No. 21-2325

IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

SAINT 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
Hon. Steven C. Seeger
1:20-cv-02561

BRIEF AND REQUIRED SHORT APPENDIX OF PLAINTIFF-APPELLANT SAINT ANTHONY HOSPITAL

Michael L. Shakman
Edward W. Feldman
William J. Katt
Mary Eileen Cunniff Wells
MILLER SHAKMAN
LEVINE & FELDMAN LLP
180 N. LaSalle Street, Suite 3600
Chicago, Illinois 60601
Tel: (312) 263-3700
mlshak@aol.com
efeldman@millershakman.com
wkatt@millershakman.com
mwells@millershakman.com

Counsel for Saint Anthony Hospital

APPEARANCE & CIRCUIT RULE 26.1 DISCLOSURE STATEMENT

Appellate Court No: 21-2325

Short Caption: Saint Anthony Hospital v. Theresa Eagleson

To enable the judges to determine whether recusal is necessary or appropriate, an attorney for a non-governmental party, amicus curiae, intervenor or a private attorney representing a government party, must furnish a disclosure statement providing the following information in compliance with Circuit Rule 26.1 and Fed. R. App. P. 26.1.

The Court prefers that the disclosure statements be filed immediately following docketing; but, the disclosure statement must be filed within 21 days of docketing or upon the filing of a motion, response, petition, or answer in this court, whichever occurs first. Attorneys are required to file an amended statement to reflect any material changes in the required information. The text of the statement must also be included in the front of the table of contents of the party's main brief. **Counsel is required to complete the entire statement and to use N/A for any information that is not applicable if this form is used.**

☐ **PLEASE CHECK HERE IF ANY INFORMATION ON THIS FORM IS NEW OR REVISED AND INDICATE WHICH INFORMATION IS NEW OR REVISED.**

(1) The full name of every party that the attorney represents in the case (if the party is a corporation, you must provide the corporate disclosure information required by Fed. R. App. P. 26.1 by completing item #3):
Saint Anthony Hospital

(2) The names of all law firms whose partners or associates have appeared for the party in the case (including proceedings in the district court or before an administrative agency) or are expected to appear for the party in this court:
Miller Shakman Levine & Feldman LLP

(3) If the party, amicus or intervenor is a corporation:

i) Identify all its parent corporations, if any; and

N/A

ii) list any publicly held company that owns 10% or more of the party's, amicus' or intervenor's stock:

N/A

(4) Provide information required by FRAP 26.1(b) – Organizational Victims in Criminal Cases:

N/A

(5) Provide Debtor information required by FRAP 26.1 (c) 1 & 2:

N/A

Attorney's Signature: /s/ Edward W. Feldman Date: September 9, 2021

Attorney's Printed Name: Edward W. Feldman

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ☑ **No** ☐

Address: Miller Shakman Levine & Feldman LLP, 180 North LaSalle Street, Suite 3600, Chicago, Illinois 60601

Phone Number: 312-263-3700 Fax Number: 312-263-3270

E-Mail Address: efeldman@millershakman.com

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes, Rules and Regulations

Other Authorities

INTRODUCTION

This appeal concerns two matters of vital concern to Plaintiff-Appellant Saint Anthony Hospital, and to other hospitals serving low-income, Medicaid patients. One is timely payment of Medicaid claims under the timetable set by statute. The other is disclosure of how payments are calculated.

Prompt payment. Late payments strangle cash flow and imperil the finances of safety-net hospitals struggling to serve Medicaid patients. The Medicaid statute requires that 90% of a hospital's uncontested Medicaid claims be paid within 30 days, and 99% within 90 days. Saint Anthony sued the State because this mandate is chronically violated. The district court ruled that Saint Anthony had no right to sue under the Medicaid statute. That conflicts with this Court's precedents and ignored the only three reported decisions considering the specific prompt payment statute at issue.

Transparency. Computation of payment for Medicaid claims is extremely complex. Payment remittances do not describe how paid claim amounts are computed. That deprives hospitals of the ability to determine whether they are paid what is owed. Due Process requires that when government pays a benefit, it provide notice of how the payment was determined. This is a critical problem given the highly complex criteria for paying Medicaid claims. Saint Anthony believes it has been underpaid millions of dollars since 2018, when the current system of payment via managed care organizations expanded. But the remittances it receives omit the payment calculations, leaving it unable to determine and contest underpayments.

Saint Anthony sought leave to add this Due Process claim less than a year after the case was filed, when no prior amendments had been sought and discovery was in its infancy. The district court denied leave to amend because the amendment would "expand" the case and it had "doubts" as to the merits of the claim. That conflicted with precedent that leave to amend be freely granted, especially early in a case. There was no basis for any "doubts" under cited precedent that the district court did not mention.

The denial of leave to add the Due Process claim and the dismissal of the prompt payment claim should be reversed.

JURISDICTIONAL STATEMENT

The district court had subject-matter jurisdiction under 28 U.S.C. §1331 (federal questions) and 28 U.S.C. §1343 (civil rights) based on Saint Anthony Hospital's ("**Saint Anthony**" or the "**Hospital**") claims under 42 U.S.C. §1983 against Theresa Eagleson, in her official capacity as Director of the Illinois Department of Health and Family Services ("**HFS**" or the "**State**"), to enforce rights created by the federal Medicaid statute, 42 U.S.C. §§1396a(a)(8) & (a)(37), 1396u-2(f), and 1396b(m)(2)(A)(xii). (A1.)[1] Saint Anthony's Motion for Leave to File Supplemental Complaint ("**Motion to Supplement**") also sought leave to bring a

[1] The short appendix is cited "SA__"; the separate appendix is cited as "A__"; documents on the district court's CM/ECF docket are cited "R__:__," for the docket number and page number. The use of "(cleaned up)" indicates that internal quotation marks, alterations, and citations have been omitted from quotations. Italics in quoted material have been added unless noted.

claim under the Due Process Clause of the Fourteenth Amendment of the U.S. Constitution pursuant to 42 U.S.C. §1983. (A33-89.)

This Court has jurisdiction under 28 U.S.C. §1291. The district court entered final judgment on July 13, 2021 after dismissing with prejudice Saint Anthony's Complaint and denying its Motion to Supplement. (SA2-39.) Saint Anthony filed a Notice of Appeal on July 19, 2021. (R112.)

STATEMENT OF THE ISSUES

1. Whether Medicaid providers have a private right of action under the Medicaid statue against the State agency that administers the federal Medicaid program for its failure to enforce the statute's prompt payment requirements for payments made by managed care organizations.

2. Whether the district court abused its discretion by denying Saint Anthony leave to file a supplemental complaint adding a claim alleging that the State is depriving Saint Anthony of due process by not providing adequate notice of how claim payments are calculated, leaving Saint Anthony unable to determine if it has been correctly paid – where (i) it was the first request to amend or supplement and it was made during the early stages of the case; (ii) there was no undue prejudice to any party; (iii) the supplement was not futile; and (iv) the denial was based on arguments the State raised to which the district court denied Saint Anthony an opportunity to respond.

STATEMENT OF THE CASE

A. Summary of Relevant Facts Alleged in the Complaint

1. Saint Anthony Hospital

Saint Anthony provides medical care and social services to underserved residents of the west and southwest sides of Chicago, without regard to their ability to pay. It has done so since 1898. Virtually all of its patients are Medicaid recipients. (A5-6.)

Saint Anthony has been, until threatened by the State's recent overhaul and expansion of its Medicaid managed care system, fiscally sound. (A7.) As the State began delegating most Medicaid claims processing and payment to managed care organizations ("**MCOs**"), Saint Anthony's cash on hand fell from more than $20 million (enough to fund 72 days of operation) in 2015 to less than $500,000 (less than 2 days) in 2019. Its net revenue-per-patient dropped more than 20%. (A7.) This decrease is due almost entirely to unnecessary, often unexplained payment delays and denials by the MCOs, and the State's failure to ensure that the MCOs comply with the law regarding timely and transparent payments. (A7.)

2. The Illinois Medicaid Program

The federal government provides Medicaid funds to States, which contribute additional funds and administer the program. States must comply with the federal Medicaid laws, including having a "plan" approved by the federal government. *See* 42 U.S.C. §1396a(a), (b); *see also* 42 C.F.R. §430.10-430.25. HFS administers the Illinois Medicaid program. (A8.)

a. Medicaid Fee-for-Service and Medicaid Managed Care

States can pay Medicaid providers on a fee-for-service or a managed-care basis. Under fee-for-services, the State directly pays physicians, hospitals, and other providers, typically based on a set fee for a particular service. *See* 42 U.S.C. §1396a(a)(30)(A). Under managed care, the State contracts with private healthcare insurance companies (MCOs) to administer Medicaid services to people who enroll in the MCOs' health plans. *See* 42 U.S.C. §§1396u-2, 1396b(m). The State pays the MCOs a fixed rate per member, per month (referred to as "capitation" payments). MCOs process and pay claims to providers for their enrollees. *See, e.g.*, 42 C.F.R. §438.6(c). If MCOs pay out less than they receive from the State, with certain exceptions, they get to keep the difference.

The Medicaid statute sets forth a series of requirements for States that use MCOs. *E.g.,* 42 U.S.C. §1396u-2. States must monitor "all aspects" of the MCOs, including their claims management. 42 C.F.R. §438.66(b). States must collect data, including provider complaints, appeal logs, and audited financial and patient-encounter data. *See* 42 C.F.R. §438.66(c).[2]

---

[2] Illinois law requires that HFS publish at least quarterly an "MCO Performance Metrics Report" describing "each MCO's operational performance, including, but not limited to . . . claims payment, including timeliness and accuracy [and] provider disputes." 305 ILCS 5/5-30.1(g-6). Every six months HFS must publish "an analysis of MCO claims processing and payment performance . . . , which identifies the percentage of claims adjudicated within 30, 60, 90, and over 90 days, and the dollar amounts associated with those claims." *Id.* §5-30.1(g-7). When Saint Anthony filed its complaint, HFS had published only one such report during the previous two years. (A14-15.)

Illinois' Medicaid managed care program was introduced in 2006 and significantly expanded in the last four years. In 2017-18, Illinois expanded use of MCOs to cover 80% of Medicaid beneficiaries. It consolidated a number of MCOs, reducing the number of MCOs that could participate to seven. (A10-11.) The process to become one of the seven MCOs was so opaque that the Illinois Office of the Comptroller recommended that the procurement be put on hold. (A11.) Nonetheless, in 2017 HFS finalized contracts with seven MCOs, most affiliates of large health insurers. The total value of the seven contracts was $63 *billion*, the largest single procurement in Illinois history. (A12.) Between 2010 and 2019, HFS's annual expenditures on MCOs increased from $251 million to $12.73 billion. (A10-11.) It has continued to grow every year. As of January 2020, over 2.1 million people, the vast majority of Illinois Medicaid recipients, were enrolled with MCOs. (A12.)

The State's expansion of managed care generated problems from the start. (A12-14.) Saint Anthony's Complaint alleges in detail that HFS has failed to ensure that the MCOs are meeting Medicaid's federal statutory obligations, seriously harming Saint Anthony and its patients, as well as other hospitals.[3] Saint Anthony is no longer paid as promptly or as fully as previously. Due to the lack of disclosure in the MCOs' payment remittances, Saint Anthony cannot determine whether claims were paid correctly. It alleges that this violates the Medicaid statute and Due Process. Saint Anthony's Complaint and its proposed Supplemental Complaint

[3] See Abe Dunn, et al., *A Denial a Day Keeps the Doctor Away*, Becker Friedman Institute for Economics at the University of Chicago (Working Paper No. 2021-80, Jul. 2021), https://bfi.uchicago.edu/working-paper/2021-80/.

("**Supplement**") focus on two issues: lack of timely payment and nondisclosure of how payments are calculated.

b. Delays in Claims Payments

The Medicaid statute requires that States "ensure" payment of 90% of all claims "for which no further written information or substantiation is required in order to make payment"[4] within 30 days, and 99% within 90 days. 42 U.S.C. §1396a(a)(37)(A) ("**Section (a)(37)(A)**")[5]; 42 C.F.R. §447.45(d)(2)-(3). If States use MCOs, the State's contracts with the MCOs "shall provide that the [MCOs] shall make payment to health care providers . . . on a timely basis consistent with the claims payment procedures [applicable to States] described in section 1396a(a)(37)(A) . . . ." 42 U.S.C. §1396u-2(f) ("**Section u-2(f)**"); 42 C.F.R. §447.46; 305 ILCS 5/5-30.1(g). The Medicaid statute requires States to furnish "medical assistance" with "reasonable promptness," 42 U.S.C. §1396a(a)(8) ("**Section (a)(8)**"), and defines "medical assistance" to include "payment of part or all of the cost of . . . care and services." 42 U.S.C. §1396d(a).

HFS allows MCOs regularly to fail to comply with these requirements. (A16-17, 23-24.) In 2020, for example, the CountyCare MCO owed Saint Anthony over $1.1 million, and had $350 million in unpaid claims overall. (A17.) Payment delays severely impact safety-net hospital like Saint Anthony. While waiting from 90 days

---

[4] Claims meeting this requirement are "clean claims." In this brief, "claims" in the context of prompt payment deadlines means "clean claims."

[5] Excerpts of the relevant statutes are found in the separate appendix at A90-92.

to two years to be paid, it must make payroll and pay its vendors, something it has struggled to do. (A17, 25.)

c. Lack of Transparency in Claims Payments

Under the Illinois Medicaid program, hospitals like Saint Anthony receive (i) individual claim payments for services to patients, and (ii) payments from the Illinois Hospital Assessment Program ("**HAP**"), discussed below. (A42.)

For individual claims, Saint Anthony bills based on the hospital's chargemaster, a list of prices for services. Like virtually all hospitals, its chargemaster price for each service is listed without regard to who pays (e.g., private insurer, Medicare, or Medicaid). The amount Saint Anthony is paid for Medicaid services is determined by the rate paid under the Illinois Medicaid Fee-for-Service program set by HFS, which is usually lower than the hospital's chargemaster prices. (A42-43.)

Calculating per-claims amounts due for services under the Illinois Fee-for-Service rates (which includes payments directly from HFS and from MCOs) is very complicated. Claims are classified to inpatient Diagnostic Related Grouping ("**DRG**") or outpatient Enhanced Ambulatory Procedure Grouping ("**EAPG**"). The calculation contains several components, depending on the service provided and whether the provider serves a disproportionate number of low-income patients, or otherwise qualifies for payment adjustments. Components include (i) a hospital's base DRG and EAPG rates, as periodically updated by HFS, (ii) the DRG or EAPG grouper

determined by a software program, (iii) the weight of the grouper as set by HFS, (iv) add-on payments, and (v) policy adjusters.[6] (A43.)

"Add-ons" are additional payments for services to which certain providers are entitled, calculated on a *per diem* basis (a dollar amount times the number of covered patient service days). Saint Anthony is entitled to add-on payments under the Medicaid Percentage, Medicaid High Volume, and Safety Net adjustment programs. *See* 305 ILCS 5/5-5.02(c), (d), and 5-5e.1. They are supposed to be included as part of each payment by an MCO of a qualifying claim. Saint Anthony usually has no idea whether they are. (A18-20, A43-45.) "Policy Adjusters" increase payment for certain types of claims and certain types of facilities, as a percentage increase to DRG or EAPG reimbursement rates. Saint Anthony is entitled to Policy Adjusters, including the outpatient high-volume adjuster and a perinatal adjuster. (A44.)

i. Payment Increases from the Hospital Assessment Program

There is yet more complexity: HFS and the MCOs are required to pay the Hospital under the Illinois Hospital Assessment Program – sometimes referred to as a "Robin Hood" tax because it was intended to redistribute from more affluent hospitals to the poorest. The State collects HAP taxes from hospitals and generates matching federal funds. The combined funds are then distributed to hospitals that

[6] If a hospital has a base DRG weight for a service of $3,500, and the software groups the services provided by the hospital into a DRG grouper with a weight of 1.5, the hospital is entitled to a DRG payment of $5,250 ($3,500 x 1.5). Added are add-ons, adjustors, and other components of payments depending on the service and provider.

provide Medicaid services under a State formula. Safety-net hospitals like Saint Anthony receive HAP amounts that exceed what they pay. (A19, A45-46.)

Before July 1, 2018, HAP payments were "supplemental payments" – supplemental because they were paid separately from individual claim payments for Medicaid services. They were paid in fixed monthly amounts per hospital. Saint Anthony knew with each payment whether it was receiving what was due. (A19, A46.)

The Illinois legislature amended HAP beginning July 1, 2018. For Fiscal Years 2018-2019, known as "Phase 1," a portion of the HAP funds became linked to and paid as part of the myriad Medicaid claims for services provided to individual patients. Rather than coming in clear monthly lump-sum payments from HFS, HAP payments were minced into thousands of pieces embedded in each item of service in each patient's individual bills to be paid by the MCOs or HFS. (A22; A46-47.) These payments were to be effectuated by increasing certain claims-based payment rates and add-ons for payment of individual claims, as set forth in 305 ILCS 5/14-12 ("**Section 14-12**"). 305 ILCS 5/5A-12.6(b)(1) (repealed July 1, 2020, by 305 ILCS 5/5A-14(f)). Ultimately, about $571 million financed from HAP was allocated for Phase 1 rate increases, add-ons, and rate adjusters – referred to in this brief and the Supplement as "**HAP Claims Payment Increases**." (A47.)

