No. 21-2325

IN THE
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

ST. ANTHONY HOSPITAL, Plaintiff-Appellant, v. THERESA EAGLESON, in her official capacity as Director of the Illinois Department of Healthcare and Family Services, Defendant-Appellee.	)))))))))))	Appeal from the United States District Court for the Northern District of Illinois, Eastern Division No. 20-cv-02561 The Honorable Steven C. Seeger, Judge Presiding.

BRIEF OF DEFENDANT-APPELLEE

KWAME RAOUL
Attorney General
State of Illinois

JANE ELINOR NOTZ
Solicitor General

100 West Randolph Street
12th Floor
Chicago, Illinois 60601
(312) 814-3312

Attorney for Defendant-Appellee

RICHARD S. HUSZAGH
Assistant Attorney General
100 West Randolph Street
12th Floor
Chicago, Illinois 60601
(312) 814-2587
richard.huszagh@ilag.gov

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INTRODUCTION

This case concerns payments by managed care organizations ("MCOs") to hospitals for Medicaid services provided to patients enrolled with the MCOs under Illinois' federally approved Medicaid plan. In its complaint, plaintiff-appellant St. Anthony Hospital alleged that two provisions of Title XIX of the Social Security Act (the "Medicaid Act," or "Act") — 42 U.S.C. §§ 1396u-2(f) and 1396a(a)(8) — impose on States a duty to "ensure" that MCOs pay hospitals 90 percent of "clean claims" (for which all necessary information has been supplied) within 30 days after the claims are submitted, and pay 99 percent of such claims within 90 days (the "30-day/90-day schedule"). St. Anthony's complaint further alleged that these statutes give hospitals private rights, which they can enforce under 42 U.S.C. § 1983, to require States to comply with this alleged duty, thus relieving the hospitals of any need to enforce their rights directly against MCOs. The district court correctly held that neither proposition is true.

On appeal, St. Anthony relies mainly on section 1396u-2(f) of the Act. That section requires States to include in their contracts with MCOs a default schedule for making payments to Medicaid providers, which MCOs and providers are free to modify. But this default provision adopts the 30-day/90-day schedule only for payments to "practitioners," not hospitals. And, as the district court held, section 1396u-2(f) merely requires States to *include* this provision in their contracts with MCOs, giving States the right to require compliance with it. It does not impose on States a duty to *enforce* that contractual provision and "ensure" that MCOs do not

breach it, as St. Anthony alleged. St. Anthony's proposed interpretation of section 1396u-2(f) improperly reads words into the statute that Congress did not enact. And it contemplates an absurd statutory scheme, that Congress could not have intended, in which Medicaid providers in managed care programs would not have to enforce their contract rights directly against MCOs, but instead would have States to do that for them, not only eliminating a State's statutory discretion over how to address an MCO's violations of its contract with the State, but also requiring the State to establish and administer a duplicate claims-processing system for each MCO and provider. Given the federalism and judicial enforcement concerns that arrangement would raise, section 1396u-2(f) cannot be read either to impose this claimed duty on States, or to give Medicaid providers like St. Anthony a right to enforce that duty.

The other provision of the Medicaid Act on which St. Anthony bases this claimed right to have States ensure that MCOs pay all Medicaid providers on a 30-day/90-day schedule is section 1396a(a)(8). But as the district court held, that provision says nothing about Medicaid providers, and instead mandates that state plans provide medical assistance with reasonable promptness to eligible *individuals* who apply for it. 42 U.S.C. § 1396a(a)(8). It does not govern Medicaid payments to *providers*, which Congress addressed in other sections of the Act, and does not give providers private rights to enforce a duty to pay them under a specific schedule.

The last issue in this appeal concerns the details in Medicaid payment remittances to providers. St. Anthony does not allege that MCOs' remittances violate the Medicaid Act, nor does it dispute that they comply with the federal statute

governing their form. Nine months after filing this action, however, it sought leave to file a supplemental complaint, ostensibly based on new information, alleging that such remittances by MCOs — and by the Illinois Department of Healthcare and Family Services ("HFS") under its separate fee-for-service Medicaid program — violate St. Anthony's right to due process. The district court properly denied that request where St. Anthony offered no convincing explanation for its delay; its proposed claim would have expanded the scope of the litigation, after the parties had already conducted discovery, beyond the timing of MCOs' payments to include new issues and a different program; and its due process claim lacked legal or factual merit.

JURISDICTIONAL STATEMENT

Defendant adopts the jurisdictional statement of the MCOs (Dkt. 42).

ISSUES PRESENTED FOR REVIEW

1. Whether section 1396u-2(f) or section 1396a(a)(8) of the Medicaid Act imposes on States a duty to ensure that managed care organizations pay 90 percent of hospitals' clean claims within 30 days, and 99 percent within 90 days.

2. Whether, if either provision of the Medicaid Act establishes such a duty, it also creates private rights for Medicaid providers that are enforceable under section 1983 (42 U.S.C. § 1983).

3. Whether the district court abused its discretion by denying St. Anthony leave to file a supplemental complaint alleging that the details on the MCOs' remittances under Illinois' managed care Medicaid program, and on HFS's remittances under Illinois' separate fee-for-service Medicaid program, violate due process.

STATEMENT OF THE CASE

Federal Medicaid Law

Medicaid, established under Congress's Article I spending power (Const. Art. I, § 8), is a joint federal-state program that provides medical assistance to low-income and other needy individuals. 42 U.S.C. §§ 1396 *et seq*.; *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990); *Planned Parenthood of Ind., Inc. v. Comm'r of Ind. State Dep't of Health*, 699 F.3d 962, 969 (7th Cir. 2012). Under this program, the federal government provides financial assistance to States to furnish medical care to needy individuals, and the States administer their own Medicaid programs in accordance with the Act, implementing regulations, and Medicaid plans approved by the Secretary of the U.S. Department of Health and Human Services (the "Secretary"), who generally acts through the Centers for Medicare and Medicaid Services ("CMS"). *Wilder*, 496 U.S. at 502; *Planned Parenthood of Ind.*, 699 F.3d at 969; *Abraham Lincoln Mem'l Hosp. v. Sebelius*, 698 F.3d 536, 543 (7th Cir. 2012); 42 U.S.C. § 1396a(a); 42 C.F.R. §§ 430.10, 430.12(b). After notice and an opportunity for a hearing, the Secretary may withhold funds from any State that he determines is in substantial noncompliance with its plan. 42 U.S.C. § 1396c; 42 C.F.R. § 430.35; *Planned Parenthood of Ind.*, 699 F.3d at 969.

Medicaid began with traditional fee-for-service programs, under which a State "enters into direct provider plan agreements with healthcare service providers," and providers are reimbursed by the State at a predetermined rate. *Midwest Emergency Assocs.-Elgin Ltd. v. Harmony Health Plan of Ill., Inc.*, 888 N.E.2d 694, 696 (Ill. App.

Ct. 2008); see also *State v. Rettig*, 987 F.3d 518, 524 (5th Cir. 2021); 63 Fed. Reg. 52022. The Medicaid Act was later amended to authorize States to establish managed care programs under which eligible individuals enroll with an MCO that receives a flat "capitation" payment from the State for each person enrolled, and the MCO contracts with health care providers and pays them directly. *Rettig*, 987 F.3d at 524; *Midwest Emergency Assocs.*, 888 N.E.2d at 697; A 3. Section 1396n(b)(4) of the Act first allowed such managed care programs under "waivers" by the Secretary of certain plan requirements. 42 U.S.C. § 1396n(b)(4); see 67 Fed. Reg. 40989-90; 63 Fed. Reg. 52022. Since 1997, section 1396u-2 of the Act authorizes all States to include such programs in their Medicaid plans. 42 U.S.C. § 1396u-2; Pub. L. 105-33, § 4708(c); 63 Fed. Reg. 52022.

"In an MCO arrangement, the state and providers are not in privity of contract with each other in connection with reimbursement for services that are provided to an MCO's enrollees." *Midwest Emergency Assocs.*, 888 N.E.2d at 697 (emphasis omitted). Instead, the State contracts with MCOs, which in turn enter into separate contracts with providers governing their relationship, including the MCOs' payments to providers for covered services to enrolled individuals. See 42 U.S.C. §§ 1396u-2(a)(1)(A)(ii), (a)(5)(B)(i), (b)(D), (f); 42 C.F.R. Part 438, Subpart A; *Cmty. Health Care Ass'n of N.Y. v. Shah*, 770 F.3d 129, 137 (2d Cir. 2014) (explaining that under managed care system, "the state enters into a contract with an MCO . . . [and] [t]he MCO, in turn, contracts with a health service provider . . . to provide medical services to its enrollees"). MCOs must "agree[] to comply with all rules and

regulations governing the Medicaid program." *Midwest Emergency Assocs.*, 888 N.E.2d at 696. States are generally prohibited from paying providers for Medicaid services provided to individuals enrolled with an MCO. 42 C.F.R. § 438.60.

Section 1396u-2(e) of the Medicaid Act governs a State's sanctions against an MCO for noncompliance with the MCOs' statutory or contractual obligations. 42 U.S.C. § 1396u-2(e); see 42 C.F.R. §§ 438.700 – 428.730. A "State shall have the authority to terminate" its contract with an MCO that "has failed to meet the requirements of" section 1396u-2 or its contract with the State. 42 U.S.C. § 1396u-2(e)(4)(A), (B); see 42 C.F.R. § 438.708. Before doing so, the State must give the MCO notice of its intent to terminate the contract, the reason for the proposed termination, and a hearing. 42 U.S.C. § 1396u-2(e)(4)(B), (C); 42 C.F.R. § 438.710.

Section 1396b(m) of the Act governs federal payments to States for Medicaid services pursuant to their contracts with MCOs. 42 U.S.C. § 1396b(m). For managed care programs under section 1396u-2(f), section 1396b(m)(2)(A)(xii) provides that no payment shall be made to a State for its expenditures under a contract with an MCO "unless . . . such contract, and the entity complies [sic] with the applicable requirements of section 1396u-2 of this title." 42 U.S.C. § 1396b(m)(2)(A)(xii).

Medicaid Prompt Payment Requirements

Separate provisions of the Act establish time frames for payments to Medicaid providers. Section 1396a(a)(37)(A), which governs payments by a State to "practitioners" under a fee-for-service program, states that a state plan must:

> provide for claims payment procedures which . . . ensure that 90 per centum of [clean claims] for services covered under the plan and furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of the date of receipt of such claims and that 99 per centum of such claims are paid within 90 days of the date of receipt of such claims . . . .

