Id.* at A19-A20.

While the case was pending in this Court, Althea Keup passed away. The administrator of her estate has been substituted as petitioner, pursuant to this Court's Rule 35.1.

DISCUSSION

Petitioner is correct that the Wisconsin law that permits health care providers to retain the pre-paid funds of Medicaid beneficiaries, see Wis. Stat. Ann. § 49.49(3m) (West 2003 & Supp. 2004); Wis. Admin. Code § HFS 104.01(11) (2002), is inconsistent with the federal requirement that Medicaid reimbursement be accepted by participating providers as payment in full. Petitioner is also correct that the Wisconsin Supreme Court's analysis of whether the statutory payment-in-full provision creates individual rights is flawed. Nevertheless, the court's conclusion that petitioner lacks a Section 1983 remedy against *respondents* appears correct. In any event, this Court's review is not warranted because petitioner may lack standing; the Wisconsin law is an isolated deviation from federal law that the Secretary of Health and Human Services can independently address through established procedures; and there is no conflict with the decisions of federal courts of appeals or state supreme courts that necessitates this Court's intervention.

1. Wisconsin law is inconsistent with the federal requirement that Medicaid payments be accepted as payment in full and that no further compensation or payment be sought or received from Medicaid beneficiaries. Federal law is explicit and straightforward. A State "must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency," with the exception of any pre-authorized deductible, coinsurance, or copayment required by the plan. 42 C.F.R. 447.15; see 42 U.S.C. 1396r(c)(5)(A)(iii) ("[A] nursing facility must * * * not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under [an approved] State plan * * *, any gift, money, donation, or other consideration as a precondition of admitting (or expediting the admission of) the individual to the facility or as a requirement for the individual's continued stay in the facility."); 42 C.F.R. 483.12(d)(3); cf. 42 U.S.C. 1320a-7b(d)(2) (criminalizing the

willful or deliberate exaction of additional payments from Medicaid beneficiaries).[3]

Indeed, it is well-established that a State may not permit, let alone affirmatively authorize, a participating health care provider to require an individual to "pay anything beyond" her statutorily established contribution amount. *Barney* v. *Holzer Clinic, Ltd.*, 110 F.3d 1207, 1210 (6th Cir. 1997).[4] And the United States Department of Health and Human Services has consistently taken the position that any such state requirement violates the federal Act and regulations.[5]

---

[3] Keup's overpayment cannot be characterized as a permissible co-payment because, in finding her eligible for Medicaid, Wisconsin determined that Keup would not be responsible for any monthly copayment. Pet. C.A. App. 11.

[4] See also, *e.g.*, *Pennsylvania Med. Soc'y* v. *Snider*, 29 F.3d 886, 889 (3d Cir. 1994) ("Medicaid service providers (including doctors and hospitals) must accept the Medicaid payment as payment in full, and may not ask the Medicaid patient to pay any money beyond that amount."); *Banks* v. *Secretary of Indiana Family & Soc. Servs. Admin.*, 997 F.2d 231, 243 (7th Cir. 1993) ("[A] Medicaid provider is prohibited from seeking payment from a Medicaid recipient of amounts not reimbursed by the state program."); *New York City Health & Hosps. Corp.* v. *Perales*, 954 F.2d 854, 856 (2d Cir.) ("Those doctors and hospitals who are willing to treat Medicaid patients must agree to accept the designated Medicaid rate and not ask the patient to pay any money beyond that amount."), cert. denied, 506 U.S. 972 (1992); *Florence Nightingale Nursing Home* v. *Perales*, 782 F.2d 26, 29 (2d Cir.), cert. denied, 479 U.S. 815 (1986).

[5] See Memorandum from Director, Survey and Certification Groups, Ctr. for Medicaid and State Operations, Ctrs. for Medicare & Medicaid Servs., to State Survey Agency Directors, *Clarification on Nursing Homes Requiring Promissory Notes or Deposit Fees as a Condition of Admission, and Implications Related to Surety Bonds* 2 (Jan. 8, 2004), available at <http://www.cms.hhs.gov/medicaid/survey-cert/sc0417.pdf> ("[T]he NF [Nursing Facility] must accept as payment in full the amounts determined by the state for all dates the resident was both Medicaid eligible and a NF resident. Therefore a NF that charged a recipient for services between the first month of eligibility established by the state and the date notice of eligibility was received is obligated to refund any payments received for that period less the state's determination of any