In July 2020, the Illinois legislature amended HAP, known as "Phase 2." *See* 2020 Ill. Legis. Serv. P.A. 101-650 (S.B. 2541) (codified at 305 ILCS 5/5A-12.7). Phase 2 continues HAP Claims Payment Increases provided for in Phase 1 in Section 14-12.

The HAP Claims Payment Increases are supposed to include across-the-board increases in the DRG and EAPG base rates, 305 ILCS 5/14-12(a)(10), (b)(5), and other add-on payments and policy adjustors, 305 ILCS 5/14-12(a)(11), 12(b)(4), 12(a)(8), 12(a)(9), 12(b)(3). (A48.)

Saint Anthony is entitled to HAP Claims Payment Increases because it provides qualifying services to Medicaid patients. The Illinois Health and Hospital Association, a hospital association involved in developing HAP Phases 1 and 2, informed Saint Anthony that it was estimated to receive more than $6.2 million annually as a result of the HAP Claims Payment Increases (net of Saint Anthony's own HAP tax payments). (A48.) But opaque remittances make it impossible to determine the amounts actually paid or underpaid. (A18-20; A44-45, 48-50.)

ii. No Notice of HAP Payment Increases

Saint Anthony submits hundreds of thousands of claims annually. Unlike the easily verified prior fixed HAP payments, payment remittances by MCOs do not identify HAP Claims Payment Increases. They generally do not disclose how the MCO calculated the payment, nor list component parts, such as the DRG or EAPG grouper, the add-ons, or adjusters. Instead, remittance forms typically include only the total amount paid per claim. (A44-45.) Saint Anthony cannot determine whether, for example, the MCO included the appropriate HAP Claims Payment Increases or selected the correct DRG or EAPG grouper or base rate (or other variables). (A18-20; A44-45, 48-50.) HFS also does not inform Saint Anthony if it has been paid—or not paid—the HAP Payment Increases. (A44-45, 48-50.)

The MCOs have an incentive to underpay – they retain funds HFS provides that they do not pay out. Underpayments happen regularly. On occasion MCOs have acknowledged using incorrect payment methods or formulas. For example, even though hospitals were entitled to add-on payments for expensive devices and drugs for certain outpatients, effective on July 1, 2018, *see* 305 ILCS 5/14-12(b)(4), the MCOs were not paying the add-on 1-1/2 years later. HFS only learned when one provider happened to discover it and complained. (A50.)

Saint Anthony and other hospitals repeatedly asked HFS to require more information with remittances. HFS repeatedly refused. (A51-52.) When Saint Anthony raised the issue at a January 2020 meeting, HFS's Medicaid Director stated that HFS would need to discuss the issue with the MCOs. In February 2020, he stated that it was "not possible" for the MCOs to provide an itemization and that the issue was "closed." At his subsequent deposition,[7] he testified that he did not ask the MCOs what it would cost to change their remittances to disclose the payment components. He admitted that his failure to do so could have been wrong. (A51-52.) When Saint Anthony again raised the issue in July 2020, HFS's Deputy Administrator of Medical Programs said HFS would look into it. Shortly thereafter HFS again closed the issue. (A52.) Another HFS deponent admitted at his deposition in 2020 that HFS does not track whether the MCOs accurately pay hospitals the required HAP Claims Payment Increases or other add-on payments. (A49-50.)

[7] Before the district court vacated the discovery cut-off and briefing schedule for Saint Anthony's preliminary injunction motion (R81), depositions of four HFS officials were taken.

Another HFS policymaker said that determining whether Saint Anthony has been properly paid the HAP Payment Increases "is for the hospital to do, not HFS or the MCOs." (A52-53.)

B. Proceedings in the District Court

On April 27, 2020, Saint Anthony filed a two-count complaint against HFS under 42 U.S.C. §1983, seeking to remedy HFS's violations of federal Medicaid laws by failing to require that MCOs timely and accurately pay it. (A1.) Count I alleged that HFS violated Section (a)(37)(A), Section u-2(f), and 42 U.S.C. §1396b(m)(2)(A)(xii) by failing to ensure that MCOs meet the timely payment requirements. Count II alleged that HFS violated Section (a)(8) by failing to ensure that the MCOs furnish "medical assistance," defined as including "payment for" medical services, with "reasonable promptness," as required by the Medicaid law. Both counts sought relief directing HFS to comply with the federal Medicaid laws by ensuring that the MCOs pay claims within the 30/90 day deadlines with transparent remittance forms. (A27-32.)

Saint Anthony moved for a preliminary injunction. (R9.) HFS moved to dismiss the complaint on May 15, 2020. (R16.)

On May 18, 2020, the parties filed a Joint Status Report and Proposed Expedited Discovery Plan. (R20.) They reached partial agreement regarding expedited "limited discovery focused on the issues raised by the Preliminary Injunction Motion, recognizing the pressures the parties are facing with the pandemic and that full-blown merits discovery can be conducted later if the matter does not resolve." (R20:11.)

A week later, the district court entered an expedited discovery and briefing schedule on Saint Anthony's preliminary injunction motion and set a briefing schedule on HFS's motion to dismiss. (R22.)

On June 18, 2021, and in the days that followed, four MCOs (Meridian, IlliniCare, BCBS, and CountyCare) moved to intervene. (R28; R36; R41; R45.)

On June 18, 2020, HFS moved to suspend the preliminary injunction proceedings, including discovery, or, alternatively, to extend the discovery schedule and compel the MCOs to comply with its subpoenas to them. (R43.) Saint Anthony objected. (R50.) On June 29, the case was reassigned to a new judge. (R60.)

On July 15, 2020, the district court granted the MCOs' motions to intervene (R75), over Saint Anthony's objection (R57). Shortly thereafter, the MCOs moved to compel arbitration and stay this lawsuit. (R78-80, 83.) Saint Anthony opposed the motions. (R86.) The court never ruled on the MCOs' motions to compel arbitration, dismissing them as moot when it dismissed the Complaint a year later, on July 9, 2021. (SA2.)

On July 17, 2020, the district court "granted in part" HFS's motion to suspend the preliminary injunction schedule. (R81.) The court ordered HFS and the MCOs to file statements regarding their discovery dispute and vacated the deadline for depositions and briefing related to the preliminary injunction motion, stating that it would reset the schedule after reviewing the submissions. (*Id.*) It did not do so.

From August 11, 2020 to January 26, 2021 the only action in court related to two motions for leave to file supplemental authority. (R94-100.)

On January 26, 2021, Saint Anthony filed its Motion to Supplement under Fed. R. Civ. P. 15(d) to add a single claim against HFS for violation of due process. (A33.) It alleged events occurring after the filing of the Complaint, including those set forth in the 2020 discovery testimony by HFS officials. It sought remittance transparency similar to relief requested in Counts I and II of the Complaint. (A56; A28, 31.) HFS objected and requested 28 days to file a response. Saint Anthony requested 14 days for a reply. (A37.)

The next day, the district court entered a minute order stating that the "court should freely give leave [to file a supplemental complaint] when justice so requires." (SA1.) It gave HFS nine days to respond to Saint Anthony's Motion to Supplement, and denied Saint Anthony's request to file a reply. (*Id.*) After an extension, on February 9, 2021, HFS filed a 22-page opposition, with a declaration and exhibits. (R106.) The district court did not rule until July 2021, when it dismissed the Complaint (on July 9) and denied leave to file the Supplement (on July 13). (SA2-32; SA33-38.) It denied as moot Saint Anthony's preliminary injunction motion and the MCOs' motions to compel arbitration. (SA2.) In the minute entry denying permission to file the Supplement the district court also denied leave to amend the dismissed Complaint because it saw "no avenue for an amended complaint to state a private right of action against the state." (SA33.) Judgment was entered for HFS. (SA39.)

Saint Anthony timely appealed on July 19, 2021. (R112.)

SUMMARY OF ARGUMENT

This case is about prompt and transparent payment to healthcare providers who serve Illinois' neediest patients. Federal law requires prompt payment of Medicaid claims. Due process requires notice of what is paid or not paid. Saint Anthony sued HFS because it gets neither. HFS has the duty and power to remedy that.

Medicaid law requires payment on the 30/90-day schedule. It is an essential right granted to providers and is enforceable by them. The district court ignored three district court opinions so holding. No court of appeals has decided the issue, but Seventh Circuit case law on similar Medicaid provisions upholds private enforcement. The district court erred in denying Saint Anthony the right to sue HFS to enforce prompt payment.

In the hyper-complex world of Medicaid claims, the need for detailed remittance information is obvious. MCOs know how they calculate each remittance. HFS's refusal to require MCOs to "show their work" deprives hospitals of essential information. Case law holds that a party entitled to a governmental payment is entitled to sufficient information to determine whether it has received what is due. Remittances without adequate information violate Due Process, as alleged in the Supplement. The Supplement should have been permitted. Denying permission to file it without permitting the Hospital to brief the issue was serious error.

ARGUMENT

I. The Complaint Stated a Right to Relief.

A. Standard of Review.

Grant of a motion to dismiss is reviewed *de novo*. *Cheli v. Taylorville Cmty. Sch. Dist.*, 986 F.3d 1035, 1038 (7th Cir. 2021).

B. Saint Anthony Has a Right to Sue HFS Under the Medicaid Statute.

Sections u-2(f) and (a)(8) and related provisions support a private right for providers to enforce Medicaid's prompt payment requirements. Plaintiffs "seeking redress for an alleged violation of a statute through a section 1983 action 'must assert the violation of a federal *right*, not merely a violation of federal *law*." *Talevski v. Health & Hosp. Corp. of Marion Cty.*, 6 F.4th 713, 719 (7th Cir. 2021) (quoting *Blessing v. Freestone*, 520 U.S. 329, 340 (1997)) (emphasis in original). "'Three factors help determine whether a federal statute creates private rights enforceable under §1983.'" *Id.* (quoting *Planned Parenthood of Indiana, Inc. v. Comm'r of Indiana State Dep't of Health*, 699 F.3d 962, 972 (7th Cir. 2012)).

> 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. In other words, the provision giving rise to the asserted right must be couched in mandatory, rather than precatory, terms.

Id. (quoting *Blessing*, 520 U.S. at 340-41). It is not enough for plaintiffs to fall "within the general zone of interest that the statute is intended to protect;" rather, the statute

conferring the right must be "phrased in terms of the persons benefited." *Gonzaga University v. Doe*, 536 U.S. 273, 283-84 (2002).

The district court viewed recent Supreme Court decisions and this Court's opinion in *Nasello v. Eagleson*, 977 F.3d 599 (7th Cir. 2020), as foreclosing private rights of action under the Medicaid statute. (SA16 ("[T]he *Wilder* approach to section 1983 seems to have reached the end of the line."); SA17-18 ("The Court of Appeals [in *Nasello*] noted the steady flow of cases from the Supreme Court finding no private right of action under Spending Clause legislation.").) This conflicts with this Court's recent *Talevski* decision expressly rejecting the idea that *Nasello* "indicates an unwillingness to find enforceable private rights in a statute passed pursuant to Congress's powers under the Spending Clause." *Talevski*, 6 F.4th at 723. Rather, while the Supreme Court has not recognized a new private right under Medicaid after *Wilder v. Virginia Hospital Association*, 496 U.S. 498 (1990), it has never disapproved of *Wilder*, and has reiterated that private rights *can* exist if the statute reflects "the necessary rights-creating language to support a private right of action." *Talevski*, 6 F.4th at 725; *accord Planned Parenthood*, 699 F.3d at 976 ("[T]he Supreme Court's recent statutory-right-of-action cases 'do not stand for a broad rule that spending power statutes can never be enforced by private actions' under §1983." (quoting *Indiana Prot. & Advoc. Servs. v. Indiana Fam. & Soc. Servs. Admin.*, 603 F.3d 365, 378 (7th Cir. 2010) (en banc))).

Blessing remains good law. Under it, Saint Anthony has the right to sue to enforce prompt payment required by the Medicaid statute.

1. Saint Anthony Has a Right of Action Under Section u-2(f).

No court of appeals has decided whether a private right of action exists under Section u-2(f). But the three district courts to consider it all agree that Section u-2(f) meets the *Blessing* factors: *Appalachian Reg'l Healthcare v. Coventry Health & Life Ins. Co.*, 970 F. Supp. 2d 687, 699 (E.D. Ky. 2013); *Medevac MidAtlantic, LLC v. Keystone Mercy Health Plan*, 817 F. Supp. 2d 515, 526 (E.D. Pa. 2011); and *Nat'l Med. Care, Inc. v. Rullan*, No. Civ. 04-1812(HL), 2005 WL 2878094, at *8 (D.P.R. Nov. 1, 2005). Two held that providers have a private right of action to enforce Section u-2(f) against state agencies; the third concluded that "if procedures were so inadequate that the state was not hitting the benchmarks for timely payment, individual (or groups of) providers may have enforceable rights to ensure compliance with the benchmark." *Medevac*, 817 F. Supp. 2d. at 526. Only the district court in this case concluded that Section u-2(f) cannot be privately enforced. It did not acknowledge or distinguish the three cases to the contrary.

As shown next, Section u-2(f) satisfies the *Blessing* criteria.

a. "Health Care Providers" Are the Intended Beneficiaries of Section u-2(f).

This Court and the Supreme Court have repeatedly emphasized that "for a statute to create private rights, its text must be phrased in terms of the persons benefited." *Gonzaga*, 536 U.S. at 274 (cleaned up). *See also*, *e.g.*, *Cannon v. Univ. of Chicago*, 441 U.S. 677, 690 n.13 (1979) ("With the exception of one case, in which the relevant statute reflected a special policy against judicial interference, this Court has never refused to imply a cause of action where the language of the statute explicitly

conferred a right directly on a class of persons that included the plaintiff in the case." (listing cases)); *Talevski*, 6 F.4th at 718 (quoting *Gonzaga* and citing *Cannon*). Here, the statute, applicable case law, and legislative history all confirm that "health care providers" like Saint Anthony are the intended beneficiaries of Section u-2(f).

i. The Statute Is Clear that "Health Care Providers" Are Intended Beneficiaries of Section u-2(f).

Section u-2(f) is clear that "health care providers" are its intended beneficiaries. Entitled "Timeliness of Payment," it states terms under which a State contracts with MCOs to administer Medicaid benefits. It requires that any State contract with an MCO

> *shall* provide that the organization *shall make payment to health care providers* for items and services which are subject to the contract and that are furnished to individuals eligible for medical assistance under the State plan under this subchapter who are enrolled with the organization *on a timely basis consistent with the claims payment procedures described in section 1396a(a)(37)(A)* of this title, unless the health care provider and the organization agree to an alternate payment schedule . . . .

42 U.S.C. §1396u-2(f).

Section (a)(37)(A) requires that a State plan have procedures that

> *ensure* that *90 per centum of claims* for payment (for which no further written information or substantiation is required in order to make payment) made 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 . . . .

Section u-2(f) requires states to "ensure" that MCOs pay providers "on a timely basis" in accordance with the procedures of Section (37)(A), which states the 30/90-day requirement.

Congress identified "Timeliness of Payment" as the central purpose of Section u-2(f) in its title. It expressly identified "health care providers" as entitled to timely payments. Section u-2(f) is exactly the type of provision "phrased in terms of the persons benefited," *Gonzaga*, 536 U.S. at 283-84, that this Court and the Supreme Court have found is privately enforceable.

In *Wilder*, the Supreme Court considered 42 U.S.C. 1396a(a)(13)(A). At the time, it required a state Medicaid plan to provide for "payment . . . of the hospital services . . . provided under the plan." 496 U.S. at 502-03. The Court found the language "payment . . . of the hospital services" to be "phrased in terms benefiting health care providers" and, thus, privately enforceable. *Id.* at 510. Section u-2(f)'s phrasing ("payment to health care providers") is nearly identical. It even more clearly identifies "health care providers" as the intended beneficiary.[8]

This Court's quartet of decisions finding privately enforceable rights in the Medicaid statute supports the view that Section u-2(f) is intended to benefit "health care providers." *Bontrager v. Indiana Family and Social Services Administration*,

[8] Although abrogated by statute, *Wilder* has never been overruled. *See, e.g., Talevski*, 6 F.4th at 725 ("[T]he Court has never disapproved *Wilder*."); *BT Bourbonnais Care*, 866 F.3d 815 (7th Cir. 2017) ("[E]ven though the Supreme Court has never overruled its decision in *Wilder*, that decision addressed a version of the statute that is now history."); *Bontrager*, 697 F.3d at 607 ("*Wilder* has not been overruled.").

697 F.3d 604, 606-07 (7th Cir. 2012), held that Section 1396a(a)(10)'s requirement that a state plan "provide . . . for making medical assistance available . . . to all [eligible] individuals" supported a private right of action. *Bontrager* found persuasive *Watson v. Weeks*, 436 F.3d 1152, 1160-61 (9th Cir. 2006). It found statutory language making assistance available "to all individuals" "is unmistakably focused on the specific individuals benefited." Section u-2(f) contains similar language, requiring timely payments "to health care providers."