42 U.S.C. § 1396a(a)(37)(A); see 44 Fed. Reg. 30341. Section 1396a(a)(37)(A) does not impose a similar requirement for Medicaid payments to providers who are not "practitioners through individual or group practices or through shared health facilities," such as nursing homes and hospitals. *Id.*; *Ill. Council*, 957 F.2d at 308.

42 C.F.R. § 447.45, which "implements section [1396a](a)(37)]," specifies times when "[t]he Medicaid agency" must pay clean claims by certain types of providers. *Id.*, § 447.45(a), (d). For "practitioners . . . in individual or group practice or who practice in shared health facilities," the State must pay clean claims on the 30-day/90-day schedule. *Id.*, § 447.45(d)(2), (3). "The [State] must pay all other claims within 12 months of the date of receipt, ..." *Id.*, § 447.45(d)(4); see also *Ill Council*, 957 F.2d at 310 (holding that under § 447.45, nursing homes, unlike "practitioners," are entitled to payment by the State only within "the 12-month limit for 'all other claims'"); see also 42 C.F.R. § 447.45(b) (excluding "hospitals" from definition of "shared health facility").

For managed care programs under a state plan, payments by MCOs to Medicaid providers are governed by 42 U.S.C. § 1396u-2(f). (Managed care programs under a federal "waiver" of a state plan's requirements, not at issue here, are governed by 42 U.S.C. § 1396n(b)(4).) Section 1396u-2(f) directs that a State's contract with an MCO "shall provide that the [MCO] shall make payment to health

care providers on a timely basis consistent with the claims payment procedures described in section 1396a(a)(37)(A) . . . , unless the health care provider and the [MCO] agree to an alternate payment schedule." *Id.* 42 C.F.R. § 447.46, which implements section 1396u-2(f), states that "[a] contract with an MCO must provide that the [MCO] will meet the requirements of § 447.45(d)(2) and (d)(3)," but "[t]he MCO and its providers may, by mutual agreement, establish an alternative payment schedule," which "must be stipulated in the contract." 42 C.F.R. §§ 447.46(c).

Federal law requires a standard form of remittance — a "Form 835" — to accompany Medicaid payments to providers, including payments by MCOs. 42 U.S.C. § 1320d-2(a)(2)(E); 45 C.F.R. §§ 160.103, 162.1601(b), 162.1602(d)(2); 65 Fed. Reg. 50312, 50318. A failure to comply may result in statutory penalties. 42 U.S.C. § 1320d-5.

Illinois' Medicaid Program

Illinois has both a traditional fee-for-service Medicaid program (primarily for persons recently enrolled in Medicaid before they enroll with an MCO) and a managed care program under § 1396u-2. *Midwest Emergency Assocs.*, 888 N.E.2d at 696-97; see also *Ciarpaglini v. Norwood*, 817 F.3d 541, 545 (7th Cir. 2016); A 8-10, 43. Under Illinois' managed care program, HFS does not have a contractual relationship with Medicaid providers for these services, *Midwest Emergency Assocs.*, 888 N.E.2d at 697, and HFS's standard-form contract with MCOs requires the MCOs, rather than HFS, to pay providers. 305 ILCS 5/5-11(b); 89 Ill. Admin Code

§ 140.12(i)(1); Doc. 24-1, § 5.29.[1] The MCOs establish provider networks through private contracts with healthcare providers, and their enrollees are generally required to utilize healthcare providers within their MCO networks. See 42 C.F.R. § 438.206(b)(1); *Midwest Emergency Assocs.*, 888 N.E.2d at 697. HFS pays MCOs "on a capitated basis" (a flat fee per patient per month) that is "actuarially sound." 42 U.S.C. § 1396b(m)(2)(A)(iii); 305 ILCS 5/5-30.1(a); *see Midwest Emergency Assocs.*, 888 N.E.2d at 697. The MCOs then pay providers for services to enrolled Medicaid patients on terms and rates negotiated between them, which may differ from the rates paid by the State in a fee-for-service arrangement. 42 C.F.R. § 438.12(b)(2); 305 ILCS5/5-30.1(g); *Midwest Emergency Assocs.*, 888 N.E.2d at 697. Illinois' program also includes statutory and contractual provisions regarding MCO payments to providers, including payment deadlines, dispute resolution procedures, interest on late payments, and medical loss ratios. 215 ILCS 5/368a; 305 ILCS 5/5-30(h), 5-30.1(g), (g-8); 89 Ill. Admin. Code § 140.75; Doc. 24-1, § 5.29.

St. Anthony's Complaint

St. Anthony filed a two-count complaint against Theresa Eagleson, the HFS Director, challenging its management and supervision of Illinois MCOs' processing and payment of St. Anthony's claims for Medicaid-eligible services. (A 1-2, 12.) According to the complaint, "Saint Anthony has repeatedly tried to resolve [billing

[1] This standard-form contract in effect when St. Anthony filed this action is available at *www.illinois.gov/hfs/SiteCollectionDocuments/2018MODELCONTRACTadministrationcopy.pdf* (visited Dec. 22, 2021). Relevant excerpts were filed with the district court (Doc. 24-1), which could take judicial notice of the contract as an official record, see *Denius v. Dunlap*, 330 F.3d 919, 926 (7th Cir. 2003), and because it was "incorporated into the complaint by reference" (A 11-12), *Tellabs, Inc. v. Makor Issues & Rights, Ltd.*, 551 U.S. 308, 322.

and payment] disputes with the MCOs, but its attempts have been met with delays, unreasonable requests for additional information, and a general lack of responsiveness." (A 20-21.) The complaint alleged that multiple provisions of the Medicaid Act require MCOs to pay all Medicaid providers, including hospitals, on the 30-day/90-day schedule; the MCOs routinely failed to comply with this obligation, causing a cash shortage that impeded St. Anthony's ability to serve its patients; and HFS's "lack of oversight and effective management of MCOs" contributed to this problem. (A 1-4, 7, 9, 12-25, 15-17, 23-24, 26-32.) The complaint did not allege the absence of any factual disputes with the MCOs about whether claims are "clean," properly decided (e.g., denied for failing to obtain prior authorization for a service as required under its contract with an MCO), or properly calculated.

Count I alleged that sections 1396a(a)(37), 1396u-2(f), and 1396b(m)(2)(A)(xii) of the Medicaid Act require HFS to "ensure" that MCOs pay St. Anthony's claims in accordance with the 30-day/90-day schedule, and that HFS had violated this alleged duty. (A 26-32.) Count II made similar allegations regarding section 1396a(a)(8) of the Medicaid Act. (A 29-32.) Both counts of the complaint sought redress for these alleged violations under section 1983. (A 26-32.) The complaint requested a declaratory judgment that HFS violated the Medicaid Act by failing to "ensure" timely payments by MCOs to St. Anthony on the 30-day/90-day schedule, and an injunction ordering HFS to "use all available means" to cause the MCOs to make such payments, and to "deem any claims not paid within 90 days granted and pay such claims immediately." (A 27-28, 30-31.) To the extent that HFS could not force

the MCOs to make payments under the 30-day/90-day schedule, the complaint sought an order requiring it to terminate its contracts with the noncompliant MCOs and itself pay St. Anthony on this schedule. (A 27-28, 30-31.)

The complaint also alleged that MCOs "refuse to provide the detail necessary for Saint Anthony to determine if it is receiving proper payment or, if not, why not," and that HFS has "permitted MCOs to operate without transparency in their dealings with providers, which has prevented Saint Anthony . . . from determining whether the MCOs . . . are paying . . . what [is] due." (A 3, 18.) The complaint did not allege that the MCOs had a duty under federal law to provide such detail, or that HFS had a duty under federal law to require the MCOs to provide it. Nor did it allege that, for any payments they made, any of the MCOs failed to provide a completed Form 835. The complaint nonetheless requested, as a remedy for HFS's alleged violations of the Medicaid Act, an injunction requiring HFS to require MCOs to use a "standard, transparent format for all claim payment remittances that identifies core, add-on, access, partial, and other payments." (A 28, 31.)

Motions for preliminary injunction and to dismiss action

St. Anthony moved for a preliminary injunction requiring HFS to use "all available means" to cause each MCO to make payments to St. Anthony on the 30-day/90-day schedule; "deem any claims not paid within 90 days granted and pay such claims immediately"; and show for each claim the dollar amount of "base rates, add-ons, and other components." (Doc. 9 at 1, 26.) HFS moved to dismiss the action, asserting that the statutes St. Anthony relied on do not require HFS to ensure the

timeliness of MCOs' payments to it, and do not create private rights that it can enforce under section 1983. (Docs. 16, 24.) The parties submitted a joint discovery report in which HFS said it would need oral discovery because "many of the allegations in Plaintiff's complaint relate to its dealings with MCOs, for which it has direct knowledge, but [HFS] does not" (Doc. 20 at 5.) The court set an expedited schedule for discovery, including oral discovery, to proceed during briefing on the Department's motion to dismiss. (Doc. 22.)

MCOs' motions to intervene, stay proceedings, and compel arbitration

HFS initially obtained limited information from some MCOs that disclosed "major discrepancies" between St. Anthony's factual allegations and what the MCOs reported about the timing of their payments to St. Anthony. (Docs. 50 at 5, 56 at 4-9.) HFS then served subpoenas on the MCOs to obtain additional documents and information, but several MCOs refused to produce them, asserting that doing so could jeopardize their contractual right to arbitrate any disputes with St. Anthony, and HFS moved to compel discovery from them or to suspend proceedings on the preliminary injunction motion. (Docs. 43 to 43-3.) St. Anthony opposed that motion, maintaining that HFS did not need discovery from the MCOs, and that St. Anthony's preliminary injunction motion should proceed without such discovery. (Doc. 50.)

The MCOs moved to intervene, to stay the case pending arbitration, and to compel arbitration. (Docs. 28, 34, 36, 41, 45, 78-80, 83.) In its response, St. Anthony recognized that "[i]t is not possible for HFS to 'ensure' compliance" by the MCOs' of their alleged payment obligations "without compiling the data needed to determine

compliance." (Doc. 68 at 3.) St. Anthony further asserted that if an MCO negotiates a payment schedule with a provider, HFS must "monitor and enforce the MCO's compliance with the federal mandate, including by requiring the MCOs to report data that permits the hospital and HFS to know whether the revised scheduled is being met." (Doc. 72 at 3.) HFS supported the MCOs' motions to stay the case pending arbitration, stating that St. Anthony's "complaints about its billing disputes with the MCOs should be resolved directly between it and the MCOs according to their contracts"; that the court, to determine whether St. Anthony's allegations are true, would "need to consider thousands of claims that Plaintiff has alleged are relevant to prove its allegations"; and that "letting arbitration proceed while staying this litigation will promote efficiency [and] avoid duplicative proceedings and potentially inconsistent rulings." (Doc. 51 at 2, 3, 6.)