Yet that is precisely what Wisconsin has done here. Keup was an authorized Medicaid beneficiary for the entire month of October, and no copayment at all was due from her. As a result, when Mequon accepted Medicaid payment for Keup's October care, federal law prohibited Mequon from charging or receiving any further compensation for her care that month. The Medicaid payment was to be treated as payment in full. By allowing a provider to retain additional payment for medical services pursuant to state law, see Wis. Stat. Ann. § 49.49(3m) (West 2003 & Supp. 2004); Wis. Admin. Code § HFS 104.01(11) (2002), Wisconsin impermissibly allows participating providers to accept payment beyond the Medicaid rate of reimbursement.

In holding otherwise, the Wisconsin Supreme Court mistakenly characterized petitioner as a "private pay patient." See Pet. App. A20-A23. Because the state agency determined that petitioner was eligible for Medicaid benefits as of October 1, 1999, and paid the nursing home for petitioner's care for the entire month of October, *id.* at A6, petitioner was at all relevant times a Medicaid "recipient," not a "private pay patient," with respect to the medical services she received from Mequon in October 1999. See 42

---

resident's share of the NF costs for that same period."); Letter from the Health Care Fin. Admin., U.S. Dep't of Health & Human Servs., to State Medicaid Directors, *Medicaid Requirements Concerning Treatment of Private Rate Payments for Nursing Facilities* (Nov. 25, 1998) (reproduced at Complaint, Exh. B-7, at 1) ("We have recently become aware that some Medicaid participating nursing facilities are retaining money they are required to refund to residents when Medicaid eligibility is made retroactive. * * * Federal statutory and regulatory requirements mandate that the NF accept Medicaid payment as payment in full when the person's Medicaid eligibility begins. Thus, NFs are required to refund any payment received from a resident or family member for the period of time that the Medicaid eligibility was pending and the resident is determined eligible for Medicaid.").

C.F.R. 400.203 ("Recipient means an individual who has been determined eligible for Medicaid.").[6]

2. Although the Wisconsin Supreme Court erred in its analysis of whether a full refund was required, it nonetheless reached the proper disposition of the case, and thus the Court should deny review. Keup, who is now deceased, brought this action not against the nursing home to recover the payment it retained in violation of federal law, but against the state official responsible for administering the state Medicaid program, seeking injunctive and declaratory relief. Her claim against the state official does not appear to be cognizable under 42 U.S.C. 1983, and petitioner also may lack Article III standing.[7]

a. Section 1983 creates a private cause of action against any person who, under color of state law, deprives another "of any rights, privileges, or immunities secured by the Constitution and laws" of the United States. This Court held in *Maine* v. *Thiboutot*, 448 U.S. 1 (1980), that Section 1983 "means what it says" and thus authorizes suits by private individuals against state actors who violate rights created by federal "laws," including laws enacted pursuant to Congress's authority under the Spending Clause, U.S. Const. Art. 1, § 8, Cl. 1. *Thiboutot*, 448 U.S. at 4. This Court has reaffirmed that holding on numerous occasions. See, *e.g.*, *Gonzaga Univ.* v. *Doe*, 536 U.S. 273, 279-284 (2002); *Blessing* v. *Freestone*, 520 U.S. 329, 340 (1997); *Suter* v. *Artist M.*, 503

---

[6] The United States agrees with the Wisconsin Supreme Court that the Wisconsin law does not violate the federal uniformity or retroactivity provision, see 42 U.S.C. 1396a(a)(10)(B) and (a)(34), because the reimbursement policy does not deprive Medicaid beneficiaries of the same monthly Medicaid benefits enjoyed by other beneficiaries, nor does it deny them the full retroactive coverage to which they may be statutorily entitled.

[7] Keup also named the Wisconsin Department of Health and Family Services as a defendant, but that state agency is not a "person" subject to suit under 42 U.S.C. 1983. *Will* v. *Michigan Dep't of State Police*, 491 U.S. 58 (1989).

U.S. 347, 355 (1992); *Wilder* v. *Virginia Hosp. Ass'n*, 496 U.S. 498, 508 (1990); *Wright* v. *City of Roanoke Redevelopment & Housing Auth.*, 479 U.S. 418, 423 (1987).