Planned Parenthood of Indiana, Inc. v. Commissioner of Indiana State Department of Health, 699 F.3d 962, 973-77 (7th Cir. 2012), held that the requirement that a State's plan provide that "any individual eligible for medical assistance . . . may obtain such assistance from any [qualified provider]," supports a private right of action: "Medicaid patients are the obvious intended beneficiaries of the statute; it states that any Medicaid-eligible person may obtain medical assistance from any institution, agency, or person qualified to perform that service." *Id*. at 974. The Court held that the statute is "unmistakably 'phrased in terms of the persons benefited.'" *Id*. (quoting *Gonzaga*, at 287, 284). Section u-2(f) "unmistakably" identifies its beneficiary as "health care providers."

BT Bourbonnais Care, LLC v. Norwood, 866 F.3d 815 (7th Cir. 2017), focused on Section 1396a(a)(13)(A)'s requirement that a State plan "provide for a public process for determination of rates . . . under which . . . providers . . . are given a reasonable opportunity for review and comment." This Court was "confident that" the statute was intended to benefit the nursing-home-operator plaintiffs who sought

to enforce it, asking: "Who else would have a greater interest than the Operators in the process 'for determination of rates of payment under the [state] plan for … nursing facility services'?" 866 F.3d at 821. Likewise, for Section u-2(f), who would have a greater interest in payments being timely made to "health care providers" than the health care providers? *Bourbonnais* found that the statutory language expressly gave a right to comment to "providers," including nursing home operators. This meant private enforcement. *Id.* Section u-2(f) also expressly identifies the beneficiary of the timely payments: "health care providers."

Talevski held that nursing home residents have the right to enforce Sections 1396r(c)(1)(A)(ii) and 1396r(c)(2)(A). 6 F.4th at 720. These provisions require that nursing home facilities "protect and promote the rights of each resident, including . . . [t]he right to be free from physical or mental abuse . . . ." and that such facilities "permit each resident to remain in the facility . . . unless [specified conditions are met]." The result: "nursing-home residents are the expressly identified beneficiaries." *Talevski*, 6 F.4th at 718. Section u-2(f) similarly expressly identifies its beneficiaries as "health care providers."

Another provision, 42 U.S.C. §1396u-2(h)(2)(B), confirms that Congress intended Section u-2(f) to benefit "providers." After Section u-2(f) was enacted, Congress added §1396u-2(h)(2)(B) to set special rules for Indian Medicaid enrollees, providers, and MCOs. Congress included a prompt payment provision that incorporated Section u-2(f). Congress expressly referred to Section u-2(f) as the "rule

for prompt payment of providers." *Id.* Congress could not have been clearer that Section u-2(f) is provider-focused.

ii. Legislative History Confirms "Health Care Providers" Are the Intended Beneficiaries of Section u-2(f).

Section u-2 is clear on its face that it benefits providers. Legislative history confirms that conclusion. Section u-2 (also referred to as Section 1932 of the Social Security Act) was enacted as part of the Balanced Budget Act of 1997, Pub. L. No. 105-33, §4708(c), 111 Stat. 251, 506.[9] As proposed by the House, it did not include what would become Section u-2(f). *See* H.R. Rep. No. 105-217 at 866 (1997) (Conf. Rep.) (no provision for "Timeliness of Payment" in House bill). The Senate proposed an amendment for "Timeliness of Payment." It was adopted by conference agreement and is described in the report as follows: "Requires managed care organizations to pay affiliated providers in a timely manner for items and services provided to Medicaid beneficiaries." *Id.* The Senate amendment stated:

> Sec. 1946. PROTECTION FOR PROVIDERS.
>
> (a) Timeliness of Payment.—A medicaid managed care organization shall make payment to health care providers for items and services which are subject to the contract under section 1941(a)(1)(B) and which are furnished to individuals eligible for medical assistance under the State plan under this title who are enrolled with the entity on a timely basis consistent with section 1943 and under the claims payment procedures described in section 1902(a)(37)(A), unless the health care provider and the managed care entity agree to an alternate payment schedule.

---

9 *Available at* https://www.congress.gov/105/plaws/publ33/PLAW-105publ33.pdf.

S. 947, 105th Cong. §1946(a) (1997).[10] Section u-2(f) was enacted through Section 4708(c) of the Balanced Budget Act of 1997. It stated:

> (c) ASSURING TIMELINESS OF PROVIDER PAYMENTS — Section 1932 is further amended by adding at the end the following:
>
> "(f) TIMELINESS OF PAYMENT.—A contract under section 1903(m) with a medicaid managed care organization shall provide that the organization shall make payment to health care providers for items and services which are subject to the contract and that are furnished to individuals eligible for medical assistance under the State plan under this title who are enrolled with the organization on a timely basis consistent with the claims payment procedures described in section 1902(a)(37)(A), unless the health care provider and the organization agree to an alternate payment schedule."

Pub. L. No. 105-33, §4708(c), 111 Stat. 251, 506.

This history could not be more explicit that providers are the intended beneficiaries. Congress focused on "providers" being paid on time, in capital letters. The Senate amendment was entitled "PROTECTION FOR PROVIDERS." It required "timely payment" to "health care providers." The Conference report described this provision as requiring MCOs "to pay affiliated providers in a timely manner." The section creating Section u-2(f) is entitled "ASSURING TIMELINESS OF PROVIDER PAYMENTS." The final text of Section u-2(f) requires "health care providers" to be paid "on a timely basis." Congress was clear: "Health care providers" are the intended beneficiary of Section u-2(f).

---

[10] *Available at* https://www.congress.gov/105/bills/s947/BILLS-105s947pcs.pdf at 723.

iii. The District Court Was Wrong.

The district court read Section u-2(f) as creating an "entitlement" to providers, but not as giving them "an enforceable right" because providers are merely "within the 'general zone of interest'" of the statute, not its intended beneficiary. (SA20 (quoting *Gonzaga*, 536 U.S. at 283).) That is contrary to the statute, and to the "general zone of interest" concept. As *Gonzaga,* 536 U.S. at 284, requires, Section u-2(f) is "phrased in terms of the persons benefited": MCOs "shall make payment *to health care providers* . . . on a timely basis . . . ." 42 U.S.C. §1396u-2(f). Saint Anthony is not seeking to enforce a statute that does not refer to providers, as was the case in *Gonzaga*. "Health care providers" is squarely in the text.

The district court, in effect, rewrote Section u-2(f) by excluding the key phrase "to health care providers." It described the Section as requiring only that:

> A "contract" with MCOs "shall provide" that the MCOs "shall make payment" on a "timely basis consistent with the claims payment procedures described in section 1396a(a)(37)(A)." *See* 42 U.S.C. §1396u-2(f).

(SA20.) A court may not excise relevant statutory language.

The district court added that the "procedures" of Section (a)(37)(A) setting the schedule for Section u-2(f)'s "timely" "payment" to "health care providers" do not create a right for providers because Section (a)(37)(A) does not refer to "providers." (SA21.)

But Section u-2(f) does exactly that. In the phrase the court excised. Section (a)(37)(A) supplies the schedule, and Section u-2(f) requires that "health care

providers" be paid "in a timely manner" "consistent with" that schedule. By ignoring the words "health care providers" in Section u-2(f), the district court plainly erred.[11]

The district court read Section u-2(f) as prescribing only the content of State-MCO contracts, not as requiring timely payment to health care providers. But the statute itself is titled "Timeliness of Payment." It expressly requires timely payment "to health care providers." Other parts of the statute even describe it as the "rule for prompt payment of providers." 42 U.S.C. §1396u-2(h)(2)(B). The only content it requires to be included in State-MCO contracts directs that "health care providers" be paid on time.

The district court's reasoning echoes an argument rejected in *Talevski*: that a statute directing nursing homes to protect rights of residents is only a directive to the facilities, and does not confer benefit upon the residents. 6 F.4th at 718. *Talevski* held otherwise: "It is thus of no consequence that section 1396r(c)(1)(A) begins with the phrase '[a] nursing facility must … .' What must it do? '[P]rotect and promote the rights of each resident … .'" *Id*. It matters not that Section u-2(f) directs the state

[11] Section (a)(37)(A) refers to payment of claims submitted by "practitioners." The federal agency responsible for administering Medicaid has repeatedly stated that Section u-2(f) applies the payment deadlines for "practitioners" to "providers" paid through MCOs. *See* 63 Fed. Reg. 52,022, 52,06364 (Sept. 29, 1998), *available at* https://www.govinfo.gov/content/pkg/FR-1998-09-29/pdf/98-26068.pdf; 66 Fed. Reg. 43,614, 43,643-44 (Aug. 20, 2001), *available at* https://www.federalregister.gov/documents/2001/08/20/01-20715/medicaid-program-medicaid-managed-care; 67 Fed. Reg. 40,989, 41,075 (June 14, 2002), *available at* https://www.federalregister.gov/documents/2002/06/14/02-14747/medicaid-program-medicaid-managed-care-new-provisions.

to include contract provisions in state-MCO contracts. Why? To assure "payment to health care providers … on a timely basis."

The district court stated that Saint Anthony "is not claiming that the contracts between the state of Illinois and MCOs are missing provisions required by the statute," but instead that "it has a right to prompt payment." (SA20-21.) But including a prompt payment provision in the State's contracts with MCOs – but not enforcing it – fails the statutory requirement that the State "ensure" timely payment by MCOs. Section (a)(37)(A) requires procedures that "*ensure* that 90 per centum of claims . . . 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." Congress used the word "ensure." HFS's contracts with MCOs fail to "ensure" timely payment because HFS is not requiring timely payments to happen.[12]

The district court stated that that Section u-2(f) "requires the state to include certain provisions in its contracts with MCOs" but "does not require the state to enforce those provisions, or otherwise ensure that MCOs pay providers promptly." (SA20.) That is wrong. Provisions that do not "ensure" prompt payment by definition violate Sections (a)(37)(A) and u-2(f). This is confirmed by another section, 42 U.S.C. §1396b(m)(2)(A)(xii). It explicitly requires as a condition for Illinois to receive federal funding that MCOs *actually comply* with the requirements of Section u-2, including

[12] Saint Anthony made this point in the district court. (R26:29 ("Whether timely payments are 'ensured' is measured by the dates actual payments are made, not the existence of unenforced or ineffective state 'procedures.' State policies, procedures and statutes that fail to deliver the required payments on time violate federal law.").)

the prompt payment requirements of Section u-2(f). Section 1396b(m)(2)(A)(xii) requires the contract language *and compliance* for the State to get federal Medicaid funds. It requires that "such contract, *and the entity* complies with the applicable requirements of section 1396u-2 of this title. . ." The "contract" is the contract between the State and the MCOs. The "entity" required to comply with Section u-2 is the MCO. A State that does not enforce its MCO contracts violates that law.

The district court stated that because the federal government could withhold funds there is no private right of action. (SA31 ("The typical remedy for violating the terms of Spending Clause legislation is no more spending.").) This Court has held otherwise: "[P]ower to shut off all or part of a state's funding is not a 'comprehensive enforcement scheme'" that forecloses private enforcement. *Planned Parenthood of Indiana, Inc.*, 699 F.3d at 974-75; *see also id.* at 975 ("[T]he Medicaid Act's 'administrative scheme cannot be considered sufficiently comprehensive to demonstrate a congressional intent to withdraw the private remedy of §1983.'" (quoting *Wilder*, 496 U.S. at 522).) In Section1396b(m)(2)(A)(xii), Congress expressly stated that complying with Section u-2(f) on paper, but not in the real world, is not enough. States must ensure that prompt payment actually happens.

The district court stated that Section u-2(f) creates an "aggregate plan requirement" but not a "personal right" in each provider. (SA21.) HFS argued (R24:25), and the district court found, that Congress merely intended that all MCOs, collectively, pay 90% of all claims to all providers within 30 days, and 99% within 90 days. Under this interpretation, if payments were timely to 75 hospitals and

untimely to 25 hospitals, the 25 late-paid hospitals would have no recourse so long as all the payments, aggregated, met the prompt payment metric. This misreads Section u-2(f) and misapplies the reference to "aggregate" results in *Blessing*, 520 U.S. at 343, and *Gonzaga*, 536 U.S. at 288.

Section u-2(f) refutes the "aggregate" interpretation. It provides an exception to the prompt payment requirement if "*the* health care provider and *the* organization agree to an alternate payment schedule." This exception is on a provider-by-provider and MCO-by-MCO basis. It makes no sense if the requirement were aggregate.

Neither *Blessing* nor *Gonzaga* supports the "aggregate" interpretation of Section u-2(f). In both, plaintiffs sought to enforce statutory provisions that did not directly benefit them, but that did create aggregate, system-wide performance rights. In that context, the Court addressed aggregate performance.

In *Blessing*, five mothers sought to force Arizona to substantially comply with the entirety of Title IV-D of the Social Security Act, 42 U.S.C. §§651-669b. 520 U.S. at 332. "[S]ubstantial compliance" was a regulatory standard created to determine whether the federal oversight agency should impose sanctions on a state for noncompliance. *Id*. at 343-44. The Court described the "substantial compliance" concept as an "aggregate" yardstick intended to measure systemwide performance where the plaintiff otherwise had no statutory claim. It held that the statute did not confer any private right of action. *Id*. The plaintiffs in *Blessing* did not identify any specific provision within Title IV-D that they contended created rights specific to them. *Id*.

Gonzaga is much the same. A student sued a university for disclosing personal information. 536 U.S. at 277. A statute prohibited federal funding of institutions with "a policy or practice of permitting the release" of protected information. *Id.* at 279 (quoting 20 U.S.C. §1232g(b)(1)). The Secretary of Education could terminate funding if a school "is failing to comply substantially" with the statute. *Id.* at 279. The law prohibited a "policy or practice" of disclosure and only required that schools "comply substantially." *Id.* The Court concluded that the statute had an "aggregate" focus on compliance and did not confer individual rights to sue for violations. *Id.* at 288.

Section u-2(f) specifically refers to "health care providers" being paid on time, and its exception confirms it is focused on individual providers. Sections u-2(f) and (a)(37)(A) say nothing about averages across all providers. HFS is not permitted by statute merely to comply substantially with the timely payment requirement.

The aggregate reading ignores the stated purpose of Section (a)(37)(A) – to encourage individual physicians to participate in Medicaid by promising prompt payment. A "primary consideration underlying the passage of the legislation" that enacted Section (a)(37)(A) was that payment delay "discourages participation by physicians." 44 Fed. Reg. 30,341, 30,342 (1979).[13] Section u-2(f) adopts the same principle for hospitals and other providers paid through an MCO.

[13] *See also* S. Rep. No. 95-453, at 7 (1977) ("The committee has received testimony indicating that undue delay in medicaid claims payments . . . discourages physicians from participating in the program."); 44 Fed. Reg. at 30,341 (Section (a)(37)(A) was intended to "increase provider participation in Medicaid").

Citing nothing, the district court concluded that "Congress decided that providers would enter into contracts with MCOs, and that the contracts would carry the load." (SA23.) But the statute says nothing like that. It does not reflect any "decision" by Congress precluding health care providers from privately enforcing statutory rights, forcing them instead to redress a state's failure to comply with federal law by suing third-party MCOs. The district court conflated Saint Anthony's statutory rights against HFS with its contractual rights against MCOs. These are different rights, arising from different sources, involving different parties. Whether Saint Anthony has the right to enforce Section u-2(f) against the State depends on what the statute says, measured under *Blessing*, not whether Saint Anthony has a different or additional remedy against MCOs by individual contracts.

A private right under *Blessing* is presumptively enforceable via 42 U.S.C. §1983, and the presumption is only overcome "by 'showing that Congress specifically foreclosed a remedy under §1983 . . . expressly, through specific evidence from the statute itself, or impliedly, by creating a comprehensive enforcement scheme that is incompatible with individual enforcement under §1983.'" *Talevski*, F.4th at 720 (quoting *Gonzaga*, 536 U.S. at 284 n.4). Nothing in Section u-2(f) overcomes the presumption of enforceability. Nothing expressly forecloses private enforcement or creates a comprehensive enforcement scheme. Nothing in the statute suggests that the exclusive remedy is to bring arbitration claims against MCOs under the hospital-MCO contracts. Indeed, the Medicaid law does not even mention arbitration rights of providers vis-à-vis MCOs.

Nor could separate arbitrations with individual MCOs address the systemic problems Saint Anthony describes. Arbitration with an MCO cannot join or bind the other MCOs or HFS. The arbitrator cannot require HFS and other MCOs to adopt procedures that ensure timely payment. Nor can an arbitrator impose a uniform remittance disclosure policy on all MCOs. Only HFS can adopt, and compel the MCOs to adopt, policies and procedures that ensure timely payment and disclosure of necessary information to providers.[14]

The district court cited *Minerva Surgical, Inc. v. Hologic, Inc.*, 141 S. Ct. 2298, 2307 (2021), and *Astoria Federal Savings & Loan Association v. Solimino*, 501 U.S. 104, 108 (1991), for the proposition that "Congress legislates against the backdrop of the common law, and undoubtedly knew that contractual rights could give rise to breach-of-contract claims." (SA23.) The cited cases make a different point that is irrelevant in the present context: Congress does not intend to *limit common-law* rights unless it says so explicitly. *Minerva Surgical*, 141 S. Ct. at 2307 ("Congress gave no indication of wanting to terminate [patent assignor estoppel] or disturb its development"); *Astoria*, 501 U.S. at 108 (common-law preclusion principles are understood to apply unless Congress says otherwise). That principle has no application, since Congress said nothing about common law rights of providers.