The case was reassigned to a new judge with eight motions pending. (Docs. 58, 69.) The court granted the MCOs' motions to intervene, ruling that "deciding the case without the input of the MCOs would impair their interests" where the relief sought "would require payments from the MCOs themselves, not the State, in the first instance," or "require[e] the State to immediately terminate its MCO contracts." (Doc. 75 at 4.) St. Anthony opposed the MCOs' motions to stay the case pending arbitration, asserting that its claims "are brought solely against HFS" and "seek[] no judicial relief from the MCOs." (Doc. 86 at 1.) St. Anthony said the MCOs "may require arbitration of certain disputes if the Hospital were to seek relief from the MCOs, but it has not done so." (*Id.*)

The court canceled the deadline to take depositions and briefing on the motion for a preliminary injunction but directed HFS to submit a statement explaining what discovery it needed from the MCOs, and why, to respond to the preliminary injunction motion. (Doc. 81.) HFS advised that discovery from the MCOs was justified "to shed light on key factual questions, such as (1) the extent to which MCOs are not paying 'clean' Medicaid claims on time; (2) the actual amount of payments to Plaintiff delayed by the MCOs' allegedly untimely processing of payments, which Plaintiff, despite repeated requests by the Department, has not provided; [and] (3) the MCOs' reasons for any alleged payment delays, including the extent to which delays are attributable to Plaintiff (such as providing services that are medically unnecessary, failing to obtain prior authorization, or errors in procedure coding)." (Doc. 85 at 2.) The MCOs' reply in support of their motion to compel arbitration asserted that "factual questions go[ing] to the heart of [St. Anthony's] claims against HFS" required that an arbitrator determine, before the court, "whether [St. Anthony's] claims (1) are 'clean' or not, (2) have been properly billed/submitted, (3) have been properly rejected, (4) have been properly adjusted, (5) have been timely/properly paid, and (6) have been properly adjudicated." (Doc. 93 at 1.) The MCOs also took issue with St. Anthony's contention "that there is no need for 'extensive debate over whether individual claims were "clean" or not,'" asserting that "there is an 'extensive debate' between [St. Anthony] and the MCOs over which claims are owed/not owed and clean/not clean," and that the MCOs "are prepared to present their own evidence and testimony on these points in arbitration." (*Id.* at 10.)

St. Anthony's motion to file a supplemental complaint

Nine months after it filed this suit, almost six months after HFS's motion to dismiss was fully briefed, and after the parties had conducted initial discovery on St. Anthony's motion for a preliminary injunction, St. Anthony moved for leave to file a supplemental complaint alleging that the remittances it receives from the MCOs, as well as HFS's remittances under its separate fee-for-service Medicaid program, do not provide enough detail for St. Anthony to determine whether it is paid what it is owed, and that this lack of "transparency" violates its right to due process. (A 33-89.) St. Anthony asserted that it sought leave to file this new claim "based in part on developments that have occurred since" it filed its complaint, including, in particular, a statutory adjustment in payment rates that had taken effect seven months earlier. (A 33, 35-36.) Its proposed pleading represented the first time that it sought to challenge any aspect of HFS's fee-for-service program.

St. Anthony's proposed supplemental complaint, like its original complaint, alleged that it was unable to determine from the MCOs' remittances whether it was being paid what it was owed, and it sought an injunction requiring HFS to force the MCOs "to use a standard, transparent format for all claim payment remittances" that identifies all components of their payments. (A 18-22, 53-56.) The supplemental complaint also sought to require HFS to notify St. Anthony, for any payments by MCOs or by HFS, when it "is or is not paid an add-on or adjustor payment." (A 56.)

HFS disputed that St. Anthony had shown a valid justification for adding a new claim that relied almost entirely on facts that existed when it filed its complaint,

and where this claim would expand the scope of the litigation, after discovery had been conducted, to challenge the content of the MCOs' remittances and HFS's remittances under its fee-for-service program, which was never a part of the case. (Doc. 106 at 1-2, 8-11.) HFS also disputed that the MCOs' payment practices involved state action. (*Id.* at 7.) And, based on a detailed description of the payment-related information that HFS makes available to Medicaid providers, it asserted that St. Anthony can ascertain precisely what it is owed by HFS for its services, with the only difference for MCOs reflecting any alternate payment terms in their contracts with St. Anthony. (*Id.* at 11-16; Doc. 106-1 at 2-13.)

District court order dismissing the action

The district court granted the Department's motion to dismiss the original complaint, holding that sections 1396u-2(f) and 1396a(a)(8) do not establish the duties alleged by St. Anthony and do not create private rights in Medicaid providers enforceable under section 1983. (SA 2, 12-30.) The court held that section 1396u-2(f) requires only that States' contracts with MCOs contain timely payment provisions, not that States "ensure" that MCOs comply with those provisions, and that section 1396u-2(f) does not give Medicaid providers private rights to enforce that alleged requirement. (SA 25.) The court further held that section 1396a(a)(8) requires States to provide medical assistance under its Medicaid plan to "individuals" who apply for and are eligible for such assistance, not to hospitals or other Medicaid providers, and that section 1396a(a)(8) does not give such providers private rights to enforce that alleged requirement. (SA 26-29.) Based on its rulings regarding sections

1396u-2(f)'s and 1396a(a)(8)'s substantive requirements, the court also held that the complaint failed to state a valid claim. (SA 29-30.) Addressing St. Anthony's claim under section 1396u-2(f), the court stated (SA 23):

> Instead of imposing a statutory obligation of prompt payment, Congress decided that providers would enter into contracts with MCOs, and that the contracts would carry the load. Providers like Saint Anthony who believe that they are not receiving timely payment can assert whatever rights they may have under those agreements. But the remedy is contractual in nature, not a statutory claim against the state to compel the MCOs to do what they promised to do.
>
> [H]aving taken a pass on the opportunity to pursue contractual rights – rights contemplated by the statute – Saint Anthony cannot be heard to argue that this Court should open a backdoor to the courthouse.

District court order denying leave to file supplemental complaint

The district court also denied St. Anthony's motion to file its supplemental complaint. (SA 33-38.) The court reasoned that the proposed complaint did not result from anything that "happened" after the filing of the original complaint and "would radically change the scope and nature of the case" by bringing HFS's fee-for-service program "into the case for the first time" and raising "a new theory about a new program, opening up whole new frontiers of discovery." (SA 36-37.) The court stated that it also had "doubts about the legal sufficiency of Saint Anthony's proposed new claim, especially with respect to the managed care program," because "[t]he MCOs are private parties, not state actors." (SA 36-37.)

SUMMARY OF ARGUMENT

The district court correctly dismissed St. Anthony's complaint and denied its motion to file a supplemental complaint. As contemplated by the Medicaid Act, St. Anthony has individual contracts with MCOs, with whom it claims to have disputes regarding the payment of its Medicaid claims. But instead of enforcing its rights directly against the MCOs under these contracts in state court or by arbitration under applicable Illinois law, St. Anthony brought this action against HFS to achieve indirectly what it refuses to seek directly from the MCOs. As the district court held: "Saint Anthony brought the wrong claim in the wrong forum." (SA 30.)

St. Anthony's operative complaint rests on two disputed principles of law: (1) that two Medicaid Act provisions — sections 1396u-2(f) and 1396a(a)(8) — impose on HFS a duty to "ensure" that the MCOs pay St. Anthony under the default 30-day/90-day schedule that governs MCOs' payments to individual doctors and other "practitioners"; and (2) that these statutory provisions give Medicaid providers private rights to compliance with this alleged duty that are enforceable under section 1983. The district court rightly rejected both propositions.

As a matter of statutory interpretation, the district court correctly concluded that while section 1396u-2(f) expressly requires States to include in their contracts with MCOs a default schedule for the MCOs' payment to providers, it does not impliedly impose on States an additional duty to "ensure" that MCOs adhere to that schedule, or unambiguously give providers a right to enforce that alleged duty. (SA 20-25.) That proposed reading of section 1396u-2(f) inserts words that Congress

did not enact and produces a meaning that Congress could not have intended. St. Anthony's claim under section 1396u-2(f) also assumed, incorrectly, that the default payment schedule it establishes for MCO payments to *hospitals* is the same as the payment schedule that sections 1396a(a)(37)(A) and 1396u-2(f) establish for payments to *practitioners*.

St. Anthony's reliance on section 1396a(a)(8) fares no better. That section requires medical assistance to "individuals" who apply for and are eligible for such assistance. It does not create duties toward Medicaid providers or establish a specific schedule for payments to them, which instead is governed by sections 1396a(a)(37)(A) (for State payments under fee-for-service programs) and 1396u-2(f) (for MCO payments under managed care programs). For similar reasons, section 1396a(a)(8) does not unambiguously create rights in providers enforceable under section 1983.

Finally, the district court acted well within its discretion by denying St. Anthony's motion for leave to file a supplemental complaint adding a due process claim challenging the MCOs' remittances, as well as HFS's remittances under its separate fee-for-service program. St. Anthony offered no good reason for waiting nine months before seeking leave to file this claim, which was based on old facts and, after the parties had conducted discovery, would have expanded the scope of the case beyond the timing of MCO payments to include new issues and a challenge HFS's fee-for-service program. In addition, the proposed due process claim lacked merit because the MCOs are not state actors, and because HFS gives St. Anthony all the information necessary to determine what it is owed and paid.

ARGUMENT

I. St. Anthony Did Not State a Valid Section 1983 Claim to Require HFS to Ensure that MCOs Pay St. Anthony on a 30-Day/90-Day Schedule.