Congress has ratified *Thiboutot*'s construction of Section 1983 in this context, by statutorily providing that certain provisions of the Medicaid Act and other subchapters of the Social Security Act pertaining to the content of a state plan may be enforceable by beneficiaries in appropriate circumstances in a private action under 42 U.S.C. 1983. See 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."); 42 U.S.C. 1320a-10 (same).[8]

Section 1983, however, permits the enforcement only of "*rights*, not the broader or vaguer 'benefits' or 'interests'" that might be reflected in federal law. *Gonzaga*, 536 U.S. at 283. Accordingly, to create "rights" enforceable under Section 1983, the relevant law "must be phrased in terms of the persons benefited," *id.* at 284 (quoting *Cannon* v. *University of Chicago*, 441 U.S. 677, 692 n.13 (1979)), and its text and

---

[8] See also *Wilder*, 496 U.S. at 512 (health care providers could bring an action under Section 1983 to enforce a provision of the Medicaid Act, which required a State plan to adopt "reasonable and adequate" rates for paying providers); *S.D. ex rel. Dickson* v. *Hood*, 391 F.3d 581, 603-606 (5th Cir. 2004); *Rabin* v. *Wilson-Coker*, 362 F.3d 190, 202 (2d Cir. 2004). Congress enacted 42 U.S.C. 1320a-2 in the wake of *Suter* v. *Artist M.*, *supra*. See 42 U.S.C. 1320a-2 ("This section is not intended to limit or expand the grounds for determining the availability of private actions to enforce State plan requirements other than by overturning any such grounds applied in [*Suter*], but not applied in prior Supreme Court decisions respecting such enforceability."). In *Suter*, the Court declined to allow an action under 42 U.S.C. 1983 to enforce a provision of the Adoption Assistance and Child Welfare Act of 1980 that required state plans to make "reasonable efforts" to avoid removing children from their homes and to help children return to their homes. See 503 U.S. at 351 (quoting 42 U.S.C. 671(a)(15)).

structure must unambiguously confer a right on individuals, *Gonzaga*, 536 U.S. at 283.[9]

The payment-in-full obligation can be construed to confer a right on individual Medicaid beneficiaries not to have a nursing home retain prepaid amounts when the beneficiary later qualifies for Medicaid and the facility chooses to accept the Medicaid payment. The relevant statutory provision prohibits participating nursing facilities from "charg[ing], solicit[ing], accept[ing], or receiv[ing] * * * any gift, money, donation, or other consideration as a precondition of admitting (or expediting the admission of) the *individual* to the facility or as a requirement for the *individual's* continued stay in the facility." 42 U.S.C. 1396r(c)(5)(A)(iii) (emphases added). That statutory proscription is, by its terms, a protection for individuals and a guarantee that covered individuals and their families will not have to pay additional money to receive Medicaid services. Indeed, the quoted provision is part of a statutory subsection entitled "Requirements relating to residents' rights." 42 U.S.C. 1396r(c). Section 1396r(c)(5)(A)(iii) thus creates a specific and individualized financial right or entitlement.

This Court has held in other circumstances that federal statutory provisions for the financial protection of private parties were enforceable under Section 1983. See *Wilder*, 496 U.S. at 522-523 (reimbursement provision of the Medicaid Act enforceable under Section 1983 because it created an objective and individualized monetary entitlement for individual health care providers); *Wright*, 479 U.S. at 430, 432 (rent-ceiling provision in the Public Housing Act enforceable under Section 1983 because it conferred a "specific and definite" right "focusing on the individual family and its

---

[9] Even if a statute creates individually enforceable rights, an action under Section 1983 will not be available if the statute forecloses private enforcement either expressly or impliedly, for example, through the creation of an alternative remedial mechanism. See, *e.g.*, *City of Rancho Palos Verdes* v. *Abrams*, 125 S. Ct. 1453 (2005). That aspect of Section 1983 analysis is not implicated in this case.

income"). In *Gonzaga*, the Court reaffirmed those holdings, explaining that Section 1983 is available to enforce "explicitly conferred specific monetary entitlements." 536 U.S. at 280; see also *Blessing*, 520 U.S. at 345-346.