[14] One MCO initiated an arbitration against Saint Anthony in 2020, based on the allegations of the Complaint. The arbitrator stayed proceedings because the MCO failed to comply with pre-arbitration dispute resolution requirements. The MCO never moved to lift the stay. (R96-97.) The arbitration could not, in any case, have addressed the systemic issues described in the Complaint.

b. The 30/90-Day Payment Schedule Is Specific.

The district court acknowledged satisfaction of the second *Blessing* factor: the 30/90-day payment schedule "is not vague or amorphous" and "would not strain 'judicial competence.'" (SA24.) (quoting *Blessing*, 520 U.S. at 340-41). The district court stated that "if the statute hypothetically *did* entitle providers to receive a certain percentage of payment by a certain period of time, courts could use that yardstick to measure compliance." (*Id.*) (emphasis in original). Paying 90% of claims within 30 days and 99% within 90 days states a clear rule that is judicially administrable.

c. The Statute Imposes a Binding Obligation.

The district court acknowledged that the third *Blessing* factor is satisfied: Section u-2(f) and Section (a)(37)(A) "contain mandatory language, as exemplified by the use of the words 'shall' and 'must.'" (SA25.) Yet the district court concluded that the mandatory language only mandated inclusion of certain language in HFS-MCO contracts. (*Id.*) That is wrong for the reasons discussed above at 28-29.

d. All Other Courts that Have Considered the Issue Have Found that Section u-2(f) Satisfies *Blessing*.

Three other district court opinions address claims by health care providers against state agencies under Section u-2(f). All conflict with the district court's conclusion. *See Appalachian Regional*, 970 F. Supp. 2d at 699; *Medevac*, 817 F. Supp. 2d at 526; *Nat'l Med. Care*, 2005 WL 2878094, at *8. Although these decisions are not controlling, it is noteworthy that the district court chose not to discuss them, especially in the absence of any circuit court precedent regarding Section u-2(f).

All three cases agree that Section u-2(f) meets the *Blessing* factors to create a private right of action. *Appalachian Regional*, 970 F. Supp. 2d at 699 ("Accordingly, all of the requirements of *Blessing* and *Gonzaga* are met in the present case, and health care providers have a cause of action to pursue their federal claims."); *Nat'l Med. Care*, 2005 WL 2878094, at *8 ("Accordingly, the Court concludes that section 1983 provides plaintiffs, health care providers, with a cause of action to pursue their claims under section 1396a(a)(37) and section 1396u-2f."); *Medevac*, 817 F. Supp. 2d at 524 ("Thus, facially, the provisions use rights-creating language and therefore appear to confer an enforceable individual right to timely payment on healthcare providers.").

Regarding the first *Blessing* factor, *Appalachian Regional* stated:

> [T]he beneficiaries of [Section u-2(f) and Section (a)(37)(A)] are expressly named as "health care practitioners" and "health care providers." Medicaid recipients are not obligated to pay providers for their care, except a possible co-pay or deductible. Prompt payment requirements certainly do not benefit the MCO, which would prefer to keep its money instead of paying it to a provider. Each provider of services would benefit so long as the claim does not require further written information or substantiation.

970 F. Supp. 2d at 699. *Medevac* agreed:

> [T]he provisions providing for timely payment to providers appear intended to benefit providers. Such a provision would not benefit eligible Medicaid recipients because Medicaid recipients, in most cases, are not obligated to pay the provider directly; failure to timely pay providers would not impose payment liability on them. Moreover, timely payment by MCOs would not necessarily benefit the state or MCOs against whom the requirement is imposed. And though, arguably, such a provision benefits the Medicaid program as a whole by ensuring providers are not discouraged from participating in the state's plan, the direct benefit to providers is unmistakable.

817 F. Supp. 2d at 523-24. *See also Nat'l Med. Care*, 2005 WL 2878094, at *8 (holding that Section u-2(f) and (37)(A) identify "a discrete class of beneficiaries").

Appalachian Regional and *National Medical Care* hold that providers have a private right of action to enforce Section u-2(f). *Medevac* holds that Section u-2(f) meets all the *Blessing* factors, but incorrectly interpreted Section (a)(37)(A) to require payment of 90% and 99% of claims in the "aggregate." 817 F. Supp. 2d at 524. It did so without explaining why. *Id*. at 524-25. Even *Medevac* acknowledged that "if procedures were so inadequate that the state was not hitting the benchmarks for timely payment, individual (or groups of) providers may have enforceable rights to ensure compliance with the benchmark." *Id*. at 526. Saint Anthony alleged both that it is not being paid as required and that the problem is statewide. (A10, A16-17, A23-24 (¶¶30, 50-51, 72-73) (not being paid); A3, A10, A12, A15, A25 (¶¶6, 30, 36, 43, 76) (problem is statewide).) Thus, Saint Anthony would have the right to sue even under the rule as stated in *Medevac*.

Appalachian Regional considered and rejected *Medevac*'s conclusion that Section u-2(f) applies an aggregate test. 970 F. Supp. 2d at 700. It criticized *Medevac*'s analysis for disregarding express statutory language, chiding the opinion as stating that "[i]n other words, the statute does not mean what it so plainly says." *Id*. It stated that *Medevac* ignored Section u-2(f)'s exception where "the health care provider and the [MCO] agree to an alternate payment schedule," which *Appalachian Regional* found to be "provider specific" and to "further demonstrat[e] that the general rule is intended to benefit individual providers." *Id*. *Appalachian Regional* is the

better-reasoned opinion. It is consistent with the Senate and agency statements, cited above, that Section (a)(37)(A) was intended as an inducement to individual providers.

2. Saint Anthony Has the Right to Sue Under Section (a)(8).

Saint Anthony is also entitled to enforce timely payment under Section (a)(8). It requires a state Medicaid plan to "provide that … medical assistance … shall be furnished with reasonable promptness to all eligible individuals." 42 U.S.C. §1396a(a)(8). "Medical assistance" is defined as including both "care and services" and "*payment* of part or all of the cost of . . . care and services." 42 U.S.C. §1396d(a). This Court found that Section (a)(8) supports a private right of action by Medicaid recipients in *O.B. v. Norwood*, 838 F.3d 837, 840 (7th Cir. 2016). It affirmed a preliminary injunction in favor of plaintiffs suing to enforce Section (a)(8)). *Id.* Other courts agree. *See, e.g.*, *Romano v. Greenstein*, 721 F.3d 373, 379 (5th Cir. 2013); *Doe v. Kidd*, 419 F. App'x 411, 416 (4th Cir. 2011), *reaff'g* 501 F.3d 348, 356-57 (4th Cir. 2007); *Sabree v. Richman*, 367 F.3d 180, 183 (3d Cir. 2004); *Bryson v. Shumway*, 308 F.3d 79, 89 (1st Cir. 2002); *Koss v. Norwood*, 395 F. Supp. 3d 897, 908-09 (N.D. Ill. 2018); *Doctors Nursing & Rehab. Ctr., LLC v. Norwood*, No. 1:16-CV-9836, 2017 WL 2461544, at *5-6 (N.D. Ill. June 7, 2017). No appellate decision is to the contrary.

These cases – none of which the district court acknowledged – hold that Medicaid beneficiaries can enforce the right to the "care and services" required by Section (a)(8). Under these cases, Section (a)(8)'s requirement of "reasonably prompt[]" "medical assistance" has been held to be sufficiently specific and mandatory

(*Blessing* factors 2 and 3). Therefore, the only *Blessing* issue presented by this case is whether a provider like Saint Anthony is the intended beneficiary (factor 1) of the right to prompt payment.

BT Bourbonnais provides the answer. 866 F.3d at 821. It found a provision dealing with the rate-setting process for nursing homes to be privately enforceable by nursing-home operators. The Court asked: "Who else would have a greater interest than the Operators in the process 'for determination of rates of payment under the [state] plan for … nursing facility services'*?" Id.* at 821. The same analysis applies to the "reasonabl[y] prompt[ ]" "payment" language of Section (a)(8). Paying promptly does not benefit the State or MCOs. It does not directly benefit Medicaid patients. They have some interest in seeing that providers are paid, but no interest in when. They are entitled to medical care without advance payment or personal liability.[15] Providers are plainly the primary beneficiary of prompt payment.

The district court focused on the word "individuals" in Section (a)(8) to preclude any benefit to anyone other than individual Medicaid recipients. (SA26-27.) That renders meaningless much of Section (a)(8). *See Liu v. SEC*, 140 S. Ct. 1936, 1948 (2020) (A "cardinal principle of interpretation [is] that courts must give effect, if

[15] *See Appalachian Regional*, 970 F. Supp. 2d at 699 ("Medicaid recipients are not obligated to pay providers for their care, except a possible co-pay or deductible."); *Medevac*, 817 F. Supp. 2d at 523 ("Such a provision would not benefit eligible Medicaid recipients because Medicaid recipients, in most cases, are not obligated to pay the provider directly; failure to timely pay providers would not impose payment liability on them.").

possible, to every clause and word of a statute." (quoting *Parker Drilling Mgmt. Servs., Ltd. v. Newton*, 139 S. Ct. 1881, 1890 (2019))).

"Individuals" in Section (a)(8) is not defined. *Black's Law Dictionary* (11th ed. 2019) defines "individual" as "[o]f, or relating to, or involving a single person or thing, as opposed to a group." Thus, it is not automatically limited to Medicaid beneficiaries. Section (a)(8) requires "medical assistance" to be provided promptly to "eligible" individuals. 42 U.S.C. §1396a(a)(8). "Medical assistance" is defined to include payment. Medicaid beneficiaries are not "eligible" to receive payment. Only hospitals and other providers are. Thus, the only interpretation of the reasonable promptness language in Section (a)(8) and the definition of "medical assistance" in Section 1396d(a) that gives effect to all the language is that providers are entitled to prompt payment. *See Wilder*, 496 U.S. at 514 (rejecting interpretation "render[ing] [one of] the statutory requirements . . . essentially meaningless").

Applied to providers, Section (a)(8) is not "so 'vague and amorphous' that its enforcement would strain judicial competence." *Blessing*, 520 U.S. at 340-41. The district court concluded otherwise, reasoning that it "does not set any standards for what is 'reasonable,' and what is 'prompt[ ].'" (SA28.) This went beyond HFS's motion to dismiss, which never argued Section (a)(8) was "vague and amorphous" (R24:22-23). In doing so the district court went awry of *O.B. v. Norwood*, in which this Court affirmed a district court ruling granting a preliminary injunction based on reading Section (a)(8) to require HFS to "take prompt measures to obtain home nursing for class members" as a "reasonably clear directive." 383 F.3d at 840. *See also Wilder*,

496 U.S. at 519-20 (statute requiring "reasonable and adequate" Medicaid reimbursement rates was privately enforceable and not too "vague and amorphous"). Neighboring Section (a)(37)(A) and its regulations supply a specific measure of reasonable promptness: the 30/90-day rule, as held in *Doctors Nursing and Rehabilitation Center, LLC v. Norwood*, No. 1:16-cv-9837, 2017 WL 3838031, at *5 & n.15 (N.D. Ill. Sep. 1, 2017) (Section (a)(8)'s "reasonable promptness" provision requires payment according to the "timely payment" requirements in Section (a)(37)(A) and its regulations). *See also Edelman v. Jordan*, 415 U.S. 651, 659, n.8 (1974) ("reasonable promptness" of statutory benefits can be measured by timelines in regulations).

Section (a)(8) is "couched in mandatory, rather than precatory, terms" – as the district court acknowledged. *Blessing*, 520 U.S. at 340-41; (SA16.) Thus, the third *Blessing* factor is met.

The district court's conclusion that Section (a)(8) merely "sets requirements for a state's Medicaid plan" and cannot "create direct private rights" is wrong. (SA26.) So is its alternative ruling that the statutory requirements were met when HFS included them in its contracts with MCOs. (SA29.) It is wrong because every provision of 42 U.S.C. §1396a(a) "sets requirements for a state's Medicaid plan." If the district court were right that it *only* dictates plan requirements, decades of Medicaid private-right cases would be thrown out, including *Wilder*, *Bontrager*, *Planned Parenthood*, and *Bourbonnais*. All found various provisions required in state plans also created privately enforceable rights. Indeed, Section 1320a-2 confirms

that a Medicaid provision "is not to be deemed unenforceable because of its inclusion in a section. . . . specifying the required contents of a State plan." 42 U.S.C. §1320a-2.

This Court so held in *Planned Parenthood of Indiana.*, 699 F.3d at 976 n.9 ("[T]he mere fact that an obligation is couched in a requirement that the State file a plan is not itself sufficient grounds for finding the obligation unenforceable under §1983." (quoting *Harris v. James*, 127 F.3d 993, 1003 (11th Cir. 1997))). Section (a)(8) meets all the *Blessing* factors. Saint Anthony has the right to enforce it.

II. Saint Anthony Should Have Been Permitted to Supplement Its Complaint.

The district court erred by denying Saint Anthony's motion to file the Supplement. Contrary to the State's arguments, to which the Court did not allow Saint Anthony a response, the Supplement stated a claim for relief, and there was no undue prejudice to the State or other reason justifying denial of leave under Rule 15's liberal approach to amending pleadings.

A. Standard of Review.

Courts "should freely give leave [to amend pleadings] when justice so requires." Fed. R. Civ. P. 15(a)(2). "[T]his mandate is to be heeded." *Foman v. Davis*, 371 U.S. 178, 182 (1962); *see also Runnion ex rel. Runnion v. Girl Scouts of Greater Chicago*, 786 F.3d 510, 519 (7th Cir. 2015) (although denials of leave to amend are generally reviewed for abuse of discretion, when a district court denies an opportunity to amend after dismissing complaint "its decision will be reviewed rigorously on appeal"). The same standard applies to a motion supplement under Rule 15(d). *Glatt v. Chicago*

Park Dist., 87 F.3d 190, 194 (7th Cir. 1996). "Unless it is *certain* from the face of the complaint that any amendment would be futile or otherwise unwarranted, the district court should grant leave to amend after granting a motion to dismiss." *Runnion*, 786 F.3d at 520. Denying leave to amend requires a "justifying reason" such as "undue delay, bad faith or dilatory motive on the part of the movant, repeated failure to cure deficiencies by amendments previously allowed, undue prejudice to the opposing party by virtue of allowance of the amendment, futility of amendment." *Foman*, 371 U.S. at 182. All are absent here.

B. The District Court Provided No "Justifying Reason."

In denying the Motion to Supplement, the court did not cite any of the recognized reasons that are required for denying leave to supplement. *Foman*, 371 U.S. at 182. There were none. Saint Anthony 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. The Supplement alleged facts discovered after filing the Complaint, some of which concerned events occurring after the suit was filed. It was Saint Anthony's first and only request to amend. It came while even limited discovery was stopped on Saint Anthony's preliminary injunction motion, and before any substantive rulings.[16] Merits discovery had not begun. No answer to the complaint or deadline for amending the Complaint had been set.

---

[16] Saint Anthony filed its initial Complaint and preliminary injunction motion at the end of April 2020. (A1.) In July, at HFS's request and over Saint Anthony's objection, the district court vacated the discovery and briefing deadlines related to the preliminary injunction motion while it considered motions from HFS and the

(*continued on next page*)

The district court allowed HFS to file an oversized brief opposing the Supplement, but rejected Saint Anthony's request to file a reply to HFS's objections. (SA1; R106.) Then the case lay dormant for five months, until the district court dismissed the Complaint, and denied the Motion to Supplement shortly thereafter. The court did not allow the Supplement's new Count III because it had "doubts" about its legal sufficiency and noted that the Supplement would expand the case and "unnecessarily prolong the case because the case is otherwise over." (SA36.) As discussed below, the Supplement stated a valid claim for relief. The district court's other reasons were also wrong.

First, that a proposed supplement to a complaint would "expand" a case is not, by itself, grounds for denial. Most supplements and amendments expand cases. A leading commentator states:

> [Rule 15's] purpose is to provide maximum opportunity for each claim to be decided on its merits rather than on procedural technicalities. This is demonstrated by the emphasis Rule 15 places *on the permissive approach that the district courts are to take to amendment requests, no matter what their character may be*; the rule is in sharp contrast to the common-law and code restriction that amendments could not change the original cause of action.