St. Anthony asked a federal court to require HFS to enforce St. Anthony's alleged payment rights against the MCOs. That claim fundamentally misconceives the Medicaid Act's design and intended mechanism for providers to be paid by MCOs — i.e., by directly invoking their rights under their individual contracts with MCOs. St. Anthony's claim to bypass this mechanism and instead have States enforce providers' alleged payment rights lacks two essential elements: (1) the Medicaid Act provisions on which it relies — sections 1396u-2(f) and 1396a(a)(8) — do not impose on States a *duty* to ensure that MCOs pay hospitals under a 30-day/90-day schedule; and (2) even if either provision did create such a duty, it does not create *private rights* in Medicaid providers that are enforceable under section 1983.[2]

This Court reviews *de novo* the district court's decision dismissing St. Anthony's complaint for failure to state a valid claim for relief. *White v. United Airlines, Inc.*, 987 F.3d 616, 620 (7th Cir. 2021). That decision involves questions of statutory interpretation, also reviewed *de novo*. *Id.*

[2] St. Anthony's complaint also asserted a right under section 1983 to enforce sections 1396a(a)(37)(A) and 1396b(m) of the Act (SA 5, 26-27), but it has abandoned those claims (Doc. 26; Doc. 56 at 4, n.1; Doc. 91 at 1, 3; Pl. Br. at 19-41).

A. The Medicaid Act Provisions Relied on by St. Anthony Do Not Impose on States a Duty to Ensure that MCOs Pay Hospitals on a 30-Day/90-Day Schedule.

1. Section 1396u-2(f)

Regardless of whether section 1396u-2(f) creates private rights in hospitals that are enforceable under section 1983, St. Anthony's claim under section 1396u-2(f) fails because it does not impose on States the *duty* that St. Anthony alleges: "to 'ensure' that MCOs pay providers 'on a timely basis' in accordance with . . . the 30/90-day requirement." (Pl. Br. 21.) That is true for two reasons. First, as the district court held, section 1396u-2(f) does not require States to "ensure" that MCOs adhere to the schedule that section specifies. Second, section 1396u-2(f) does not adopt a 30-day/90-day schedule for payments to *hospitals*, as opposed to *practitioners* in individual or group practices.

a. Section 1396u-2(f) requires States to include in their contracts with MCOs a default schedule for the MCOs' payments to Medicaid providers, not to ensure the MCOs' compliance with that schedule.

The district court correctly held that while section 1396u-2(f) of the Act obliges States to include in their contracts with MCOs the prescribed default payment schedule for MCO payments to providers (which they are free to change by agreement), it does not also require States to ensure that MCOs meet that schedule. (SA 20-22, 29.) St. Anthony addresses this issue in just a few paragraphs. (Pl. Br. 28-29.) But its interpretation of section 1396u-2(f) is wrong for multiple reasons. The most obvious is that St. Anthony reads into section 1396u-2(f) language that Congress did not enact.

As the district court observed, section 1396u-2(f) — which provides that a State's contract with an MCO "shall provide that the [MCO] shall make payment to health care providers on a timely basis consistent with the claims payment procedures described in section 1396a(a)(37)(A) . . . , unless the health care provider and the [MCO] agree to an alternate payment schedule," 42 U.S.C. § 1396u-2(f) — does not state that States shall "ensure" that MCOs pay providers on the schedule that section 1396u-2(f) specifies. (SA 20-22, 29.) St. Anthony declares, correctly, that "Congress used the word 'ensure.'" (Pl. Br. 28.) What it fails to mention is that Congress did *not* use that word in section 1396u-2(f). It used that word in section 1396a(a)(37)(A), relating to States' own payments to providers under fee-for-service programs, not in section 1396u-2(f), dealing with MCO payments to providers under managed care programs. Thus, as the district court ruled, Medicaid providers are free to enforce their rights to payment from MCOs directly, but section 1396u-2(f) does not oblige States to prevent MCOs from failing to meet their contractual payment obligations to providers. (SA 20-22, 29.)

St. Anthony's argument to the contrary is defeated by the statute's plain language. Statutes must be interpreted according to the ordinary meaning of the text that Congress enacted. *New Prime, Inc. v. Oliveira*, 139 S. Ct. 532, 539 (2019); *Intel Corp. Inv. Policy Comm. v. Sulyma*, 140 S. Ct. 768, 776 (2020). "A court has no right, in the guise of construction of an act, to either add words to or eliminate words from the language used by congress." *GE Betz, Inc. v. Zee Co.*, 718 F.3d 615, 624-25 (7th Cir. 2013) (cleaned up); see *Rotkiske v. Klemm*, 140 S. Ct. 355, 360-61 (2019).

Thus, courts are not free to supplement what Congress enacted based on their views about good policy. *Borden v. United States*, 141 S. Ct. 1817, 1829 (2021); *GE Betz*, 718 F.3d at 624-25. But that is what St. Anthony asks the Court to do here.

The absence of any language in section 1396u-2(f) imposing the duty that St. Anthony alleges is particularly significant because it is clear from other provisions of the Medicaid Act that when Congress wants to impose duties on States, including in their dealings with MCOs, it does so explicitly. See *Jama v. Immigration & Customs Enf't*, 543 U.S. 335, 341 (2005) ("We do not lightly assume that Congress has omitted from its adopted text requirements that it nonetheless intends to apply, and our reluctance is even greater when Congress has shown elsewhere in the same statute that it knows how to make such a requirement manifest."); see also *Rotkiske*, 140 S. Ct. at 361. The Medicaid Act is replete with provisions that expressly require States to take, or refrain from taking, certain actions. Section 1396u-2 itself contains numerous provisions specifying that States "shall" do certain things, see 42 U.S.C. §§ 1396u-2(a)(3)(A), 1396u-2(a)(4)(B), (C), (D), 1396u-2(a)(5)(C), (D), 1396u-2(c)(1)(A), 1396u-2(d)(1)(B), (d)(6)(A), including things the State shall do "directly or through" managed care entities, *id.*, § 1396u-2(a)(5)(C), (D). Even section 1396u-2(f) provides that a State's contract with an MCO "shall provide" that the MCO "shall make payment to health care providers" under the specified schedule, unless the MCO and provider "agree to an alternate payment schedule." *Id.*, § 1396u-2(f). But section 1396u-2(f) nowhere states that States shall "ensure" that MCOs always meet that default payment schedule, or any other schedule they negotiate with a provider.

Section 1396u-2(f) also must be read in accordance with the principle that "if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously," and "speak with a clear voice." *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981); see also *Md. Psych. Soc., Inc. v. Wasserman*, 102 F.3d 717, 719 (4th Cir. 1996). Yet St. Anthony's interpretation of section 1396u-2(f) assumes the imposition of a significant duty on States without any textual support.

In the district court, St. Anthony insisted that because section 1396a(a)(37) requires States to establish procedures to "ensure" that their own payments to practitioners in a fee-for-service program are made under the 30-day/90-day schedule, section 1396u-2(f), which incorporates that schedule by reference for MCO payments under a managed care program, also requires States to "ensure" that MCOs pay providers (not just practitioners) on that same schedule. (Doc. 26 at 2-3.) But the difference between the text and operation of each provision shows just the opposite. Section 1396a(a)(37) expressly requires a State plan to provide for procedures which ensure payments *by them* on this schedule. Section 1396u-2(f), which applies to payments by MCOs, does not state that States must "ensure" the *MCOs'* payments on this schedule.

There is a logical reason why section 1396a(a)(37)(A) requires Medicaid plans to require that States adopt procedures to ensure payments to providers according to a certain schedule, but section 1396u-2(f) does not. Section 1396a(a)(37)(A) governs direct payments to providers by States themselves under a fee-for-service program. See 42 C.F.R. §§ 447.45(d), (e); 44 Fed. Reg. 30341 ("Section 1396a(a)(37)(A) . . .

provides that *States* must pay 90 percent of individual practitioner claims within 30 days and 99 percent within 90 days . . . .") (emphasis added). In that arrangement, a State can establish procedures to ensure that *it* pays providers on a specified schedule. But under section 1396u-2(f), MCOs, not the State, pay providers. And while there is no difficulty in requiring a State, in a managed care program, to include in its contracts with MCOs an obligation that they pay providers according to a specified schedule (subject to the provider's right to negotiate a different schedule), requiring the State to "ensure" that MCOs always adhere to that schedule would raise obvious practical difficulties.

Nor can section 1396u-2(f)'s requirement that State contracts with MCOs oblige the MCOs to make payments to health care providers "consistent with the claims payment *procedures* described in section 1396a(a)(37)(A)," 42 U.S.C. § 1396u-2(f) (emphasis added), be read to thrust on States any duty regarding MCOs' payments to providers. The term "procedures" refers to the definition of "clean claims" and the payment schedule specified in section 1396a(a)(37)(A), not the State's procedures to fulfill its own obligation to pay providers in a fee-for-service program. Any possible doubt on that point is eliminated by the next clause, which authorizes a departure from section 1396u-2(f)'s "claims payment procedures" if a provider and MCO "agree to an alternate payment schedule." Thus, St. Anthony's interpretation of 1396u-2(f) rests on multiple flawed assumptions that section 1396u-2(f)'s language cannot plausibly support, and fails to show that Congress "unambiguously" imposed the duty it alleges. *Pennhurst*, 451 U.S. at 17.

St. Anthony's proposed interpretation of section 1396u-2(f) to impose an unwritten duty on States is unsound for the additional reason that it conflicts with, and would negate, section 1396u-2(e)'s express grant to States of discretion to seek termination of an MCO's contract for violating section 1396u-2 or its contract with the State. See 42 U.S.C. § 1396u-2(e)(4)(A) ("In the case of a managed care entity which has failed to meet the requirements of this part or a contract under section 1396b(m) or 1396d(t)(3) of this title, the State shall have the *authority* to terminate such contract . . . .") (emphasis added). That authority follows the principle that a contracting party need not always insist on the other party's strict performance or enforce its rights in the event of a breach, including breach of a performance deadline. *United States v. Blankenship*, 382 F.3d 1110, 1134 (11th Cir. 2004); *Bratton v. Roadway Package Sys., Inc.*, 77 F.3d 168, 175 (7th Cir. 1996); *Comm'l Contractors, Inc. v. United States Fid. & Guar. Co.*, 524 F.2d 944, 954 (5th Cir. 1975); *Peterson Steels v. Seidmon*, 188 F.2d 193, 195-96 (7th Cir. 1951). The same principle applies to administrative enforcement rights. As the Supreme Court explained in *Heckler v. Chaney*, 470 U.S. 821, 831 (1985), "an agency's decision not to prosecute or enforce, whether through civil or criminal process, is a decision generally committed to an agency's absolute discretion," and "[a]n agency generally cannot act against each technical violation of the statute it is charged with enforcing" because it "must not only assess whether a violation has occurred, but whether agency resources are best spent on this violation or another[.]"

The district court correctly recognized that principle's relevance here. (SA 31-32.) A State's discretion under section 1396u-2(e)(4) is especially important due to the massive disruption that terminating an MCO's contract would cause to enrolled individuals and other providers. Yet St. Anthony's reading of section 1396u-2(f) would negate that discretion under section 1396u-2(e)(4) and require a State to seek termination of its contract with an MCO, if necessary, to "ensure" its timely payments to providers. That cannot possibly be what Congress intended.