The problem for petitioner is that, to the extent that Section 1396r(c)(5)(A)(iii) creates such an individual financial right, it is phrased in terms of duties imposed on the nursing home, not on the state administrators. The relevant statutory language directs that "a *nursing facility* must * * * not charge, solicit, accept, or receive" payment beyond the allotted Medicaid reimbursement. 42 U.S.C. 1396r(c)(5)(A)(iii) (emphasis added); cf. 42 U.S.C. 1320a-7b(d)(2) (criminalizing the willful or deliberate exaction of additional payments from Medicaid beneficiaries by the person who extracts the payment). There is no parallel statutory command that, by its terms, invests beneficiaries with a right to have the state Medicaid program either compensate the individual for any prepayments wrongfully retained by a nursing home or pursue collection or enforcement efforts against nursing facilities on behalf of individual beneficiaries whenever a facility deviates from the payment-in-full directive. Rather, a federal Medicaid regulation simply requires that a state plan commit to exclude from their Medicaid programs medical facilities that fail to accept as payment in full the amount paid by the state agency plus any deductible, coinsurance, or copayment that the state plan requires beneficiaries to pay. See 42 C.F.R. 447.15.

In determining whether and to what extent federal law creates individually enforceable rights, courts must look with care to whom the statutory "provisions speak." *Gonzaga*, 536 U.S. at 287; see *id.* at 288 (same). That is true of both rights and duties. Here, the relevant statutory text demonstrates that any individual rights created by Section 1396r(c)(5)(A)(iii) run against the nursing home, not the State (unless the State itself operates the medical facility). Thus, while the Wisconsin Supreme Court erred in holding

that the payment-in-full obligation was inapplicable to the period of care at issue in this case and that, in the abstract, it does not give rise to an individual right, that court's judgment that Keup does not have a right enforceable *against the respondents* in a suit under Section 1983 appears in the end to be correct. The payment-in-full obligation does not create individual rights vis-a-vis the state Medicaid administrators either to make the beneficiary whole or to ensure that the nursing home does.[10]

b. For similar reasons, there is a substantial question whether petitioner even has standing to seek relief against respondents from this Court. Resolution of that threshold jurisdictional inquiry could prevent or substantially distract from consideration of the question presented. Article III of the Constitution confines the federal judicial power to the resolution of actual "Cases" and "Controversies," U.S. Const. Art. III, § 2, and one "essential and unchanging" component of the case-or-controversy requirement is the rule that a plaintiff invoking the jurisdiction of the federal courts must have standing. *Lujan* v. *Defenders of Wildlife*, 504 U.S. 555, 560 (1992). Because standing goes to the power of the Court to adjudicate a case, resolution of the standing question is necessarily antecedent to any decision on the merits. *Steel Co.* v. *Citizens for a Better Env't*, 523 U.S. 83, 94 (1998).

This case arose in state court, where the Constitution's standing requirements did not apply to petitioner's suit. See *ASARCO Inc.* v. *Kadish*, 490 U.S. 605, 617 (1989). But petitioner, the personal representative of the estate of the plaintiff below, now seeks to invoke this Court's jurisdiction and, in so doing, must satisfy Article III's constitutional limitations on the jurisdiction of federal courts. *Id.* at 619. There is reason to question whether petitioner can satisfy

---

[10] Moreover, it does not appear that the payment-in-full obligation generally creates an individual right against nursing homes that would be enforceable under Section 1983, because privately owned nursing homes like Mequon would not appear to be acting under color of state law.

either prong of the *ASARCO* test. The "requisites of a case or controversy," *ASARCO*, 490 U.S. at 624, do not appear to be present, and the Wisconsin Supreme Court's judgment has not inflicted a distinct injury on petitioner.

Petitioner seeks declaratory and injunctive relief holding that Wisconsin's reimbursement provision violates federal Medicaid law. Complaint at 6-7. In order to establish "a present case or controversy regarding injunctive relief" or declaratory relief, however, petitioner must establish more than "[p]ast exposure to illegal conduct." *City of Los Angeles* v. *Lyons*, 461 U.S. 95, 102 (1983) (quoting *O'Shea* v. *Littleton*, 414 U.S. 488, 495-496 (1974)). "In order to establish an actual controversy in this case" "that would justify the equitable relief sought," petitioner must establish "a real and immediate threat that [Keup] would again be" subject to harm as a result of Wisconsin's unlawful Medicaid reimbursement policy. *Lyons*, 461 U.S. at 105.