6 Charles Alan Wright & Arthur R. Miller, Federal Practice and Procedure §1471 (3d ed. 1998); *see also id.* at §1505 (stating that a supplemental pleading "may assert new facts in support of an entirely different legal theory or remedy"). To warrant denial, the expansion must cause undue prejudice or undue delay, neither of which the

---

intervening MCOs. (R81.) Saint Anthony filed the Motion to Supplement in January 2021. (A33.)

district court found, or could find. *See Dubicz v. Commonwealth Edison Co.*, 377 F.3d 787, 792-93 (7th Cir. 2004) (abuse of discretion by denying leave to amend without showing prejudice to defendant).

The district court's reasoning that denial of leave was justified because the case was "otherwise over" (SA36), was also contrary to Rule 15(d), which expressly states that "[t]he court may permit supplementation even though the original pleading is defective in stating a claim or defense." Fed. R. Civ. P. 15(d). Accordingly, while, as discussed above, the court erred in dismissing the Complaint, even if the dismissal were proper, it did not justify denying the Motion to Supplement.

The district court stated that if Saint Anthony wanted to bring a new claim it should file a new lawsuit. (SA38 ("Saint Anthony is free to build a new claim in a new case . . . .").) This is precisely the wrong result the amendment to Rule 15(d) sought to prevent. *See* Fed. R. Civ. P. 15, 1963 Amendment advisory committee notes (stating that reasoning had resulted in plaintiffs "sometimes be[ing] needlessly remitted to the difficulties of commencing a new action even though events occurring after the commencement of the original action have made clear the right to relief"). Moreover, HFS would likely argue that a new lawsuit is barred by the district court's dismissal with prejudice.[17]

[17] See *Arrigo v. Link*, 836 F.3d 787, 799 (7th Cir. 2016). In *Arrigo*, the Seventh Circuit affirmed the denial on *res judicata* grounds of a plaintiff's motion to amend and the dismissal of a second lawsuit asserting the same claims the plaintiff had sought to bring in the first lawsuit. *Id.* This potential grave consequence of a denial of a motion to amend or supplement underscores the importance of a district court having a sound basis to do so.

Second, even if expanding the case could be a basis for denial in circumstances not present here, the district court was wrong that Count III "would substantially expand the scope of the case[.]" (SA36.) The Supplement alleged an additional legal theory supporting the claim for inadequate disclosure already in the case. The Complaint alleged that HFS is not ensuring timely and transparent payments as required by the Medicaid statute. (A1, A18-20.) The Supplement alleged recent evidence in support, and cited the Due Process Clause as an additional basis for relief. (A40-41, A48-54.) The Complaint had requested such transparency relief. (A28, A31.) The preliminary injunction motion had requested such relief. (R9:26.) The Supplement requested the same relief. (A56.)

The district court described Count III as bringing "a separate Medicaid program into the case." (SA36.) Not so. Count III concerns the same Medicaid program and complained of the same inadequate disclosures alleged in the Complaint. Like the Complaint, it focused on HFS as the sole agency charged with overseeing compliance with the Medicaid laws. It cited new evidence that HFS was not doing so, and a new legal basis – the Due Process Clause – for relief.

C. The Supplement Stated a Valid Claim.

The district court's "doubts" regarding Count III were unwarranted. The text of the Supplement cited two cases explaining why Saint Anthony was entitled to assert a Due Process claim for inadequate disclosure of payment remittances. The district court did not discuss either: *Vargas v. Trainor*, 508 F.2d 485, 490 (7th Cir.

1974), and *M.A. v. Norwood*, 133 F. Supp. 3d 1093, 1099-100 (N.D. Ill. 2015). (A54-55.)

Vargas upheld a challenge to the reduction or termination of public assistance payments to aged, blind, and disabled recipients by the Illinois Department of Public Aid:

> The [case of one of the plaintiffs] demonstrates "the possibility for honest error or irritable misjudgment" . . . that underscores the need for procedural due process in the reduction or termination of welfare benefits. There the Department not only made the initial errors that were corrected after hearing an appeal, but then promptly made the same errors all over again and thus undid what had been accomplished by [the plaintiffs'] appeal. Government agencies do make mistakes. . . . *Unless the welfare recipients are told why their benefits are being reduced or terminated, many of the mistakes that will inevitably be made will stand uncorrected, and many recipients will be unjustly deprived of the means to obtain the necessities of life.*

508 F.2d at 490. *M.A. v. Norwood* stated: "Without effective notice, a claimant's due process right to a fair hearing is rendered fundamentally illusory. . . . *[A]n agency must provide specific reasons for how the decision was reached*." 133 F. Supp. 3d at 1099-00. Many other cases apply this principle.[18]

---

[18] See *Goldberg v. Kelly*, 397 U.S. 254 (1970), cited and discussed in *Vargas*; *Murphy by Murphy v. Harpstead*, 421 F. Supp. 3d 695, 708 (D. Minn. 2019); *Schroeder v. Hegstrom*, 590 F. Supp. 121, 128 (D. Or. 1984); *Doston v. Duffy*, 732 F. Supp. 857, 872-73 (N.D. Ill. 1988) ("The due process clause requires that a state agency explain, in terms comprehensible to the client, exactly what the agency proposes to do and explain the agency's reasons for its action in enough detail that the client can assess the correctness of the agency's decision, make an informed decision as to whether to appeal, and be prepared for the issues to be addressed at the hearing."); *K.W. ex rel. D.W. v. Armstrong*, 298 F.R.D. 479, 490-91 (D. Idaho 2014), *aff'd* 789 F.3d 962 (9th Cir. 2015) ("[A] participant cannot simply compare his responses from one year to the next and gain an understanding of the reasoning behind a budget change. In the end, the participant is left to do the math and hope his post hoc analysis matches the

(*continued on next page*)

By contracting out Medicaid claims processing and payment to MCOs, HFS cannot eliminate its duty to provide sufficient information. The State's constitutional obligation to provide notice is non-delegable. "Contracting out [the payment duty] does not relieve the State of its constitutional duty" to provide adequate notice regarding the payments. *West v. Atkins*, 487 U.S. 42, 56 (1988). Otherwise, "the state will be free to contract out all services which it is constitutionally obligated to provide and leave its citizens with no means for vindication of those rights, whose protection has been delegated to 'private' actors, when they have been denied." *Id.* at 56 n.14 (citation omitted).

The principle was recently applied to Medicaid payments in a case similar to this one, *K.B. ex rel. T.B. v. Michigan Department of Health & Human Services*, 367 F. Supp. 3d 647, 662 (E.D. Mich. 2019). Michigan sought to absolve itself of Medicaid and Due Process duties by contracting with health plans. The court disagreed:

> [A] contractual relationship with [private health plans] does not absolve Defendants of assuring or auditing to be sure that the requirements of the Medicaid Act are being met . . . . Delegation of these responsibilities is permissible, but it does not excuse the Department from its obligation to provide notice and a hearing. If notice is not given or is defective due to the [health plans], the Department is still responsible because the obligation to the individual recipient ultimately lies with the Department.

---

analysis actually employed by IDHW. This burden shifting is impermissible. It is IDHW's duty to state initially the reasons for its action."); *Barnes v. Healy*, 980 F.2d 572, 579 (9th Cir.1992); *Cosby v. Ward*, 843 F.2d 967, 982 (7th Cir. 1988) ("[C]onstitutional due process requires notice that gives the [IDES's] reasons for its action in enough detail that a recipient can prepare a responsive defense." (quoting *Tripp v. Coler*, 640 F. Supp. 848, 857 (N.D. Ill. 1986))).

Id.; *see also Evans v. Newton*, 382 U.S. 296, 301 (1966) (city could not evade the Fourteenth Amendment's Equal Protection Clause by handing off control of park to "'private' trustees").

In denying leave to supplement based on its "doubts" regarding Count III, the district court essentially granted a motion to dismiss Count III without allowing Saint Anthony to brief the issue. The court stated that it had "doubts about the legal sufficiency of Saint Anthony's proposed new claim, especially with respect to the managed care program" because "[i]f Saint Anthony is not receiving what it is entitled to receive under those contracts with the MCOs, then the remedy is to pursue its rights under those agreements. . . . Maybe the state could force the MCOs to provide more information. But the failure to exercise that power is not a deprivation of due process by the government." (SA36-37.)

Contrary to the district court's doubts, HFS essentially conceded that Count III stated a claim that would withstand a motion to dismiss as to the payments that HFS makes directly, and did not dispute that that due process requires HFS to provide Saint Anthony adequate notice of those payments. (*See* R106:16 ("[I]f St. Anthony were allowed to file that claim, it is not immediately obvious that the Department would be able to challenge it through a motion to dismiss, instead of a motion for summary judgment.").) HFS confirmed that concession by supporting its opposition with an affidavit arguing that Saint Anthony could reverse engineer remittances to figure out whether was paid correctly (a fact Saint Anthony disputes). (R106-1.)

For payments made through MCOs, as stated in *K.B.,* the recent Michigan Medicaid case, and precedent upon which it is based, the State's delegation to the MCOs does not relieve the State of its constitutional duties. Thus, the district court's reliance on contracts between Saint Anthony and the MCOs does not address whether *HFS* is complying with its due process duties. Saint Anthony has not sued the MCOs and is not seeking relief under its contracts with them. It seeks to enforce its federal Due Process rights by requiring *HFS* to provide notice, or ensure the MCOs do so, to permit Saint Anthony to determine if it is paid what it is entitled to receive.

The Illinois Public Aid Code clearly puts responsibility upon HFS for payment of HAP Payment increases to Saint Anthony:

> [F]or hospital services rendered on and after July 1, 2020, *the Department shall* . . . make payments to hospitals or require capitated managed care organizations to make payments as set forth in this Section.

305 ILCS 5/5A-12.7(a). These payments are due by virtue of Illinois law, not the MCO-Saint Anthony contracts. Whether paid by the MCOs or HFS, the relief Saint Anthony seeks in Count III is within HFS's control – provide notice of how remittances are computed and what payment components they contain. HFS can provide that notice itself or through the MCOs. If the notice is inadequate HFS remains responsible.

The district court also erred by suggesting that Count III failed adequately to allege "state action." (SA37.) State action could not be clearer. Saint Anthony has plainly sued a state officer, Eagleson, in her official capacity as Director of HFS. It has plainly alleged that HFS is in breach of *its* Due Process duties to the Hospital

under *Vargas, Goldberg*, and a host of other decisions imposing such duties on the State. This is not, as the district court stated, "government inaction when the government could do something." (SA37.) It is government inaction when the law requires government action. As shown above, this duty is non-delegable. The district court essentially held that the State can erase state action by abdicating its duties. The cases cited by the district court are irrelevant. They involved claims against private parties seeking to hold them to constitutional standards, as opposed to a suit against the State itself.[19]

But even if, as the district court incorrectly held, Saint Anthony needs to allege that the MCOs' failure to provide transparency constitutes "state action," that standard is easily met. Contrary to the district court's erroneous view of "state action" that would require Saint Anthony to allege "an agreement between [HFS] and the MCOs to deprive Saint Anthony of information that it is entitled to receive," (SA37), the Supreme Court has taken a flexible approach and identified several paths to deem private parties state actors: when a private party "is controlled by an agency of the State," "has been delegated a public function by the State," is "entwined with governmental policies," or when its management or control is "entwined" with

[19] *Am. Mfrs. Mut. Ins. Co. v. Sullivan*, 526 U.S. 40, 51 (1999) ("[T]he issue . . . is whether a *private insurer's* decision to withhold payment for disputed medical treatment may be fairly attributable to the State so as to subject insurers to the constraints of the Fourteenth Amendment.") (emphasis in original); *Spiegel v. McClintic*, 916 F.3d 611, 616 (7th Cir. 2019) (affirming dismissal of §1983 claim against private citizen); *Alarm Detection Sys., Inc. v. Vill. of Schaumburg*, 930 F.3d 812, 825 (7th Cir. 2019) (private parties could be brought into §1983 suit under "conspiracy theory" or "joint participation doctrine," but Contracts Clause claim still failed).

government. *Brentwood Acad. vs. Tenn. Secondary Sch. Athletic Ass'n*, 531 U.S. 288, 295-96 (2001) (cleaned up).

HFS's relationship to the MCOs checks all the boxes described in *Brentwood*. HFS is responsible for the administration and oversight of the Illinois Medicaid program, including the managed care program. *See* 42 U.S.C. §1396a(a)(5); 42 C.F.R. §431.10. HFS is very much "entwined with [the] management and control" of the MCOs through its own contracts with MCOs, and its compliance activities, however inadequate. HFS requires MCOs to pay the HAP Payment Increases pursuant to Illinois law. HFS is well aware the MCOs are not providing notice and has refused to do so itself, or to require the MCOs to do so, even though it has the power. *See Camm v. Faith*, 937 F.3d 1096, 1105 (7th Cir. 2019) (private investigators "easily qualify as state actors" where government agent "delegated a public function when he hired them to investigate the crime scene on behalf of Indiana law enforcement" and "controlled their actions").

The district court's "doubts" about state action provide no basis to deny leave to file the Supplement. Case law required granting leave "even if the court [was] skeptical about the prospects for success." *Bausch v. Stryker Corp.*, 630 F.3d 546, 562 (7th Cir. 2010) (denial of leave to amend was abuse of discretion where "in the absence of undue delay or other fault on [plaintiff's] part, [plaintiff] submitted a revised complaint that was not futile"). When "the law is uncertain," the "liberal standard for amending under Rule 15(a)(2) is especially important" and "is the best way to ensure that cases will be decided justly and on their merits." *Runnion*, 786 F.3d at

520. The district court's decision to deny leave to supplement based on its unwarranted "doubts" prevented serious public policy issues from being "decided justly and on [the] merits." That was reversible error.

CONCLUSION

The Court should reverse the district court's dismissal of Saint Anthony's Complaint and denial of leave to file the Supplement. It should remand for further proceedings.

Saint Anthony requests upon remand that, pursuant to Circuit Rule 36, the Court direct reassignment of the case to a different district court judge. The district judge manifested apparent hostility to Saint Anthony's claims, as evidenced by actions reflected in the record: Essentially staying Saint Anthony's Motion for Preliminary Injunction and holding a motion to dismiss for almost a year in the midst of a pandemic severely affecting a safety net hospital; dismissing the Complaint without even discussing the cases Saint Anthony cited that uphold a private right of action with regard to the exact statutory provisions at issue; denying the motion to supplement after nearly six month's delay, and doing so only based on one-side's briefing, without affording Saint Anthony an opportunity to reply; and disregarding this Court's and the Supreme Court's clear guidance on the requirements of Rule 15.

Dated: September 9, 2021

Respectfully submitted,

SAINT ANTHONY HOSPITAL

By: /s/ Michael L. Shakman
One of its attorneys

Michael L. Shakman
Edward W. Feldman
William J. Katt
Mary Eileen C. Wells
Miller Shakman Levine & Feldman LLP
180 North LaSalle Street, Suite 3600
Chicago, IL 60601
(312) 236-3700

CERTIFICATE OF COMPLIANCE

I hereby certify that this brief complies with the type-volume limitations of Federal Rule of Appellate Procedure 32(a)(7)(A) and Circuit Rule 32(c) because it contains 13,935 words (excluding the parts exempted by Federal Rule of Appellate Procedure 32(a)(7)(B)(iii)). This brief also complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5) and Circuit Rule 32(a) because it has been prepared in a proportionally spaced typeface (12-point Century Schoolbook) using Microsoft Word. All materials required by Cir. R. 30(a) & (b) are included in the required short appendix and separately bound appendix of Plaintiff-Appellant.

September 9, 2021

/s/ Mary Eileen C. Wells
Attorney for Plaintiff-Appellant
Saint Anthony Hospital

Michael L. Shakman
Edward W. Feldman
William J. Katt
Mary Eileen C. Wells
Miller Shakman Levine & Feldman LLP
180 North LaSalle Street, Suite 3600
Chicago, IL 60601
(312) 236-3700

CERTIFICATE OF FILING AND SERVICE

I hereby certify that on September 9, 2021, I electronically filed this brief with the Clerk of the Court for the United States Court of Appeals for the Seventh Circuit using the CM/ECF system. All participants in the case are registered CM/ECF users and service will be accomplished by the CM/ECF system.

September 9, 2021

/s/ Mary Eileen C. Wells

Attorney for Plaintiff-Appellant
Saint Anthony Hospital

Michael L. Shakman
Edward W. Feldman
William J. Katt
Mary Eileen C. Wells
Miller Shakman Levine & Feldman LLP
180 North LaSalle Street, Suite 3600
Chicago, IL 60601
(312) 236-3700

REQUIRED SHORT APPENDIX

TABLE OF CONTENTS

UNITED STATES DISTRICT COURT
FOR THE Northern District of Illinois − CM/ECF LIVE, Ver 6.3.3
Eastern Division

Saint Anthony Hospital

Plaintiff,

v.

Case No.: 1:20−cv−02561
Honorable Steven C. Seeger

Theresa Eagleson

Defendant.