St. Anthony's reliance on three district court decisions to support its interpretation of section 1396u-2(f) — *Medevac MidAtlantic, LLC v. Keystone Mercy Health Plan*, 817 F. Supp. 2d 515 (E.D. Pa. 2011); *Appalachian Regional Healthcare v. Coventry Health & Life Ins. Co.*, 970 F. Supp. 2d 687 (E.D. Ky. 2013); and *National Medical Care, Inc. v. Rullan*, No. CIV. 04-1812 (HL), 2005 WL 2878094 (D.P.R. Nov. 1, 2005) — misses the mark. Those decisions "have no weight as precedents, no authority." *Anderson v. Romero*, 72 F.3d 518, 525 (7th Cir. 1995). Moreover, they are not persuasive on this issue because each simply assumed — mostly in *dicta*, and without an examination of the statutory text — that section 1396u-2(f) obliges States to achieve certain payment results by MCOs. The managed care plan in *Appalachian Regional* was not even a plan under section 1396u-2. See *Appalachian Reg'l Healthcare v. Coventry Health & Life Ins. Co.*, No. 5:12-CV-114-KSF, 2012 WL 2359439, *1 (E.D. Ky. June 20, 2012). Here, the district court did examine section 1396u-2(f)'s text and properly concluded that it does not impose such a duty.

Finally, St. Anthony has not shown that reading an implied enforcement duty into section 1396u-2(f) is essential to achieve Congress's objectives. As the district court noted (SA 19-25), providers may enforce their right to timely payment directly under their contracts with the MCOs, as Congress clearly anticipated. And Medicaid providers are in the best position to enforce their rights against MCOs because they deal directly with the MCOs and possess the information relevant to any claims-processing issues. Not surprisingly, Medicaid providers have brought such breach of contract actions against MCOs.[3] (As the proceedings here disclose, providers and MCOs also agree to arbitrate such contract disputes (Docs. 45, 78-80, 83).) No need exists, therefore, to supplement what section 1396u-2(f) does say with something it does not say to achieve Congress's goal of enabling Medicaid providers to receive timely payment.

St. Anthony's interpretation of section 1396u-2(f), by contrast, envisions a circuitous and unwieldy regulatory scheme where providers, instead of directly enforcing their own payment rights against MCOs, force States to do it for them through fact-intensive federal court actions that do not involve the MCOs, who have a clear stake in any such dispute and thus would be required parties. See Fed. R. Civ. P. 19(a)(1)(B); *N. Ind. R. Co. v. Mich. Cent. R. Co.*, 56 U.S. 233, 245-46 (1853); M*cCluer v. Super Maid Cook-Ware Corp.*, 62 F.2d 426, 429 (10th Cir. 1932). Under

[3] See *G. v. Hawaii, Dep't of Human Servs.*, 703 F. Supp. 2d 1078, 1099 (D. Haw. 2010); *C.S. Sewell, M.D. P.C. v. Amerigroup Tennessee, Inc.*, No. 2:17-CV-00062, 2018 WL 6591429, at *5-6, 9 (M.D. Tenn. Dec. 14, 2018); *Bourbon Cmty. Hosp., LLC v. Coventry Health & Life Ins. Co.*, No. 3:15-CV-00455-JHM, 2016 WL 51269, at *7 (W.D. Ky. Jan. 4, 2016); *Baylor Univ. Med. Ctr. v. Ark. Blue Cross Blue Shield*, 331 F. Supp. 2d 502, 505, 512 (N.D. Tex. 2004).

that scheme, a State would have to create a duplicate accounting system for every MCO and monitor all of its claim and payment information, including information sufficient to determine whether provider claims are "clean" and are for services that are medically necessary pursuant to any required prior authorization, as well as how much is owed, and when it is owed, under the provider's particular contract. The duplicate bureaucracy this would require cannot be what Congress envisioned by enacting 1396u-2, which was intended to have MCOs assume day-to-day functions previously performed by States under a traditional fee-for-service model.

b. Section 1396u-2(f) adopts the default 30-day/90-day payment schedule only for MCO payments to practitioners, not hospitals.

St. Anthony's claim under section 1396u-2(f) fails for the additional reason that the default payment schedule that States must include in their contracts with MCOs requires payments to *practitioners*, not *hospitals*, under the 30-day/90-day schedule borrowed from section 1396a(a)(37)(A). (The district court mentioned but did not reach this issue (SA 11-12).) By requiring States to include in their contracts with MCOs a provision obliging the MCOs to pay providers "on a timely basis *consistent with* the claims payment procedures described in section 1396a(a)(37)(A) . . . , unless the health care provider and the [MCO] agree to an alternate payment schedule," 42 U.S.C. § 1396u-2(f) (emphasis added), section 1396u-2(f) does not require MCOs to *exceed* what section 1396a(a)(37)(A) requires.

As this Court explained in *Illinois Council*, section 1396a(a)(37)(A), which applies to States' direct payments to providers under traditional fee-for-service

programs, mandates the 30-day/90-day schedule only for "practitioners [in] individual or group practices or . . . shared health facilities," not institutions like nursing homes and hospitals. 957 F.2d at 306, 308-10. The regulation that implements section 1396a(a)(37)(A) likewise distinguishes between such *practitioners* and other Medicaid providers by establishing the 30-day/90-day schedule for the former, and only requiring the latter to be paid within one year. 42 C.F.R. §§ 447.45(d)(2), (3), (4); see *Ill. Council*, 957 F.2d at 306, 308-10. Institutional providers opposed that distinction when section 447.45 was being drafted, but the federal government explained that it strictly followed the statutory text. 44 Fed. Reg. 30342 ("In the final rule, the timely claims requirements still apply only to individual, rather than institutional providers. This is exactly the requirement imposed by statute.").[4]

St. Anthony essentially ignores this key distinction in section 1396a(a)(37)(A) between "practitioners" and other providers, which section 1396u-2(f) borrows. It never mentions *Illinois Council* or the language in section 447.45 discussed in *Illinois Council* that specifically limits the 30-day/90-day schedule to claims by "practitioners" and allows other providers, including hospitals and nursing homes, to be paid within 12 months. *Ill. Council*, 957 F.2d at 306, 308 (discussing 42 C.F.R. §§ 447.45(d)(2), (3), (4)).

Contrary to St. Anthony's interpretation, section 1396u-2(f) incorporates this distinction rather than modifying it. A default schedule for MCOs to pay providers is

[4] See also 44 Fed. Reg. 30342 ("[A] primary consideration underlying the passage of the legislation was that undue delay in the payment of Medicaid claims to individual practitioners . . . discourages participation by physicians. Delayed payments are often more burdensome to individual practitioners than to institutional providers.").

"consistent" with section 1396a(a)(37)(A) if it is *not inconsistent* with what that section requires — in other words, if it is compatible with, and does not conflict with, section 1396a(a)(37)(A). See *Envtl. Def. Fund, Inc. v. E.P.A.*, 82 F.3d 451, 457 (D.C. Cir. 1996) ("'consistent' means 'agreeing or according in substance or form,' that is 'congruous' or 'compatible'") (quoting 3 Oxford English Dictionary 773 (2d ed. 1989), *amended*, 92 F.3d 1209 (D.C. Cir. 1996). St. Anthony insists, however, that section 1396u-2(f) does not just require *compatibility* with section 1396a(a)(37)(A), but requires that MCOs (unless a provider agrees to an alternate payment schedule) pay non-practitioner providers *faster* than section 1396a(a)(37)(A) specifies. Again, however, St. Anthony's interpretation of section 1396u-2(f) improperly changes what Congress did enact by adding something it did not enact.

Congress is presumed, when it enacted section 1396u-2(f) in 1997, to have been familiar with the Court's interpretation of section 1396a(a)(37) in *Illinois Council*. See *Guerrero-Lasprilla v. Barr*, 140 S. Ct. 1062, 1072 (2020); *Tri-State Water Treatment, Inc. v. Bauer*, 845 F.3d 350, 355 (7th Cir. 2017). Accordingly, if it wanted to require MCOs to pay *all providers* "according to" the 30-day/90-day schedule that section 1396a(a)(37) prescribes for payments to *practitioners*, it easily could have, and would have, said so.

The correct interpretation of section 1396u-2(f) is reinforced by the materially different language that Congress used in section 1396n(b)(4) of the Act, which applies to managed care programs under the Secretary's "waiver" authority that long predated managed care programs authorized by section 1396u-2. Unlike section

1396u-2(f), Section 1396n(b)(4) allows such waivers if, among other things, "providers . . . are paid on a timely basis *in the same manner as health care practitioners must be paid under section 1396a(a)(37)(A)*." 42 U.S.C. § 1396n(b)(4) (emphasis added). This provision, enacted before section 1396u-2(f), shows that when Congress intends all "providers" to be paid under the 30-day/90-day schedule for "practitioners," it says so — which it did *not* do in section 1396u-2(f). See *Rotkiske*, 140 S. Ct. at 361.

If there were any doubt about section 1396u-2(f)'s meaning, it is resolved by CMS's regulation implementing it, section 447.46, which states that, subject to an alternate schedule agreed to between an MCO and a provider, "[a] contract with an MCO must provide that the organization will meet the requirements of *§ 447.45(d)(2) and (d)(3)*." 42 C.F.R. § 447.46 (emphasis added). As the Court explained in *Illinois Council*, these identified subsections of section 447.45 — (d)(2) and (d)(3)) — apply only to payments to "practitioners," not other providers, whose payments are instead governed by the 12-month payment deadline contained in section 447.45(d)(4). 957 F.2d at 306, 308. Accordingly, even if the text of section 1396u-2(f) were not clear that its 30-day/90-day schedule applies only to practitioners, this Court should defer to CMS's reasonable interpretation of the provision in its regulation. See *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2124 (2016); *United States v. Mead Corp.*, 533 U.S. 218, 229-30 (2001).