Petitioner has not done that. Keup (now her estate) was the sole plaintiff; class certification was never sought. Cf. *County of Riverside* v. *McLaughlin*, 500 U.S. 44, 51 (1991) ("[B]y obtaining class certification, plaintiffs preserved the merits of the controversy for our review," even though their personal claims seeking a prompt probable-cause hearing could no longer be redressed through injunctive relief). The challenged Wisconsin law, moreover, applies only to persons who privately pay for medical services for a brief window in time during which they meet the eligibility requirements for Medicaid, but have not yet applied or been declared to be eligible for Medicaid benefits. Once Wisconsin qualified Keup for Medicaid benefits, there was no non-speculative prospect that she would once again find herself both ineligible for Medicaid and in possession of sufficient resources to pre-pay medical services. Indeed, because Keup, unfortunately, has now passed away, there is no prospect at all that a similar controversy involving her will recur.

Moreover, Article III requires that federal courts "act only to redress injury that fairly can be traced to the

challenged action of the defendant, and not injury that results from the independent action of some third party not before the court." *Simon* v. *Eastern Ky. Welfare Rights Org.*, 426 U.S. 26, 41-42 (1976). But both now and at the time the suit was initially brought, injunctive and declaratory relief could not have redressed the gravamen of petitioner's purely retrospective and "completed" injury, *County of Riverside*, 500 U.S. at 51—the loss of funds improperly retained by the nursing home, Mequon. Mequon was not a party to this case in state court and is not a party before this Court. "[I]njury at the hands of [the nursing home] is insufficient by itself to establish a case or controversy in the context of this suit, for no [nursing home] is a defendant." *Simon*, 426 U.S. at 41.

The complaint does seek an injunction requiring Wisconsin to order Mequon to reimburse the balance of the funds. Complaint at 7. But neither the complaint nor the petition cites anything in state law that empowers the Wisconsin Department of Health and Family Services to do that. The administrative law judge and Wisconsin courts have repeatedly disavowed such authority, Pet. App. A25, C5-C6, D3, and respondents have informed this Office that, in their view, while state law would permit Wisconsin to withhold reimbursement from Mequon or to terminate Mequon's participation in the Medicaid program prospectively if it persisted in violating the laws and rules governing the Medicaid program, see Wis. Admin. Code §§ HFS 106.06(1), 106.02(4) (2002), state law provides no authority for the Department of Health and Family Services to compel a private provider to disgorge past charges, especially when those charges were authorized by extant state law. See Wis. Br. in Opp. 10. Accordingly, petitioner has not established that it is "likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision." *Lujan*, 504 U.S. at 561 (internal quotation marks omitted).

Indeed, petitioner's claim closely parallels the claim this Court held did not amount to a constitutionally cognizable

case or controversy in *Simon* v. *Eastern Kentucky Welfare Rights Organization*, *supra*. There, as here, the plaintiffs sought to remedy a harm caused by private parties—the failure of tax-exempt hospitals to provide needed medical services for the indigent—through the mechanism of injunctive relief aimed at a regulatory agency. In *Simon*, the plaintiffs sought to enjoin an Internal Revenue Service Revenue Ruling that, in plaintiffs' view, impermissibly "encouraged hospitals to deny services to indigents." 426 U.S. at 42 (internal quotation marks omitted). This Court held that no case or controversy was presented because it was entirely "speculative whether the desired exercise of the court's remedial powers in this suit would result in the availability to respondents of such services" from third parties not before the Court. *Id.* at 43.

Likewise here, an injunction or declaratory judgment invalidating Wisconsin's statute and accompanying administrative provisions would not in itself compel Mequon to disgorge funds that state law permitted it to retain when they were paid nearly six years ago. Rather, petitioner presumably would still have to file a separate suit against Mequon, subject to whatever statute-of-limitations or other defenses Mequon might raise.