NOTIFICATION OF DOCKET ENTRY

This docket entry was made by the Clerk on Wednesday, January 27, 2021:

MINUTE entry before the Honorable Steven C. Seeger: The Court reviewed Plaintiff's motion for leave to file supplemental complaint. (Dckt. No. [101]) Rule 15(a)(2) provides that the "court should freely give leave when justice so requires." See Fed. R. Civ. P. 15(a)(2). Defendant opposes the request, and seeks 28 days to file a response. And Plaintiff seeks 14 days to file a reply. Defendant's response is due by February 5, 2021. No reply. Mailed notice. (jjr,)

ATTENTION: This notice is being sent pursuant to Rule 77(d) of the Federal Rules of Civil Procedure or Rule 49(c) of the Federal Rules of Criminal Procedure. It was generated by CM/ECF, the automated docketing system used to maintain the civil and criminal dockets of this District. If a minute order or other document is enclosed, please refer to it for additional information.

For scheduled events, motion practices, recent opinions and other information, visit our web site at ***www.ilnd.uscourts.gov***.

UNITED STATES DISTRICT COURT
FOR THE Northern District of Illinois − CM/ECF LIVE, Ver 6.3.3
Eastern Division

Saint Anthony Hospital

Plaintiff,

v.

Case No.: 1:20−cv−02561
Honorable Steven C. Seeger

Theresa Eagleson

Defendant.

NOTIFICATION OF DOCKET ENTRY

This docket entry was made by the Clerk on Friday, July 9, 2021:

MINUTE entry before the Honorable Steven C. Seeger: Defendant Eagleson's motion to dismiss (Dckt. No. [16]) is hereby granted. Memorandum Opinion and Order to follow. Plaintiff's motion for a preliminary injunction (Dckt. No. [9]) is hereby denied as moot. Intervenor's motions to compel arbitration (Dckt. Nos. [78], [79], [80], [83]) are hereby denied as moot. Mailed notice. (jjr,)

ATTENTION: This notice is being sent pursuant to Rule 77(d) of the Federal Rules of Civil Procedure or Rule 49(c) of the Federal Rules of Criminal Procedure. It was generated by CM/ECF, the automated docketing system used to maintain the civil and criminal dockets of this District. If a minute order or other document is enclosed, please refer to it for additional information.

For scheduled events, motion practices, recent opinions and other information, visit our web site at ***www.ilnd.uscourts.gov***.

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

SAINT ANTHONY HOSPITAL, Plaintiff, v. THERESA EAGLESON, in her official capacity as Director of the Illinois Department of Health and Family Services, Defendant.	)	Case No. 20-cv-2561 Hon. Steven C. Seeger

MEMORANDUM OPINION AND ORDER

Plaintiff Saint Anthony Hospital is a charitable hospital located on the west side of Chicago. It cares for a disproportionately poor patient population, so it relies heavily on Medicaid for its funding. But the Hospital has encountered all sorts of problems receiving payments from managed care organizations ("MCOs"), which are private healthcare insurance companies that administer the bulk of the Medicaid program in Illinois. All too often, the payments arrive late, or not at all.

Saint Anthony filed suit and asserted a right to payment under the Medicaid Act. But it didn't sue the MCOs. Instead, the Hospital filed a complaint against Theresa Eagleson, the Director of the Illinois Department of Health and Family Services ("HFS"). HFS is the state agency that is responsible for overseeing Medicaid in Illinois.

The theory of the complaint is that the state is failing to oversee the MCOs as required by federal law. The Hospital claims that the state's Medicaid system involving the MCOs is plagued by "dysfunction." *See* Cplt., at ¶ 38. The lack of oversight has allowed the MCOs to run rampant and shirk their responsibility to pay providers like Saint Anthony in full and in a

timely manner. Saint Anthony seeks an injunction to force the state to compel the MCOs to do better.

The state moved to dismiss on a number of grounds. For the reasons stated below, the motion to dismiss is granted.

Background

Saint Anthony Hospital opened its doors in 1898. *See* Cplt., at ¶ 16 (Dckt. No. 1). For over a century, the Hospital has provided medical care and social services to the communities on the west side of Chicago. *Id*. at ¶¶ 1, 12, 16. The patient population at Saint Anthony is disproportionately poor. *Id.* at ¶¶ 10, 16.

The patients may not have the means to pay for what they need, but that does not stop the Hospital from caring for them. Saint Anthony is a "safety net" hospital, meaning that it cares for the needy without regard for their ability to pay. *Id*. at ¶¶ 2, 16; *see also* 305 ILCS 5/5-5e.1. Saint Anthony cares for everyone, and "turn[s] away no one." *See* Cplt., at ¶ 10 (Dckt. No. 1).

The Hospital relies heavily on Medicaid to carry out its mission. *Id*. at ¶¶ 1, 16. Medicaid is a program funded by the federal and state governments to pay for health care for low-income families. *Id.* at ¶ 22; *see generally* 42 U.S.C. § 1396 *et seq.* The federal government provides funds to the states, and the states then contribute funds and administer the program within their borders. *See* Cplt., at ¶ 22.

States can elect whether to participate in the Medicaid program. But if states elect to participate, the federal government requires them to comply with certain conditions as expressed in the Medicaid Act. For example, states must submit a plan to the federal government for approval, and the plan must describe how they intend to administer their Medicaid program. *See* 42 U.S.C. § 1396a.

There is an enforcement mechanism on the back end. States must comply with the conditions in the statute, or else risk the possibility of losing federal funding. *See Planned Parenthood of Indiana, Inc. v. Comm'r of Indiana State Dep't of Health*, 699 F.3d 962, 969 (7th Cir. 2012); *Collins v. Hamilton*, 349 F.3d 371, 374 (7th Cir. 2003) ("[O]nce a state elects to participate [in Medicaid], it must abide by all federal requirements and standards set forth in the Act."); 42 U.S.C. § 1396c.

The Illinois Department of Healthcare and Family Services is the agency that administers this state's Medicaid program. *Id.* at ¶ 13. Defendant Theresa Eagleson is the Director, and is responsible for ensuring that the state program complies with federal law. *Id.* at ¶¶ 13, 24.

Medicaid patients in Illinois can enroll in one of two programs: the "fee for service" program, or the "managed care" program. *Id.* at ¶¶ 25–26; *see also Aperion Care, Inc. v. Norwood*, 2018 WL 10231154, at *1 (N.D. Ill. 2018), *aff'd sub nom Bria Health Servs., LLC v. Eagleson*, 950 F.3d 378 (7th Cir. 2020). When a patient is enrolled in the "fee for service" program, the state pays for the patient's medical care directly. *See Midwest Emergency Assocs.-Elgin Ltd. v. Harmony Health Plan of Illinois, Inc.*, 382 Ill. App. 3d 973, 975, 321 Ill. Dec. 175, 888 N.E.2d 694 (2008). So, when Saint Anthony treats a patient in the fee for service program, it sends the bill to the state.

The other program is the "managed care" program, and that's the program at issue in this case. Under that program, the state pays a private insurance company a flat monthly fee, on a per member basis. *Id.* at 975–76. And in exchange, the private insurance company agrees to pay for each patient's medical care. *Id*. The private insurance companies that participate in the Medicaid program are known as managed care organizations (again, "MCOs"). *Id*. When Saint Anthony treats a patient insured through the managed care program, it sends the bill to an MCO.

Illinois introduced the managed care program in 2006. *See* Cplt., at ¶ 31 (Dckt. No. 1). At first, the program was a small part of the state's Medicaid spending, representing less than 3% of the state's total expenditures. *Id.* But the program has expanded significantly in recent years. *Id.* Illinois spent $251 million on MCOs in 2010, and by 2019, the expenditures shot up to $12.73 billion. *Id.* As of January 2020, over 2.1 million people are enrolled in the state's managed care program. *Id.* at ¶ 35. That's roughly 80% of the state's Medicaid enrollees. *Id.*[1]

Meanwhile, the state reduced the number of MCOs from twelve to seven in 2017. *Id.* at ¶¶ 32–35. So fewer MCOs are providing an ever-growing amount of services. The total value of the state's contracts with the seven MCOs is $63 billion, the largest single procurement in Illinois history. *Id.* at ¶ 34.

As Saint Anthony tells it, the radical expansion came with significant growing pains. According to the complaint, the state presided over a "hasty roll-out" of the managed care program that was "haphazardly-planned and poorly-executed." *Id.* at ¶¶ 36–37. The Hospital claims that the state fails to provide sufficient oversight of the MCOs, who take advantage of the fact that the state is asleep at the wheel.

The complaint recounts the many problems that Saint Anthony has experienced when it attempts to receive payment from the MCOs. In the Hospital's view, the MCOs have an incentive to pay nothing, or pay as little as possible, or pay as late as possible. *Id.* at ¶¶ 26, 65. And that's exactly what the MCOs are doing. According to the complaint, the MCOs are dragging their feet, and the state isn't doing anything about it. *Id.* at ¶ 65.

[1] For additional background, *see Illinois' Massive Shift to Managed Care* at *1, 5, Illinois Comptroller, available at https://illinoiscomptroller.gov/news/fiscal-focus/illinois-massive-shift-to-managed-care/ (last visited July 1, 2021). Saint Anthony cited this article in the complaint. *See* Cplt., at ¶ 31 n.8 (Dckt. No. 1).

Saint Anthony points to four bad practices in particular. *Id.* at ¶ 43. In a nutshell, the MCOs deny many of the claims, or don't pay in full, or put up roadblocks, or don't make it clear what they are paying and what they're denying. "The MCOs have systematically delayed and denied claims without justification, failed to pay undisputed claims, and when payments are made, they refuse to provide the detail necessary for Saint Anthony to determine if it is receiving proper payment or, if not, why not." *Id.* at ¶ 6.

First, the MCOs deny Saint Anthony's claims much more often than in the past. Specifically, claims are denied at a rate that is "four times greater" than "under the previous system." *Id.* at ¶ 46. As a result, the Hospital "is not paid for a substantial amount of services it provides." *Id.* at ¶ 48. A denial means that Saint Anthony must foot the bill. *Id.*

Many of the denials involve ticky-tack issues and "technical 'gotchas.'" *Id.* at ¶ 47. For example, "Illinicare MCO denied $92,000 in charges submitted by Saint Anthony because the patient label was placed on a State-mandated consent form for the procedure instead of the patient's name being handwritten on the form." *Id.*

Second, when the MCOs do approve claims, they make Saint Anthony wait a long time for the funds. Today, Saint Anthony "has to wait anywhere from 90 days to 2 years to be paid by the MCOs." *Id.* at ¶ 51; *see also id.* at ¶¶ 72–73. But in the meantime, Saint Anthony has bills of its own to pay. Without receiving payment from the MCOs, Saint Anthony has trouble paying its vendors. *Id.* at ¶ 51.

Third, the process for requesting payment from the MCOs is unduly cumbersome. *Id.* at ¶¶ 52–54. Each MCO has its own policies and procedures for how to request payment, creating a "labyrinth" that is difficult to navigate. *Id.* at ¶ 52.

Fourth, when the MCOs do tender payment, it's difficult to tell what they're paying for. That is, the "MCOs do not provide itemized claims data showing a breakdown of how it calculated the total amount of payment for a claim, leaving Saint Anthony to guess whether it received the full amount due to it." *Id*. at ¶ 57.

Overall, Saint Anthony is facing "unjustified denials, unwarranted delays . . . and increased costs to try to navigate this broken system." *Id*. at ¶ 54. The Hospital has to devote resources to try to get paid, and any money spent on reimbursement efforts is money that it can't spend on patient care. *Id.* The lack of payment creates a risk of cutting services, and may put the Hospital itself in jeopardy. *Id.*

All of those bad practices, but especially the delays in payment, have had disastrous financial consequences for Saint Anthony. *Id*. at ¶¶ 10, 70. For one, late payments have resulted in a precipitous decline in cash on hand. "From 2015 to 2019, Saint Anthony's cash on hand has fallen 98%: from over $20 million (enough to fund 72 days of operation) to less than $500,000 (less than 2 days)." *Id*. at ¶ 21. By Saint Anthony's calculations, MCOs currently owe Saint Anthony north of $20 million in Medicaid payments. *Id*. at ¶ 4. Saint Anthony has also suffered a 20% decline in net revenue per patient. *Id.* at ¶ 71.

According to the complaint, the MCOs know that they have leverage over vulnerable hospitals like Saint Anthony. And they are taking full advantage of it. Saint Anthony has attempted to resolve disputes with the MCOs, but has encountered "delay, unreasonable requests for additional information, and a general lack of responsiveness." *Id*. at ¶ 64. The Hospital is forced to endure a "time-consuming, resource-intensive, [and] often futile appeals process." *Id*. at ¶ 48. The MCOs subject Saint Anthony to months of haggling, and all too often, the end result is a settlement offer at a "substantial discount." *Id*. at ¶ 64.

The "bottom line" is that Saint Anthony "is being paid much less than before the Medicaid managed care expansion under the prior administration [of Governor Rauner]." *Id.* at *Id*. at ¶ 61. And the financial situation of the Hospital has hit a "crisis point." *Id*. at ¶ 70; *see also id.* at ¶ 10.

At this point, a reader could be forgiven for thinking that Saint Anthony filed suit against the MCOs. But that's not the case at all. The contracts between Saint Anthony and the MCOs include an arbitration provision, so presumably the Hospital didn't sue the MCOs because it can't sue the MCOs (in federal court, anyway).[2] Instead, Saint Anthony brought this lawsuit against Theresa Eagleson in her capacity as the Director of the Illinois Department of Health and Family Services.

The theory of the case is that the Medicaid Act requires states to oversee the MCOs. Saint Anthony basically claims that the Medicaid Act requires the state to ensure that the MCOs pay providers in a timely manner. But instead of doing its job and providing oversight, the state "has given MCOs *carte blanche* to delay and deny claims and payments." *Id.* at ¶ 65. And by falling down on the job, the state is violating federal law, and placing the Hospital in peril. *Id*. at ¶¶ 70, 78.

Saint Anthony filed a two-count complaint. Each Count alleges that provisions of the Medicaid Act give providers rights that are enforceable under section 1983. The provisions

[2] Saint Anthony could have taken up these issues directly with the MCOs through arbitration. Saint Anthony has contracts with all seven MCOs in the Illinois managed care program, and those contracts detail which services each entity covers, how much they'll reimburse the Hospital, and how the claims approval process works. *See* Joint Reply Brief in Support of the MCOs' Mtns.' to Compel Arbitration and Stay Action, at 3 (Dckt. No. 93); Cplt. at ¶ 72 (Dckt. No. 1). The agreements also state the timeline when the MCOs must process certain claims. *Id*. But the contracts also contain binding arbitration clauses, which require both parties to litigate any disputes in front of an arbitrator instead of a court. *Id*. A number of the MCOs intervened in this action and filed motions to compel arbitration. As they see it, Saint Anthony's lawsuit against the state is a round-about, back-door way to get around the arbitration provisions.

differ, but the gist of each Count is the same. The Hospital claims that it has a statutory right to prompt payment, and that the state has a duty to enforce the payment obligations of the MCOs.

Count I rests largely on section 1396u-2(f), a statutory provision about the content of a contract between the state and an MCO. That section provides that a "contract" between the state and 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) of this title," unless the MCO and the provider make a different deal. *See* 42 U.S.C. § 1396u-2(f).

That section ropes in section 1396a(a)(37)(A). And section 1396a(a)(37)(A), in turn, requires a state's plan to have procedures that ensure prompt payment. "A State plan for medical assistance must . . . provide for claims payment procedures which . . . ensure" that a certain percentage of claims are paid by a certain period of time. *See* 42 U.S.C. § 1396a(a)(37)(A). Specifically, the "procedures" must "ensure" that 90% of claims are paid within 30 days, and 99% of claims are paid within 90 days. *Id.*

Count I also cites a statutory provision that creates a remedy for non-compliance. *See* Cplt., at ¶ 81. The federal government can withhold funds from a state if the MCOs do not comply with section 1396u-2, and by extension 1396u-2(f). "[N]o payment shall be made under this subchapter to a State . . . unless . . . the entity complies with the applicable requirements of section 1396u-2." *See* 42 U.S.C. § 1396b(m)(2)(A)(xii).

Viewing those provisions as a whole, Saint Anthony claims that the state has a duty to ensure that MCOs pay providers in a timely manner. The Hospital alleges that the state is falling down on the job, by shirking its responsibility to ensure payment to providers. The state's lax approach toward payment, in the Saint Anthony's view, violates federal law.

Count II rests primarily on section 1396a(a)(8), which is about the state's Medicaid plan. The state plan must provide that "medical assistance . . . shall be furnished with reasonable promptness to all eligible individuals." *See* 42 U.S.C. § 1396a(a)(8). The definition of "medical assistance" includes payment for medical care. *See* 42 U.S.C. § 1396d(a). Reading those provisions together, Saint Anthony claims that the reference to "reasonable promptness" creates a right to be paid on the 30-day/90-day schedule set out in section 1396a(a)(37)(a), the section discussed above. *See* Cplt., at ¶ 90 (Dckt. No. 1).

Saint Anthony seeks declaratory and injunctive relief. The Hospital seeks a declaratory judgment that the state has violated federal law by failing to ensure that the MCOs meet the requirements for timely payment. *Id.* at ¶¶ 87, 96.

The Hospital also requests an injunction to force the state to "caus[e]" the MCOs to pay claims by set deadlines. *Id.* The sought-after injunction also would require the state to collect monthly reports on the payment of claims by the MCOs, and would compel the state to force the MCOs to use a standard format for the payment of all claims. *Id.* So the Hospital wants an injunction to force the *state's* hand to twist the *MCOs'* arms.