Relegating its treatment of this issue to a single footnote, St. Anthony, citing CMS's preamble to its adoption of managed care regulations implementing section

1396u-2, suggests that section 447.46(c) does not mean what it says because CMS has "stated that Section u-2(f) applies the payment deadlines for 'practitioners' to 'providers' paid through MCOs." (Pl. Br. 27, n.11.) This attempt to justify St. Anthony's reading of section 1396u-2(f) is deficient on multiple levels. First, the text of this preamble simply uses the catchall term "providers" without expressly stating that section 447.46, unlike section 447.45 which it incorporates by reference, establishes for all providers the payment schedule that section 447.45 prescribes for "practitioners." 66 Fed. Reg. 43643-44. In addition, even if section 447.46 purported to do so, it could not change the unambiguous meaning of section 1396u-2(f). See *Pereira v. Sessions*, 138 S. Ct. 2105, 2113 (2018). And section 447.46 does not purport to do so, instead faithfully tracking the language of section 1396u-2(f), which in turn refers to section 1396a(a)(37)(A), adopting the 30-day/90-day schedule only for practitioners. Finally, any conflict between the actual text of section 447.46 and the preamble must be resolved in favor of that text. *Wyo. Outdoor Council v. United States Forest Serv.*, 165 F.3d 43, 53 (D.C.Cir.1999); *St. Francis Med. Ctr. v. Azar*, 894 F.3d 290, 296-97 (D.C. Cir. 2018). And, as described above (at 28), none of the district court decisions on which St. Anthony relies offer any persuasive reason to reach a contrary conclusion.

2. Section 1396a(a)(8)

There is likewise no merit to St. Anthony's claim that section 1396a(a)(8) obliges States to ensure that MCOs pay hospitals in accordance with the 30-day/90-day schedule. As the district court held (SA 26-28), any duty it creates is to *individ-*

uals, not Medicaid providers. And it does not oblige the State to ensure that MCOs make payments to providers in accordance with the 30-day/90-day schedule.

a. Section 1396a(a)(8) requires medical assistance to "individuals," not payments to medical providers.

The duty that section 1396a(a)(8) does impose is precisely what the section says: for the state plan to "provide that all *individuals* wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible *individuals*." 42 U.S.C. § 1396a(a)(8) (emphasis added). As the district court observed, it "does not even mention providers at all." (SA 26.)

St. Anthony nonetheless argues that the term "eligible individuals" in section 1396a(a)(8) includes hospitals and other Medicaid providers. (Pl. Br. 38-39.) The district court rightly rejected this interpretation, concluding that it "sits uncomfortably with the sentence as a whole." (SA 27.) Under St. Anthony's reading of section 1396a(a)(8), hospitals are "individuals" that "make application," and are "eligible," for medical assistance under a State's Medicaid plan. But these references to "individuals" signify natural persons, not institutions, which is consistent with the meaning used in the surrounding sections of the Act, as the district court noted. (SA 27, citing 42 U.S.C. §§ 1396a(a)(4), 1396a(a)(10)(A)(i), 1396a(a)(10)(A)(ii)(XII), 1396a(a)(10)(A)(ii)(XVI), 1396a(a)(10)(C)(ii).) Individuals, not hospitals, "make application[s] for medical assistance." See 42 C.F.R. §§ 435.831(f), 435.909, 435.915(a)(2).

St. Anthony does not confront this analysis. Instead, it emphasizes that "medical assistance" is defined to include payments for medical care, and that the only persons who receive such payments are medical providers, not the patients who receive such care. (Pl. Br. 39.) Thus, St. Anthony argues, the only interpretation of section 1396a(a)(8) that gives effect to all its terms is one that includes hospitals within the meaning of the term "individuals." (*Id.*) But the fact that medical assistance can be furnished to Medicaid patients by paying for their medical care does not make the providers of that care, who receive those payments, "individuals" who "make application for" and are "eligible" for such assistance. Critically, St. Anthony has not pointed to a single use of the term "individual" in section 1396a that must logically refer to someone other than a natural person. Several such uses exclude the possibility that the term could apply to anyone else. See 42 U.S.C.A. §§ 1396a(a)(3), (a)(17)(D) (a)(23), (a)(27). And every use of the term "individual" in the statutory definition of "medical assistance" clearly applies to a natural person. 42 U.S.C. § 1396d(a). In short, hospitals are not "individuals" under section 1396a(a)(8).

b. Section 1396a(a)(8) does not oblige States to require MCOs to pay medical providers on a defined schedule.

Section 1396a(a)(8) also cannot fairly be read to establish the 30-day/90-day timeline for paying providers. The subject of payments to medical providers, with specific time frames and other conditions, is expressly covered in sections 1396a(a)(37)(A) and 1396u-2(f) of the Act. Section 1396a(a)(8), by contrast, does not even mention providers, and it only refers to providing medical assistance to

individuals with "reasonable promptness." 42 U.S.C. § 1396a(a)(8). Using such general language, Congress cannot have intended section 1396a(a)(8) to imply what sections 1396a(a)(37)(A) and 1396u-2(f) declare expressly, much less to go beyond what they declare and impose on States the duties regarding MCO payments to hospitals that St. Anthony alleges.

When Congress wants to impose a specific schedule to pay certain Medicaid providers, it knows how to do so, as it did in sections 1396a(a)(37), 1396u-2(f), and 1396n(b)(4). See *Rotkiske*, 140 S. Ct. at 361. In *Illinois Council*, this Court, rejecting a similar claim based on Section 1396a(a)(13)(A), held: "Section 1396a(a)(37)(A) shows that when Congress wanted to impose time limits for the payment of certain Medicaid claims, it did so explicitly." 957 F.2d at 308; see *Lockheed Corp. v. Spink*, 517 U.S. 882, 897 (1996) ("When Congress includes a provision that specifically addresses the temporal effect of a statute, that provision trumps any general inferences that might be drawn from the substantive provisions of the statute."); *Blinder, Robinson & Co. v. S.E.C.*, 837 F.2d 1099, 1113 (D.C. Cir. 1988) ("The statute itself indicates that Congress full well knows how to express a time restriction . . . ."). The same reasoning applies to section 1396a(a)(8).

B. Sections 1396u-2(f) and 1396a(a)(8) of the Medicaid Act Do Not Give Providers Private Rights that Are Enforceable under Section 1983.

Because sections 1396u-2(f) and 1396a(a)(8) do not create the *duties* regarding MCO payments to providers that St. Anthony claims, the Court need not decide whether either of them also creates private *rights* in providers that they may enforce

under section 1983. But if the Court does reach the private rights issues, it should affirm the district court's holding that neither provision creates such rights.

1. General principles governing enforcement of Medicaid Act provisions under section 1983

The inquiry as to whether a federal statute creates a private right that may be enforced under section 1983 begins with the three factors articulated in *Blessing v. Freestone*, 520 U.S. 329 (1997):

> First, Congress must have intended that the provision in question benefit the plaintiff. Second, the plaintiff must demonstrate that the right assertedly protected by the statute is not so "vague and amorphous" that its enforcement would strain judicial competence. Third, the statute must unambiguously impose a binding obligation on the States.

Id. at 340-41. This inquiry must focus on a specific statutory provision, not by taking a "blanket approach" to whether the broader statute creates private rights. *Id.* at 344; see *Cannon v. Univ. of Chi.*, 441 U.S. 677, 689 (1979) (holding that this "question is answered by looking to the language of the statute itself"). Satisfying these factors creates a presumption that Congress intended to create private rights that can be rebutted by express language in the statute or a comprehensive enforcement scheme incompatible with individual enforcement. *Blessing*, 520 U.S. at 341.

Subsequent decisions, including *Gonzaga University v. Doe*, 536 U.S. 273 (2002), refine these criteria in several respects. *Gonzaga* explained that it is not enough for a person claiming a private right under statute to "fall[] within the general zone of interest that the statute is intended to protect," or for the statute to impose an obligation that "benefits" that person. *Id.* at 283. Instead, the statute

must demonstrate that "Congress intended to confer individual rights upon a class of beneficiaries," *id.* at 285, and manifest an "unambiguously conferred right" in that person, *id.* at 282, 283. The statute in question must (1) be "'phrased in terms of the persons benefitted,'" *id.* at 284 (quoting *Cannon*, 441 U.S. at 692, n.13); (2) establish an "'*individual* entitlement,'" rather than describing duties with an "'aggregate' focus" *id.*at 287 (emphasis in original, quoting *Blessing*, 520 U.S. at 343); and (3) contain individual "'rights-creating' language," *id.* (quoting *Alexander v. Sandoval*, 532 U.S. 275, 288-89 (2001)).

Emphasizing that judicially enforceable rights against state and local governments implicate significant federalism concerns, *Gonzaga* held that Congress's intention to create such a right must be "unmistakably clear." *Id.* at 286 (cleaned up). And it disavowed the suggestion in the Court's earlier opinions that anything less is sufficient to support judicial enforcement by a private person affected by noncompliance with a statute. *Id.* at 283; see also *Armstrong v. Exceptional Child Center, Inc.*, 575 U.S. 320, 331 n.* (2015); *Nasello v. Eagleson*, 977 F.3d 599, 601-02 (7th Cir. 2020). Thus, as this Court has recognized, Supreme Court precedent establishes a "strict test," *BT Bourbonnais Care, LLC v. Norwood*, 866 F.3d 815, 820-21 (7th Cir. 2017), and sets "a high bar," *Talevski by next friend Talevski v. Health & Hosp. Corp. of Marion Cty.*, 6 F.4th 713, 724-25 (7th Cir. 2021), for private rights of action under the Medicaid Act. See also 42 U.S.C. § 1320a-2 (stating that private rights under a Medicaid Act provision are not foreclosed merely because it "specif[ies] the required contents of a State plan").

2. Section 1396u-2(f) does not give Medicaid providers a private right to have States ensure that MCOs pay the providers on a particular schedule.

Under these principles, the district court correctly held that section 1396u-2(f) does not give Medicaid providers private rights to have States ensure that MCOs pay them according to the schedule that section 1396u-2(f) adopts. (SA 21 ("when reading the statute, that right simply isn't there").) Even if the interpretation of section 1396u-2(f) that St. Anthony proposes were plausible, it is not possible to conclude that this section gives Medicaid providers an "unambiguously conferred right," using language that is "unmistakably clear," *Gonzaga Univ.*, 536 U.S. at 283, 286, to have States "'ensure' that MCOs pay providers" as St. Anthony alleges.