"[U]nadorned speculation" that some concrete form of relief might ultimately be obtained "will not suffice to invoke the federal judicial power." *Simon*, 426 U.S. at 44. In light of the apparent limitations on the availability of relief from state officials discussed above, petitioner in effect seeks an advisory ruling on whether state-law provisions that have no continuing application to Keup violate federal law, based on the possibility that such a ruling might assist her estate in recovering a single past payment from a third party who is not before the Court. Regardless of whether state law empowered the Wisconsin courts to entertain such a claim, there is a substantial question whether Article III would allow review by this Court. Compare *ASARCO*, 490 U.S. at 619 ("We are not confronted, certainly, with parties

attempting to secure an abstract determination by the Court of the validity of a statute," nor were petitioners "seeking review of an advisory opinion") (internal quotation marks omitted).

Furthermore, in *ASARCO*, it was the state court *defendant* who was permitted to obtain review in this Court of an adverse and binding state supreme court decision predicated on federal law because that adverse judgment "caus[ed] direct, specific, and concrete injury" to the defendant. *ASARCO*, 490 U.S. at 623-624. In this case, by contrast, it is the state court *plaintiff* who seeks to invoke federal jurisdiction, and the state supreme court simply declined to recognize her cause of action. That judgment is non-coercive and does not compel petitioner to engage or refrain from engaging in any conduct. The judgment did not invalidate any state law upon which petitioner's pre-existing property, liberty, or other rights rested. Cf. *ASARCO*, 490 U.S. at 618 (state court judgment invalidated law under which defendants' mineral leases were issued). The state supreme court's judgment leaves petitioner in the same position she was in before she filed suit, with her asserted claim against Mequon still unadjudicated, and in the same position she would have been in had she attempted to initiate this suit in federal court. It therefore is not evident that petitioner has suffered the sort of distinct injury traceable to the Wisconsin Supreme Court's judgment that would provide an Article III basis for this Court's exercise of its certiorari jurisdiction.

c. In addition to the questions concerning petitioner's ability to invoke Section 1983 and this Court's jurisdiction under Article III, other considerations militate against review. First, Wisconsin's impermissible reimbursement policy appears to be an isolated anomaly. The United States Department of Health and Human Services is not aware of any other State that has adopted the same or even an

analogous payment policy.[11] For that reason, there has been little occasion for courts to address either the validity of such a policy or the more precise question presented here of whether the payment-in-full requirement gives rise to rights that are individually enforceable against state Medicaid officials in an action under 42 U.S.C. 1983. No other state supreme court or federal court of appeals has decided those questions. There accordingly is no conflict in the decisions of the federal courts of appeals or state courts of last resort that necessitates this Court's intervention.

Although petitioner alleges that the Wisconsin Supreme Court's decision conflicts with other court rulings (Pet. 17-19), not one of the cases she cites addresses the Section 1983 question for which she seeks this Court's review. Indeed, petitioner admits that each of the cases she cites did *not* address the Section 1983 issue. See Pet. 17 (recognizing that *Blanchard* v. *Forrest*, 71 F.3d 1163 (5th Cir.), cert. denied, 518 U.S. 1013 (1996), was decided "without detail as to the § 1983 aspects," and that *Rodriguez* v. *City of New York*, 197 F.3d 611 (2d Cir. 1999), cert. denied, 531 U.S. 864 (2000), "assum[ed] without deciding" the existence of a cause of action under Section 1983); see also Pet. 19. In addition, neither of those cases involved the underlying payment-in-full requirement that is at issue in this case.

Furthermore, Wisconsin's deviation from federal law can and will be addressed by the Secretary of Health and Human Services and the Department's Centers for Medicare and Medicaid Services through established mechanisms, both informal and formal, for ensuring state compliance with the requirements of federal Medicaid law. See generally 42 C.F.R. 430.35. That process could largely empty the underlying procedural question presented by this case of prospective significance.

---

[11] That is not surprising, given the clarity of the longstanding federal requirement that Medicaid payments be accepted by health care providers as payment in full for their services.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

PAUL D. CLEMENT
Acting Solicitor General

ALEX M. AZAR II
General Counsel

PETER D. KEISLER
Assistant Attorney General

ROBERT P. JAYE
Acting Associate General Counsel

EDWIN S. KNEEDLER
Deputy Solicitor General

MARK D. POLSTON
Acting Deputy Associate General Counsel for Litigation

PATRICIA A. MILLETT
Assistant to the Solicitor General

H. ANTONY LIM
Attorney
U.S. Department of Health and Human Services

SCOTT R. MCINTOSH
TARA LEIGH GROVE
Attorneys

MAY 2005