If the MCOs still do not comply, Saint Anthony seeks an injunction requiring the state to "terminate its MCO contracts," and "retake responsibility for payment of claims." *Id.* That relief would, in effect, end a program that currently serves 80% of the state's Medicaid enrollees, totaling more than 2.1 million people. *Id.* at ¶ 35.

The state moved to dismiss on a number of grounds. *See* Def.'s Mem. (Dckt. No. 24). The lead argument is that the Medicaid Act does not impose a 30-day/90-day payment schedule for hospitals like Saint Anthony. In its view, that timetable applies to practitioners, not

providers. Next, the state argues that the provisions in question do not give rise to a private of action. The state also invokes the Eleventh Amendment.

The Court concludes that the statutory provisions in question do not give rise to a private right of action, because they do not create rights that are enforceable under section 1983. And even if a plaintiff could bring a claim, Saint Anthony has failed to state a claim for which relief can be granted.

Legal Standard

A motion to dismiss under Rule 12(b)(6) challenges the sufficiency of the complaint, not the merits of the case. *See* Fed. R. Civ. P. 12(b)(6); *Gibson v. City of Chicago*, 910 F.2d 1510, 1520 (7th Cir. 1990). In considering a motion to dismiss, the Court must accept as true all well-pleaded facts in the complaint and draw all reasonable inferences in the plaintiff's favor. *See AnchorBank, FSB v. Hofer*, 649 F.3d 610, 614 (7th Cir. 2011). To survive, the complaint must give the defendant fair notice of the basis for the claim, and it must be facially plausible. *See Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009); *see also Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007). "A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Iqbal*, 556 U.S. at 678.

Discussion

The motion to dismiss raises a number of issues. The Court will first address whether there is a private right of action, and then will turn to whether Saint Anthony's complaint states a claim. Step one is deciding whether Congress authorized claimants to enter the courthouse at all.

I. The Existence of a Private Right of Action

"Medicaid is a cooperative program through which the federal government reimburses certain expenses of states that promise to abide by the program's rules." *See Nasello v. Eagleson*, 977 F.3d 599, 601 (7th Cir. 2020); *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 502 (1990) (noting that the Medicaid Act requires states to "comply with certain requirements imposed by the Act and regulations promulgated by the Secretary of Health and Human Services"); *see also Planned Parenthood of Indiana, Inc. v. Comm'r of Indiana State Dep't of Health*, 699 F.3d 962, 969 (7th Cir. 2012). The Medicaid Act is an example of Congress exercising its power under the Spending Clause. *See Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 576 (2012). "[L]egislation enacted pursuant to the spending power is much in the nature of a contract; in return for federal funds, the States agree to comply with federally imposed conditions." *See Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 2 (1981). The federal government provides funds, with strings attached.

Saint Anthony believes that the state is not living up to its end of the bargain. As the Hospital tells it, the MCOs are shirking their payment obligations, and the state is letting them get away with it.

A threshold issue is whether Saint Anthony can bring a claim at all. That is, the first step is deciding whether Congress created a private right of action. It is one thing to create substantive federal law; it is another to create a private right of action to enforce it in the federal courthouse. *See Alexander v. Sandoval*, 532 U.S. 275, 286–87 (2001) ("The judicial task is to interpret the statute Congress has passed to determine whether it displays an intent to create not just a private right but also a private remedy. . . . Without it, a cause of action does not exist and courts may not create one, no matter how desirable that might be as a policy matter, or how

compatible with the statute."); *see also Lampf, Pleva, Lipkind, Prupis & Petigrow v. Gilbertson*, 501 U.S. 350, 365 (1991) ("Raising up causes of action where a statute has not created them may be a proper function for common-law courts, but not for federal tribunals.") (Scalia, J., concurring).

The Medicaid Act is chock-full of requirements for the states. But it does not create a private cause of action for providers like Saint Anthony to enforce the payment obligations. The Hospital has not pointed to any foothold in the text of the statute that authorizes a claim against the state. In fact, Saint Anthony doesn't even argue that the Medicaid Act itself green-lights a private right of action.

Instead, the Hospital relies on section 1983 as the springboard for bringing a claim. The text of the statute provides:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any *rights*, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress . . . .

See 42 U.S.C. § 1983 (emphasis added).

Section 1983 "means what it says." *See Maine v. Thiboutot*, 448 U.S. 1, 4 (1980). The statute "authorizes suits to enforce individual rights under federal statutes as well as the Constitution." *See City of Rancho Palos Verdes v. Abrams*, 544 U.S. 113, 119 (2005).

For present purposes, the key word in the statute is "rights." *See* 42 U.S.C. § 1983. The text of the statute authorizes suits to enforce "*rights*, not the broader or vaguer 'benefits' or 'interests.'" *Gonzaga Univ. v. Doe*, 536 U.S. 273, 283 (2002) (emphasis in original); *see also Blessing v. Freestone*, 520 U.S. 329, 340 (1997) ("In order to seek redress through § 1983, however, a plaintiff must assert the violation of a federal *right*, not merely a violation of federal

law."). The statute "does not provide an avenue for relief every time a state actor violates a federal law." *City of Rancho Palos Verdes*, 544 U.S. at 119.

To enforce a federal statute under section 1983, a plaintiff must demonstrate that the "federal statute creates an individually enforceable right in the class of beneficiaries to which he belongs." *Id.* Three factors come into play when deciding whether a statute creates a right that is enforceable under section 1983: (1) "Congress must have intended that the provision in question benefit the plaintiff;" (2) the asserted right must not be "so vague and amorphous that its enforcement would strain judicial competence;" and (3) the statute must "unambiguously impose a binding obligation on the States," meaning that the "provision giving rise to the asserted right must be couched in mandatory, rather than precatory, terms." *Blessing*, 520 U.S. at 340–41.

Those factors "are meant to set the bar high." *See Planned Parenthood of Indiana*, 699 F.3d at 973; *see also BT Bourbonnais Care LLC v. Norwood*, 866 F.3d 815, 820–21 (7th Cir. 2017) (noting that the test is "strict"). A plaintiff must come forward with an "unambiguously conferred right to support a cause of action brought under § 1983." *See Gonzaga*, 536 U.S. at 283; *see also id.* at 290 ("In sum, if Congress wishes to create new rights enforceable under § 1983, it must do so in clear and unambiguous terms . . . ."); *Armstrong v. Exceptional Child Center, Inc.*, 575 U.S. 320, 332 (2015) ("Our precedents establish that a private right of action under federal law is not created by mere implication, but must be 'unambiguously conferred.'") (quoting *Gonzaga*, 536 U.S. at 283).

This "rigorous" approach reflects concerns about federalism, by ensuring that courts do not allow states to become embroiled in litigation based on conditions not clearly expressed in the statutory text. *See Planned Parenthood of Indiana*, 699 F.3d at 973; *Pennhurst*, 451 U.S. at

24. It promotes the separation of powers, too, by ensuring that courts do not give the green light to suits not authorized by Congress. *See Hernandez v. Mesa*, 140 S. Ct. 735 (2020); *Ziglar v. Abbasi*, 137 S. Ct. 1843 (2017); *Alexander*, 532 U.S. at 287 ("Like substantive federal law itself, private rights of action to enforce federal law must be created by Congress."); *Nasello*, 977 F.3d at 601 ("Creating new rights of action is a legislative rather than a judicial task."). It is the role of Congress, not courts, to open the courthouse doors to claimants.

"Once a plaintiff demonstrates that a statute confers an individual right, the right is presumptively enforceable by §1983." *Gonzaga*, 536 U.S. at 284. But the presumption is rebuttable. *See Blessing*, 520 U.S. at 341. The state can rebut the presumption by showing that Congress "shut the door to private enforcement either expressly, through 'specific evidence from the statute itself,' or 'impliedly, by creating a comprehensive enforcement scheme that is incompatible with individual enforcement under § 1983.'" *See Gonzaga*, 536 U.S. at 284 n.4 (quoting *Blessing*, 520 U.S. at 341).

In *Wilder v. Virginia Hospitals*, 496 U.S. 498, 508–12 (1990), the Supreme Court allowed plaintiffs to use section 1983 to bring a claim to enforce a now-defunct provision of the Medicaid Act known as the Boren Amendment. That provision permitted the federal government to reduce a state's Medicaid funding unless it paid hospitals for their services at certain rates. The Supreme Court held that the plaintiffs could bring their claim under section 1983. *Id.* at 508.

But the *Wilder* approach to section 1983 seems to have reached the end of the line. In the ensuing decades, the Supreme Court has shown little enthusiasm for using section 1983 as a gateway for claims involving Spending Clause legislation. The Supreme Court itself has acknowledged that its "later opinions plainly repudiate the ready implication of a § 1983 action

that *Wilder* exemplified." *See Armstrong*, 575 U.S. at 330 n.*; *see also Bruggeman ex rel. Bruggeman v. Blagojevich*, 324 F.3d 906, 911 (7th Cir. 2003) (holding that section 1396a(a)(19) "cannot be interpreted to create a private right of action, given the Supreme Court's hostility, most recently and emphatically expressed in *Gonzaga* . . . to implying such rights in spending statutes").

In a string of cases, the Seventh Circuit has addressed whether various provisions of the Medicaid Act create a right that is enforceable under section 1983. The outcomes are a mixed bag, meaning that the Court of Appeals has sometimes found a private right of action, and sometimes not. Each case turned on the unique statutory provisions at issue. *See Bontrager v. Indiana Family and Social Servs. Admin.*, 697 F.3d 604, 607 (7th Cir. 2012) (recognizing a private right of action under section 1396a(a)(10)(A)); *Planned Parenthood of Indiana*, 699 F.3d at 974 (holding that section 1396a(a)(23) creates a federal right vested in Medicaid-eligible individuals); *BT Bourbonnais Care*, 866 F.3d 820–23 (holding that section 1396a(a)(13) creates a federal right vested in nursing homes); *Nasello*, 977 F.3d at 601 (holding that section 1396a(r)(1)(A) does not create a federal right vested in nursing home residents).

The Seventh Circuit recently surveyed the state of the law in this area in *Nasello v. Eagleson*, 977 F.3d 599 (7th Cir. 2020). *Nasello* involved a claim under section 1983 to enforce a provision of the Medicaid Act requiring states to pay more for "medically needy" individuals. *Id.* at 600–01. Plaintiffs argued that the statute required the state to reimburse them for past bills. *Id.*

The Seventh Circuit held that the provision in question did not create a right enforceable under section 1983. "Medicaid does not establish anyone's entitlement to receive medical care (or particular payments); it requires only compliance with the terms of the bargain between the

state and federal governments." *Id.* at 601. The Court of Appeals noted the steady flow of cases from the Supreme Court finding no private right of action under Spending Clause legislation. "In the three decades since *Wilder* it has repeatedly declined to create private rights of action under statutes that set conditions on federal funding of state programs." *Id.*; *see also Armstrong*, 575 U.S. 320; *Astra USA, Inc. v. Santa Clara County*, 563 U.S. 110 (2011); *Gonzaga*, 536 U.S. 273.

Courts have no power to "enlarge the list of implied rights of action when the statute sets conditions on states' participation in a program, rather than creating direct private rights." *See Nasello*, 977 F.3d at 601. Creating a private right of action is the business of the legislature, not the judiciary. *Id.* If the state is falling down on the job under the Medicaid Act, an interested person can resort to the "administrative process – and if that fails they could ask the responsible federal officials to disapprove a state's plan or withhold reimbursement." *Id.* at 601–02.

So the question here is whether the provisions of the Medicaid Act create a right that is enforceable by providers like Saint Anthony under section 1983. Based on the standards laid down in *Blessing* and *Gonzaga*, Saint Anthony has no private right of action against the state. The Court will take up the relevant statutory provisions by Count.

A. Section 1396u-2(f) (Count I)

In Count I, Saint Anthony claims that the state has an obligation to ensure that the MCOs pay providers in a timely manner. The Hospital rests its claim on section 1396u-2(f) of the Medicaid Act, which sets requirements for a contract between a state and MCOs. Section 1396u-2(f) provides:

> A *contract* under section 1396b(m) of this title with a medicaid managed care organization *shall provide that the organization shall make payment to health care providers* for items and services which are subject to the contract and that are furnished to individuals eligible for medical assistance under the State plan under

> this subchapter who are enrolled with the organization *on a timely basis consistent with the claims payment procedures described in section 1396a(a)(37)(A)* of this title, unless the health care provider and the organization agree to an alternate payment schedule and, in the case of primary care services described in section 1396a(a)(13)(C) of this title, consistent with the minimum payment rates specified in such section (regardless of the manner in which such payments are made, including in the form of capitation or partial capitation).

See 42 U.S.C. § 1396u-2(f) (emphasis added). The "contract under section 1396b(m)" means a "contract between the State and the entity," meaning the an MCO. *Id.*; 42 U.S.C. § 1396b(m)(2)(A)(iii).

Section 1396u-2(f) expressly invokes the "claims payment procedures" in section 1396a(a)(37)(A). That section, in turn, sets requirements for claims payment procedures in a state's plan. Specifically:

> A State plan for medical assistance must . . . provide for *claims payment procedures which . . . ensure* that 90 per centum of claims for payment (for which no further written information or substantiation is required in order to make payment) made 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.

See 42 U.S.C. § 1396a(a)(37)(A) (emphasis added).

Applying the *Blessing* factors, the Court concludes that sections 1396u-2(f) and 1396a(a)(37)(A) do not create rights that are enforceable under 1983. Simply put, there is no private right of action.

The first factor under *Blessing* is whether "Congress . . . intended that the provision in question benefit the plaintiff." *Blessing*, 520 U.S. at 340. Nothing "less than an unambiguously conferred right is enforceable by § 1983." *Gonzaga*, 536 U.S. at 282.

At first blush, the provisions might give the impression that they are designed to benefit providers like Saint Anthony. After all, the provisions are about timely payment. In life, the people most interested in timely payment are the people getting paid.

But that's not the sort of entitlement that can give rise to an enforceable right. The Supreme Court made clear in *Gonzaga* that a generalized "benefit" isn't good enough. *See id.* at 283. Falling within the "general zone of interest" is not enough to have a right. *Id.* To create judicially enforceable rights, the statute's text "must be 'phrased in terms of the persons benefited,'" and have "'an *unmistakable focus* on the benefited class.'" *Id.* at 284 (quoting *Cannon v. University of Chicago*, 441 U.S. 677, 692 n.13 (1979)) (emphasis in original).

That sort of rights-creating language is missing in the provisions at hand. Section 1396u-2(f) is about the content of contracts between the state and MCOs. A "contract" with MCOs "shall provide" that the MCOs "shall make payment" on a "timely basis consistent with the claims payment procedures described in section 1396a(a)(37)(A)." *See* 42 U.S.C. § 1396u-2(f). Instead of creating rights to payment, section 1396u-2(f) requires the contracts to do the heavy lifting. *Id.* The provision itself does not entitle providers to much of anything, and does not contain any "explicit rights-creating terms." *See Gonzaga*, 536 U.S. at 284.

In other words, section 1396u-2(f) requires the state to include certain provisions in its contracts with MCOs. It does not require the state to enforce those provisions, or otherwise ensure that MCOs pay providers promptly.

Saint Anthony is not claiming that the contracts between the state of Illinois and the MCOs are missing provisions required by the statute. In other words, Saint Anthony is not attempting to change the contractual arrangement between the state and the MCOs to bring it into compliance with section 1396u-2(f). The issue isn't whether a provider has an enforceable

right to require the state to include certain provisions in its contract with MCOs. Instead, the Hospital asserts that it has a right to prompt payment, and that the state has a duty to make sure that the MCOs pay as they should. And when reading the statute, that right simply isn't there.

Section 1396u-2(f) loops in section 1396a(a)(37)(A), but the result is the same. That section is about the content of a state's plan. "A State plan for medical assistance must . . . provide for claims payment procedures . . . ." *See* 42 U.S.C. § 1396a(a)(37)(A). Those "procedures" must "ensure" that 90% of claims are paid within 30 days, and 99% of claims are paid within 90 days. *Id.*

The statute sets prompt payment as a goal, but it stops short of creating a right to prompt payment for the providers. In fact, section 1396a(a)(37)(A) does not mention providers at all. There's no "individually focused terminology" because there's no mention of the providers. *See Gonzaga*, 536 U.S. at 287. It's hard to see how section 1396a(a)(37)(A) could "unambiguously create[] an 'individual entitlement'" in the hands of the providers when it does not mention the providers at all. *See Planned Parenthood of Indiana*, 699 F.3d at 973 (citation omitted).

Taken together, the provisions create a general benchmark, not an individual right. The sections set an "aggregate plan requirement," without establishing a "personal right." *Id.* at 974. So they cannot support the weight of a claim under section 1983.