First, section 1396u-2(f) was not intended to benefit particular providers, but instead to benefit recipients of medical assistance by promoting broad participation by providers. See *Armstrong*, 135 S. Ct. at 1387-88 (plurality) ("We doubt . . . that providers are intended beneficiaries (as opposed to mere incidental beneficiaries) of the Medicaid agreement, which was concluded for the benefit of the infirm whom the providers were to serve . . . ."). As noted, the specific motivation behind enactment of section 1396a(a)(37)(A), which provided the basis for the payment obligation adopted in section 1396u-2(f), "was that undue delay in the payment of Medicaid claims to individual practitioners . . . discourages participation by physicians" in the Medicaid program. 44 Fed. Reg. 30342. St. Anthony admitted this below. (Doc. 26 at 15 ("Section 37(A)'s prompt payment rule encourages individual doctors to serve Medicaid patients.").) Thus, the ultimate goal was to benefit recipients, with

practitioners being incidental beneficiaries in furtherance of that goal. The minimal legislative history for section 1396u-2(f) described in St. Anthony's brief (at 24-25) does not warrant a contrary conclusion.

Second, the remedial scheme established in section 1396u-2 negates any inference that it gives providers private rights against States. Section 1396u-2 provides for the creation of contracts between providers and MCOs under which providers can enforce their rights directly. And, as noted, section 1396u-2(e)(4) explicitly allows a State, in its *discretion*, to terminate an MCO's contract if the MCO violates section 1396u-2(f) or its contractual obligations to the State. 42 U.S.C. § 1396u-2(e)(4); see 42 CFR §§ 438.708, 438.710. Recognizing in providers a private right to force a State to terminate an MCO's contract would conflict with section 1396u-2's remedial scheme by allowing providers to bypass the MCOs, whose contractual duties are at issue, and eliminating the State's express statutory discretion provided in the Act. See *Va. Hosp. & Healthcare Ass'n v. Kimsey*, 493 F. Supp. 3d 488, 494-95 (E.D. Va. 2020) (holding that § 1396u-2(b)(2), requiring State's contract with MCO to assure coverage for emergency services, established contract-based enforcement regimen, not private rights in health care providers).

The district court correctly found that the Court's decision in *BT Bourbonnais* is distinguishable. (SA 15.) The statute at issue there requires States to "provide . . . for a public process for determination of rates of payment" to certain Medicaid providers "under which . . . providers . . . are given a reasonable opportunity for review and comment on the proposed rates . . . ." 42 U.S.C. § 1396a(a)(13). Unlike

section 1396u-2(f), that language satisfied the *Blessing*/*Gonzaga* test by unambiguously giving providers, as the identified beneficiaries of the statute, specific procedural rights in this rate-setting process.[5]

Finally, interpreting 1396u-2(f) to give Medicaid providers the right to have federal courts control States' exercise of their statutory and contractual discretion regarding the promptness of MCOs' payments to the providers would raise serious constitutional concerns. Although *Ex parte Young*, 209 U.S. 123 (1908), generally permits federal courts to grant prospective injunctive relief against state officials to ensure compliance with an ongoing duty under federal law, the States' sovereign immunity still stands as a bar to such relief that seeks to control the manner in which state officials exercise their discretionary authority. As the Supreme Court explained,

> There is no doubt that the court cannot control the exercise of the discretion of an officer. It can only direct affirmative action where the officer having some duty to perform not involving discretion, but merely ministerial in its nature, refuses or neglects to take such action.

Id. at 158; see also *Seminole Tribe of Fla. v. State of Fla.*, 11 F.3d 1016, 1028-29 (11th Cir. 1994), *aff'd*, 517 U.S. 44 (1996).

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[5] As described above, the district court decisions on which St. Anthony relies for the contrary position are unpersuasive. The decision in *Medevac MidAtlantic* actually rejects that position. 817 F. Supp. 2d at 526-27 & nn.82-85. And *Bio-Medical Applications of North Carolina, Inc. v. Electronic Data Systems Corp.*, 412 F. Supp. 2d 549 (E.D. N.C. 2006), and *Patients' Choice Medical Center of Humphries County, LLC v. Office of the Governor*, No. 3:08-cv-696-WHB-LRA, 2009 WL 531861 (S.D. Miss. Mar. 3, 2009), which hold that section 1396a(a)(37)(A) does not create rights enforceable under section 1983, are relevant by analogy to section 1396u-2(f).

While St. Anthony has demanded that HFS be ordered to "use all available means" to ensure that MCOs meet the 30-day/90-day payment schedule, it has never explained what those "means" realistically are. Section 1396u-2(e) does authorize termination of an MCO's contract (after a hearing) for violating its contract with a State. But that section also makes clear, as noted, that a State has discretion about whether to exercise that drastic option, consistent with federalism principles that would be violated by giving a private hospital or other medical provider the right to have a federal court order a State to terminate an MCO's contract if it does not meet the 30-day/90-day schedule.

In short, St. Anthony might prefer not to have to enforce its contractual rights against MCOs for any alleged payment delays, denials, or shortfalls, but section 1396u-2(f) does not make federal courts *de facto* collection agencies for Medicaid providers in a managed care plan.

3. Section 1396a(a)(8) does not give Medicaid providers a private right to require States to ensure that MCOs pay providers in accordance with the payment schedules prescribed elsewhere in the Medicaid Act.

For many of the same reasons, section 1396a(a)(8) does not give healthcare providers a private right to require States to force MCOs to pay them on the schedule that St. Anthony reads into section 1396a(a)(8). Even if St. Anthony's interpretation of section 1396a(a)(8) were colorable, it does not "unambiguously" express a congressional intent, in language that is "unmistakably clear," to give individual *providers* a right to payment on the schedule alleged by St. Anthony. *Gonzaga*, 536 U.S. at 282, 286.

The most obvious hurdle for St. Anthony is that the intended beneficiaries of section 1396a(a)(8) are *individuals* who apply for and receive medical assistance under a State's plan, not *providers* who deliver health care services to them. Section 1396a(a)(8) requires a State plan to furnish medical assistance "with *reasonable promptness* to all eligible *individuals*." 42 U.S.C. § 1396a(a)(8) (emphasis added). Before *Armstrong*, the Supreme Court's most recent decision on private rights under the Medicaid Act (discussed below), some courts held that section 1396a(a)(8) confers rights on *individuals*. E.g., *Doe v. Kidd*, 501 F.3d 348, 356-357 (4th Cir. 2007). This Court, without deciding the issue, has cast serious doubt on whether section 1396a(a)(8) does so. *Nasello*, 977 F.3d at 602. But no circuit court has ever ruled that it creates rights in *providers*. And in *Bio-Medical Applications of North Carolina*, 412 F. Supp. 2d at 553-55, the district court specifically held that providers do not have enforceable rights under section 1396a(a)(8).

The most relevant analogous precedent concerns section 1396a(a)(30(A) of the Act, which requires state plans to "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. § 1396a(a)(30(A). Section 1396a(a)(30(A), unlike section 1396a(a)(8), does mention providers, but *Armstrong* held that it does not give them private rights. 575 U.S. at 331-32 (plurality); *id.*at 333-36 (Breyer, J., concurring). Even before *Armstrong*, multiple circuit courts rejected the view that it gives providers private

rights. See, e.g., *Sanchez v. Johnson*, 416 F.3d 1051, 1059-61 (9th Cir. 2005); *Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 56-59 (1st Cir. 2004); *Pennsylvania Pharmacists Ass'n v. Houstoun*, 283 F.3d 531, 534-43 (3d Cir. 2002); *Walgreen Co. v. Hood*, 275 F.3d 475, 477-78 (5th Cir. 2001); see also *Talevski*, 6 F.4th at 726 ("as *Armstrong* clarified, the position of providers is different from that of recipients"). Given that solid precedent rejecting provider rights under section 1396a(a)(30)(A), St. Anthony's claim for such rights under section 1396a(a)(8) is untenable.

II. The District Court Did Not Abuse Its Discretion by Denying St. Anthony Leave to Filed Its Proposed Supplemental Complaint.

The district court did not abuse its discretion in denying St. Anthony's motion for leave to file a supplemental complaint under Rule 15(d) of the Federal Rules of Civil Procedure, under which the court "may" allow a "supplemental pleading setting out any transaction, occurrence, or event that happened after the date of the pleading to be supplemented." Fed. R. Civ. P. 15(d). That ruling was fully justified where (1) St. Anthony's proposed pleading did not allege any material facts occurring after it filed its original complaint; (2) its proposed new claim would have significantly expanded the scope of the litigation after the parties had conducted discovery on St. Anthony's original claims, which challenged only the timeliness of MCOs' payments in Illinois' managed care program; and (3) the validity of its new due process claims was doubtful at best.

A. Applicable Standards

A district court's decision whether to grant a Rule 15(d) motion is reviewed for an abuse of discretion. *Otis Clapp & Son, Inc. v. Filmore Vitamin Co.*, 754 F.2d 738, 743 (7th Cir. 1985); see also *MAO-MSO Recovery II, LLC v. State Farm Mut. Auto. Ins. Co.*, 994 F.3d 869, 878 (7th Cir. 2021). Such an abuse occurs "only if no reasonable person could agree with" the district court's decision. *MAO-MSO Recovery II*, 994 F.3d at 878. Leave to file a supplemental complaint is not automatic, even if the proposed pleading "states a claim." *Glatt v. Chi. Park Dist.*, 87 F.3d 190, 194 (7th Cir. 1996).

> The court not only may but should consider the likelihood that the new claim is being added in a desperate effort to protract the litigation and complicate the defense; its probable merit; whether the claim could have been added earlier; and the burden on the defendant . . . .

Id.; see also *Foman v. Davis*, 371 U.S. 178, 182 (1962) (holding that factors relevant to allowance of amended pleading under Fed. R. Civ. P. 15(a) include "undue delay," "undue prejudice to the opposing party," and "futility of amendment"); *Otis Clapp & Son*, 754 F.2d at 743.

St. Anthony's reliance on *Runnion ex rel. Runnion v. Girl Scouts of Greater Chicago*, 786 F.3d 510, 519 (7th Cir. 2015), is misplaced, for that case involved a district court's refusal to allow the plaintiff to *replead* a claim to address curable deficiencies. Here, by contrast, St. Anthony did not seek to cure defects in its *original claim* (which were not curable), and instead sought to add a completely *new claim*, embracing an entirely separate Medicaid program.

B. St. Anthony's Unexplained Delay and the Impact of Its Proposed New Claim on the Case Justified the District Court's Denial of its Motion To Supplement its Complaint.

The district court validly found that the proposed supplemental complaint was not truly based on events occurring after St. Anthony filed its complaint, and that St. Anthony's motion was "an awkward fit, at best, with Rule 15(d)." (SA 37.) The court also observed that the proposed supplemental complaint "would substantially expand the scope of the case" where "[t]he original complaint advanced claims about the managed care program only," but the supplemental complaint "also makes allegations about the state's fee-for-service program" and "would bring that separate Medicaid program into the case for the first time[,] entail[ing] a new theory about a new program [and] opening up whole new frontiers of discovery." (SA 36.) These findings alone justify the district court's ruling.

St. Anthony tries to dismiss these findings, arguing that "[t]he Supplement alleged facts discovered after filing the Complaint" and "sought to add a single due process claim against a party already in the case (HFS), on an issue already raised — lack of transparency in payment." (Pl. Br. 42.) But St. Anthony fails to acknowledge that virtually all of the facts it relied on for its new due process claim were in its original complaint. (A 8-26.) And it offers no explanation as to why the few new facts in its supplemental complaint (involving a change in HFS's fee-for-service rates partly funded by hospital taxes) first revealed the existence of a due process claim.

In addition, as the district court accurately noted, St. Anthony's original complaint never alleged that a lack of greater detail in the MCOs' remittances

violated federal law, just that greater "transparency" was an available *remedy* for the violations it did allege, relating to the timeliness of MCO payments. (SA 36; see also A 26-28; Doc. 26 at 20, n.23; Doc. 91 at 2, n.1.) St. Anthony's contrary assertion here (Pl. Br. 45) is incorrect. Nor can St. Anthony dispute that its original complaint focused exclusively on Illinois' managed care program, while its supplemental complaint sought to include Illinois' separate fee-for-service program, which was never part of the case, and that the parties had already conducted substantial discovery on St. Anthony's original claims about the timing of MCO payments. St. Anthony's assertion, without citation, that "[m]erits discovery had not begun" (Pl. Br. 42), fails to mention that the main focus of the parties' accelerated discovery on St. Anthony's preliminary injunction motion was the merits of its claims. (Doc. 43; Doc. 50 at 2; Docs. 51, 56; Doc. 106 at 11.)

The district court also properly emphasized St. Anthony's delay and the potential prolongation of the case when it was subject to dismissal with prejudice based on purely legal questions. Without any plausible explanation for St. Anthony's delay, allowing it to supplement its complaint almost six months after HFS's motion to dismiss was fully briefed "would unnecessarily prolong the case because the case is otherwise over." (SA 36.) These circumstances amply justified the district court's ruling. See *Glatt,* 87 F.3d at 194 (affirming denial of leave to file supplemental complaint where motion was filed 16 months after original complaint based on evidence plaintiff possessed for more than a year); *Otis Clapp & Son*, 754 F.2d at 743 (affirming denial of motion to supplement complaint based on district court's "ruling

that the supplementation would raise new issues, require new discovery and necessarily prolong the litigation").

C. The District Court's Decision Denying St. Anthony Leave to File a Supplemental Complaint Was Also Justified by the Probable Lack of Merit in Its Proposed Claims.

The district court's ruling was further justified by the probable lack of merit in St. Anthony's proposed new claims, which the district court said it was free to allege in a new action. (SA 38.) Disputing this ruling, St. Anthony overlooks key distinctions between the managed care program and the fee-for-service program, and between the alleged *nonpayment* of amounts allegedly owed (the supposed *deprivation* of a property interest) and the alleged failure to provide more detailed *notice* regarding these payments (the supposed failure to provide adequate *process*).

1. St. Anthony's due process claim challenging the MCOs' remittances

The legal insufficiency of St. Anthony's proposed due process claim relating to the MCOs' remittances is obvious, as the district court noted. (SA 36.) Assuming that St. Anthony had a property right in full and timely payments by the MCOs, such a claim required it to allege that it was deprived of that right by the *government* without due process. *Lujan v. G & G Fire Sprinklers, Inc.*, 532 U.S. 189, 195 (2001); *Am. Mfrs. Mut. Ins. Co. v. Sullivan*, 526 U.S. 40, 58-61 (1999); *Banks v. Sec'y of Ind. Family & Soc. Servs. Admin.*, 997 F.2d 231, 246-47 (7th Cir. 1993). But the MCOs are not the government. They pay St. Anthony under the private contacts between them, not as agents for HFS fulfilling a duty by HFS to make such payments. Under abundant precedent, therefore, the MCOs were not state actors, triggering due

process rights if they failed to pay what they owed. See *Blum v. Yaretsky*, 457 U.S. 991, 1002-12 (1982) (no state action in Medicaid-funded nursing home's reduction of recipients' level of care without notice of right to contest change); *Am. Mfrs. Mut. Ins.*, 526 U.S. at 58-61; *Wittner v. Banner Health*, 720 F.3d 770 (10th Cir. 2013); *Wade v. Byles*, 83 F.3d 902, 905-07 (7th Cir. 1996); *Banks*, 997 F.2d at 246-47 (holding that actions by health care providers who unsuccessfully requested Medicaid reimbursement for services and then sued to recover for those services, which federal law prohibits if services are covered, was "the work of private entities"); *Forziano v. Indep. Group Home Living Program, Inc.*, 613 F. App'x 15, 19-20 (2d Cir. 2015).

The First Circuit's decision in *Gonzalez-Maldonado v. MMM Healthcare, Inc.*, 693 F.3d 244 (1st Cir. 2012), is on point. There, two physicians brought constitutional claims against a health maintenance organization that received capitation-based payments from CMS for each enrolled Medicare participant and, in turn, entered into service contracts with healthcare providers, including the plaintiffs. *Id.* at 245-46. Affirming the dismissal of these claims, the First Circuit held that the HMO's contested actions were "private conduct," not "state action." *Id.* at 247-48. See also *N.J. Primary Care Ass'n Inc. v. N.J. Dep't of Hum. Servs.*, 722 F.3d 527, 537 (3d Cir. 2013) (holding that defendant MCOs were "non-state actors," such that "the adequacy or inadequacy of the internal MCO appellate process cannot be the basis for a procedural due process claim").

St. Anthony relies on cases in which private parties acted as agents for the government in fulfilling the government's own duties or were implementing "powers

traditionally exclusively reserved to the State," *Manhattan Cmty. Access Corp. v. Halleck*, 139 S. Ct. 1921, 1928 (2019) (quotation omitted), such as the operation of a state prison. (Pl. Br. 46-50, citing *West v. Atkins*, 487 U.S. 42 (1988).) Neither situation applies here. St. Anthony correctly does not contend that health care for the needy is a traditional, exclusive government function. *Gonzalez-Maldonado*, 693 F.3d at 248; see also *Bourbon Cmty. Hosp.*, 2016 WL 51269, *5. Indeed, that would make St. Anthony's own medical services to Medicaid recipients state action, subject to suit under section 1983.

2. St. Anthony's due process claim challenging HFS's remittances

St. Anthony's proposed due process claim directed at HFS's own payments to St. Anthony was equally deficient. Its proposed pleading does not allege that HFS ever failed to pay St. Anthony what was owed. (A 40-56.) Instead, St. Anthony appears to believe it had a property right in HFS's remittances, not its payments. (Pl. Br. 45-47; A 41, 48-49.) This claim further assumes, without authority, that due process required HFS to give St. Anthony notice as a prophylactic measure — to facilitate its ability to determine *if* it was deprived of any amount owed. (*Id.*)

More fundamentally, St. Anthony wrongly assumes that if its due process claim regarding HFS's fee-for-service program was sufficient on the face of its proposed pleading, the district court had to let St. Anthony file it. (Pl. Br. 42, 51.) But as this court explained in *Glatt*, under Rule 15(d) that was not enough, and St. Anthony had to "substantiate" its claim, 87 F.3d at 194, which it failed to do. Indeed, HFS affirmatively established that St. Anthony's claimed inability to know whether

it is being paid what it is owed by HFS is simply untrue. (Doc. 106-1 at 2-13.)[6] The necessary calculations might require some effort on St. Anthony's part, which it apparently would prefer not to make, but they do not violate due process. And it is revealing that St. Anthony never sought leave to file a reply disputing this evidence.

Vargas v. Trainor, 508 F.2d 485 (7th Cir. 1974), on which St. Anthony relies, is inapposite because the challenged notice there reflected an admitted deprivation of a property right (termination of public assistance) and gave no other information besides directing the plaintiffs to ask the caseworker. *Id.* at 489-90. HFS's payment remittances, by contrast, are for all regular payments, including full payment of everything owed, which is not a deprivation of a property right. HFS's remittances and other information also give providers like St. Anthony all necessary information to calculate what is owed for a submitted charge. (Doc. 106-1 at 5-8.)

[6] As explained in the declaration submitted with HFS's opposition to St. Anthony's motion, HFS' remittances include the industry-standard code for the services rendered; HFS routinely advises each hospital of its base rate and adjustments for services covered by that code; and HFS's website, including an "Interactive Calculator," enables hospitals to calculate precisely the payment due for each claim, including the amount of any "policy adjusters" for certain hospitals and types of treatment (e.g., perinatal care) and any per diem "add-on payments" for certain hospitals. (Doc. 106-1 at 2-13.)

The same evidence also refutes St. Anthony's claimed inability to determine what it is owed by the MCOs, with the only difference being that St. Anthony must also account for any individual contract variations it negotiated. (Doc 106-1 at 13.)

CONCLUSION

For the foregoing reasons, the district court's judgment should be affirmed.

Respectfully submitted,

December 23, 2021

/s/ *Richard S. Huszagh*
RICHARD S. HUSZAGH
Assistant Attorney General
100 West Randolph Street
12th Floor
Chicago, Illinois 60601
(312) 814-2587
richard.huszagh@ilag.gov

KWAME RAOUL
Attorney General
State of Illinois

JANE ELINOR NOTZ
Solicitor General

100 West Randolph Street
12th Floor
Chicago, Illinois 60601
(312) 814-3312

Attorney for Defendant-Appellee

CERTIFICATE OF COMPLIANCE WITH WORD LIMITATION, TYPEFACE REQUIREMENTS, AND TYPE STYLE REQUIREMENTS

I hereby certify that this brief complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5) and Circuit Rule 32 and the type style requirements of Federal Rule of Appellate Procedure 32(a)(6) because this brief has been prepared in proportionally spaced typeface using Microsoft Word 2016, in 12-point Century Schoolbook BT font, and complies with Federal Rule of Appellate Procedure 32(a)(7)(A) in that the brief is 13,911 words.

/s/ *Richard S. Huszagh*

CERTIFICATE OF FILING AND SERVICE

I hereby certify that on December 23, 2021, I electronically filed the foregoing Brief of Defendant-Appellee with the Clerk of the Court for the United States Court of Appeals for the Seventh Circuit by using the CM/ECF system, which will effect service on other participants in the case, all of whom are registered CM/ECF users.

/s/ *Richard S. Huszagh*