Saint Anthony relies heavily on *BT Bourbonnais Care*, but it does not lend much of a hand. *See* Pl.'s Resp., at 11–14 (Dckt. No. 26). That case involved an express procedural right, that is, a right to notice and comment before the state changed reimbursement rates. *See BT Bourbonnais Care*, 866 F.3d at 821 ("[T]he Operators are not arguing that the current version of section 1396a(a)(13)(A) creates a substantive right to any particular level of reimbursement. Instead, they contend, it creates a procedural right to certain information, as well as a procedural

right to notice and comment."). The Court of Appeals addressed the "narrow question" whether section 1396a(a)(13)(A) created an "enforceable right to a public process." *Id.* at 820.

The Medicaid Act required the state to "provide . . . providers . . . reasonable opportunity for review and comment on the proposed rates." *See* 42 U.S.C. § 1396a(a)(13)(A). Based on the plain language of the text, the Seventh Circuit held that the statute created an enforceable right. The provisions at issue in *BT Bourbonnais Care* expressly required the state to do something for the providers, to wit, give them notice and an opportunity to chime-in before changing rates.

The provisions at hand in this case, in sharp contrast, contain no comparable language. There is no language giving providers an unmistakable right to prompt payment. *BT Bourbonnais Care* involved statutory language creating "unambiguous private rights," but this case does not. *See BT Bourbonnais Care*, 866 F.3d at 821. So it is not enough to argue that this case, like *BT Bourbonnais Care*, involves "procedures." *See* Pl.'s Resp., at 13 (Dckt. No. 26). This case does involve *procedures*, but it does not involve a claim that the state violated anyone's procedural *rights*. *See* 42 U.S.C. § 1396a(a)(37) ("A State plan for medical assistance must . . . provide for claims payment procedures . . . .").

The statute does contemplate a right of the providers in one sense. The Medicaid Act contemplates two tiers of contracts: a contract between a state and the MCOs, and a contract between the MCOs and the providers. *See Community Health Care Ass'n of New York v. Shah*, 770 F.3d 129, 137 (2d Cir. 2014) ("Under this system generally, the state does not directly reimburse health service providers that serve Medicaid recipients. Rather, the state enters into a contract with an MCO. The state then pays the MCO for each Medicaid patient enrolled with it. The MCO, in turn, contracts with a health service provider . . . to provide medical services to its enrollees."); *see also* 42 U.S.C. § 1396u-2(a)(1)(A)(ii) (referring to "provider agreements with

managed care entities"); 42 U.S.C. § 1396u-2(f) (creating a carve-out if a "health care provider and the organization agree to an alternate payment schedule"). The state provides funds to the MCOs, and the MCOs provide funds to the providers, with each link of the chain forged by contract.

So Congress had in mind that providers would have contractual rights. And contractual rights come with an ability to enforce the contract if there is a breach. Congress legislates against the backdrop of the common law, and undoubtedly knew that contractual rights could give rise to breach-of-contract claims. *See Minerva Surgical, Inc. v. Hologic, Inc.*, No. 20-440, 2021 WL 2653265, at *7 (2021); *Astoria Fed. Sav. & Loan Ass'n v. Solimino*, 501 U.S. 104, 108 (1991) ("Congress is understood to legislate against a background of common-law adjudicatory principles.").

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.

Saint Anthony could have asserted whatever rights it may have under its agreements with the MCOs. But the contracts also include arbitration provisions, and the MCOs (who intervened) rightly argue that any dispute between Saint Anthony and the MCOs about their payments belongs in front of an arbitrator. For whatever reason, the Hospital elected not to go that route. But having 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.

The second *Blessing* factor is whether the asserted right is "so 'vague and amorphous' that its enforcement would strain judicial competence." *Blessing*, 520 U.S. at 340–41 (citation omitted). This factor is closer to the line. If the statute simply required payment on a "timely basis" without more, it would stretch the ability of the judiciary to apply that standard in a particular case. *See* 42 U.S.C. § 1396u-2(f). Payors and payees may have much different views of what a "timely" payment is.

But here, the statute does place markers for what it means to be "timely." Under section 1396a(a)(37)(A), the procedures must ensure that 90% of so-called "clean claims" for payment (*i.e.*, claims that don't require more information) are paid within 30 days, and that 99% of such claims are paid within 90 days. *See* 42 U.S.C. § 1396a(a)(37)(A). Applying that standard to a busy hospital with who-knows-how-many claims could be a herculean task, but it is not vague or amorphous, either. It might strain judicial *resources*, but it would not strain "judicial competence." *Blessing*, 520 U.S. at 340–41. Applying a fixed standard to a lot of claims for payment is not easy, but it's not the same thing as applying a nebulous standard that no one can pin down.

The problem for this second factor is not so much that the standard is loosey-goosey. The problem is that the statute does not create an individual right to payment by a fixed deadline at all (*i.e., Blessing* factor one). But if the statute hypothetically *did* entitle providers to receive a certain percentage of payments by a certain period of time, courts could use that yardstick to measure compliance.

The third and final *Blessing* factor is whether the statute "unambiguously impose[s] a binding obligation on the States" using "mandatory, rather than precatory, terms." *Id.* at 341.

"[T]he statute cannot leave any room for discretion on the part of the state . . . ." *See BT Bourbonnais Care*, 866 F.3d at 822.

The provisions do contain mandatory language, as exemplified by the use of the words "shall" and "must." *See Maine Cmty. Health Options v. United States*, 140 S. Ct. 1308, 1320 (2020). The statute provides that contracts "shall" contain provisions about payment procedures. *See* 42 U.S.C. § 1396u-2(f). The statute also provides that a state plan "must" have claims payment procedures. *See* 42 U.S.C. § 1396a(a)(37).

But once again, § 1396u-2(f) simply requires the state to include certain provisions in its contracts with the MCOs. It does not require the state to ensure that the MCOs are complying with those provisions. That is, the Medicaid Act does not "require the State to ensure that the MCOs timely and properly" make payments to providers. *See* Cplt., at ¶ 5 (Dckt. No. 1); *see also id.* at ¶ 9 ("Saint Anthony brings this action . . . to order [the state] to comply with the federal and state statutory and regulatory mandate to safeguard Medicaid money and oversee and manage the MCOs . . . ."). The mandatory language is about the content of the contracts. It does not contain mandatory language that compels the state to make sure that the MCOs pay up.

If Congress had wanted to compel prompt payment to the providers, it could have easily done so. Congress could have guaranteed that providers must receive a certain amount of payments in a certain period of time. And it could have written a provision requiring the state to enforce those obligations. But it didn't. Instead, Congress elected to create requirements for contracts, and requirements for a state's plan. Those aren't rights for providers.

In sum, under the standards set out in *Blessing* and *Gonzaga*, sections 1396u-2(f) and 1396a(a)(37)(A) do not create rights that are enforceable under section 1983.

B. Section 1396a(a)(8) (Count II)

The claim under Count II fails for many of the same reasons. Saint Anthony relies on other statutory provisions, but they do not give rise to a private right of action, either.

Saint Anthony invokes section 1396a(a)(8), which sets requirements for a state's Medicaid plan. "A State plan for medical assistance must . . . 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." *See* 42 U.S.C. § 1396a(a)(8). The definition of "medical assistance" includes payment for medical care. *See* 42 U.S.C. § 1396d(a) ("The term 'medical assistance' means payment of part or all of the cost of the following care and services or the care and services themselves . . . .").

Saint Anthony believes that those provisions create a statutory entitlement to payment with "reasonable promptness." *See* 42 U.S.C. § 1396a(a)(8). And the Hospital contends that it can bring suit to enforce it. But once again, the *Blessing* factors stand in the way.

First, the statute does not contain the type of rights-vesting language required to give rise to a right of action. The statute establishes requirements for a "State plan." *Id.* It sets conditions for a state's participation in the Medicaid program. It does not create direct private rights and entitle providers to receive payment by any fixed period of time. *Cf. Nasello*, 977 F.3d at 601–02.

In fact, the provision in question does not even mention providers at all. The statute refers to "*individuals* wishing to make application for medical assistance." *See* 42 U.S.C. § 1396a(a)(8) (emphasis added). It would be unnatural to refer to a provider like a hospital as an

"individual." Individuals go to hospitals, but few of them think that the hospital *itself* is an "individual."

Saint Anthony argues that the term "eligible individuals" applies to both providers and patients. *See* Pl.'s Resp., at 10–11 (Dckt. No. 26). That reading sits uncomfortably with the sentence as a whole. Section 1396a(a)(8) uses the word "individuals" twice. *See* 42 U.S.C. § 1396a(a)(8) ("A State plan for medical assistance must . . . 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."). That word first appears in connection with an application – "all individuals wishing to make application for medical assistance under the plan." *Id.* An "application" is the form that an individual patient submits when applying to the Medicaid program. *See* 42 C.F.R. § 435.4 ("*Applicant* means an individual who is seeking an eligibility determination for himself or herself through an application submission or a transfer from another agency or insurance affordability program . . . *Application* means the single streamlined application described at § 435.907(b) of this part or an application described in § 435.907(c)(2) of this part submitted by or on behalf of an individual.") (emphasis added).

So the statutory phrase "individuals wishing to make application" refers to patients who apply to participate in Medicaid. And when the sentence later states that "such assistance shall be furnished *with reasonable promptness* to all *eligible individuals*," the phrase "all eligible individuals" refers to eligible patients who applied for Medicaid benefits and who were deemed eligible. *See* 42 U.S.C. § 1396a(a)(8) (emphasis added). It doesn't mean providers.

Neighboring provisions reinforce the point. The surrounding text repeatedly uses the word "individual" to refer to natural persons, not providers. *See, e.g.*, 42 U.S.C. § 1396a(a)(4)

(referring to "any individual employed," and "each individual who formerly was such an officer, employee, or contractor"); *id.* at § 1396a(a)(10)(A)(i) (referring to "all individuals" who are "qualified pregnant women or children," or "whose family income" falls below the cutoff, or who are "qualified family members," and so on); *id.* at § 1396a(a)(10)(A)(ii)(XII) (referring to "TB-infected individuals"); *id.* at § 1396a(a)(10)(A)(ii)(XVI) (referring to "employed individuals with a medically improved disability"); *id.* at § 1396a(a)(10)(C)(ii) (referring to "individuals under the age of 18").

Even if it's *possible* to interpret the provision to include providers, Congress did not "speak with a clear voice, and manifest an unambiguous intent to confer individual rights" on them. *See Gonzaga*, 536 U.S. at 286. To create a right enforceable under section 1983, Congress must speak loud and clear. And here, it didn't.

Second, section 1396a(a)(8) is too murky and amorphous to create enforceable rights. *See Blessing*, 520 U.S. at 340–41. The statute refers to providing medical assistance with "reasonable promptness." *See* 42 U.S.C. § 1396a(a)(8). But the text does not set any standards for what is "reasonable," and what is "prompt[]." *Id.* Without a measuring stick, courts would be ill-equipped to evaluate compliance. *See Blessing*, 520 U.S. at 345 (holding that a requirement of "sufficient" staff was "far too tenuous" to support a claim because of the "undefined standard"); *Suter v. Artist M.*, 503 U.S. 347, 359–60 (1992) (holding that a statute that required "reasonable efforts" did not give rise to a private right of action). Maybe a court could borrow the yardstick of section 1396a(a)(37)(A) (that is, the 30-day/90-day provision), but if that's what Congress had in mind, Congress could have said so.

Third, the statute does contain some mandatory language. Individuals can apply for medical assistance, and "such assistance shall be furnished with reasonable promptness to all

eligible individuals." *See* 42 U.S.C. § 1396a(a)(8). But again, the mandatory language is geared toward "eligible individuals," not providers. *Id.* The provision does not contain language creating an unmistakable mandate on the part of the state to do anything for providers. And it does not compel the state to enforce the payment obligations of MCOs.

Overall, section 1396a(a)(8) does not contain language that creates unmistakable rights in the hands of the providers. So it cannot support a claim under section 1983.

II. Failure to State a Claim

Even if, for the sake of argument, providers could bring a private right of action under the provisions in question, Saint Anthony would not have a claim. The complaint fails to state a claim for which relief can be granted, because the statute does not say what the Hospital thinks it says. So, even if a provider could *bring* a claim, the complaint in question doesn't *state* a claim.

The reasons echo some of the reasons why there is no private right of action. Section 1396u-2(f) is about the content of a contract between the state and the MCOs. *See* 42 U.S.C. § 1396u-2(f). Again, a "contract" with MCOs "shall provide" that the MCOs must make payment on a timely basis consistent with the "procedures" of section 1396a(a)(37)(A). *Id.*

So the statute is about the content of contracts. And here, Saint Anthony does not allege that the contracts with the MCOs lack the necessary provisions. The complaint stops short of alleging that the state's contracts failed to include what they *must* include. So the complaint fails to state a claim.

Saint Anthony believes that the statute requires the state to "ensure" that MCOs pay their bills in a timely manner. *See* Cplt., at ¶ 80 (Dckt. No. 1) ("The State, through HFS, has an obligation to hospitals and other providers to ensure their Medicaid claims are timely paid by Illinois' MCOs."). But that's not what the statute says at all.

Section 1396a(a)(37)(A) provides that the state plan must have "claims payment procedures which . . . ensure" payment of a certain percentage of claims in a certain period of time. *See* 42 U.S.C. § 1396a(a)(37)(A). The "*procedures*" will "ensure" payment, not the state. *Id.* (emphasis added). Nothing in that provision says that states have an ongoing obligation to ensure prompt payment by the MCOs.

The second claim fares no better. As a refresher, section 1396a(a)(8) lays down requirements for a state's Medicaid plan. "A State plan for medical assistance must . . . 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." *See* 42 U.S.C. § 1396a(a)(8). Saint Anthony does not allege that the Illinois Medicaid plan lacks that requisite language.

The bottom line is that the complaint fails to allege a claim against the state. The Medicaid Act sets requirements for the content of contracts with MCOs, and the content of a state's plan. The complaint does not allege that the contract and the plan lack the necessary provisions. So, even if the statute could give rise to a private right of action, Saint Anthony Hospital has failed to state a claim.

III. Enforcement Generally

The Court adds one final word about where the parties go from here. The gist of the complaint is that the MCOs aren't paying as they should. Maybe Saint Anthony is right about that – the Court does not reach that issue. But if Saint Anthony wants to pursue that issue, suing the state isn't the way to go. Saint Anthony brought the wrong claim in the wrong forum.

Saint Anthony entered into contracts with each of the MCOs, and has the ability to press its contractual rights under those agreements. The MCOs rightly point out that the agreements

require mandatory arbitration. So, if Saint Anthony wants to assert its right to timely payment from the MCOs, there is a brightly lit path for doing so. Saint Anthony can file for arbitration. Maybe Saint Anthony is reluctant to do so for some reason. But that reluctance is not a reason to tunnel into the federal courthouse by suing the state.

The federal government has enforcement powers, too. The federal government provides funds to states with the understanding that they will comply with certain conditions. And if they don't comply, the federal government can take funds away. The typical remedy for violating the terms of Spending Clause legislation is no more spending. *See Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 28 (1981) ("In legislation enacted pursuant to the spending power, the typical remedy for state noncompliance with federally imposed conditions is not a private cause of action for noncompliance but rather action by the Federal Government to terminate funds to the State.").

The provisions in question illustrate the point. If an MCO doesn't comply with section 1396u-2, the federal government is prohibited from funding the state's managed care program. *See* 42 U.S.C. § 1396b(m)(2)(A)(xii). If a state doesn't comply with section 1396a(a), the Secretary of Health and Human Services "may" withhold Medicaid funding "in whole or in part." *Planned Parenthood of Indiana, Inc. v. Comm'r of Indiana State Dep't of Health*, 699 F.3d 962, 969 (7th Cir. 2012); *see also* 42 U.S.C. § 1396c; 42 C.F.R. § 430.12(c).

If the MCOs failed to live up to their obligations, then the state can do something about it, too. The state can cancel a contract if an MCO fails to comply with the terms of a contract with a provider. *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 . . . ."). But

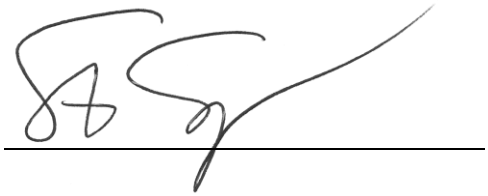
that power to terminate the contract rests with the state, not the judiciary. *See Heckler v. Chaney*, 470 U.S. 821, 831 (1985) ("This Court has recognized on several occasions over many years that an agency's decision not to prosecute or enforce, whether through civil or criminal process, is a decision generally committed to an agency's absolute discretion.").

In sum, there are well-defined contractual and statutory routes to follow if the MCOs and the state are not living up to their obligations. But suing the state in federal court is not one of them.

Conclusion

For the reasons stated above, the Court grants the motion to dismiss.

Date: July 9, 2021



Steven C. Seeger
United States District Judge

UNITED STATES DISTRICT COURT
FOR THE Northern District of Illinois − CM/ECF LIVE, Ver 6.3.3
Eastern Division

Saint Anthony Hospital

Plaintiff,

v.

Case No.: 1:20−cv−02561
Honorable Steven C. Seeger

Theresa Eagleson

Defendant.

NOTIFICATION OF DOCKET ENTRY

This docket entry was made by the Clerk on Tuesday, July 13, 2021:

MINUTE entry before the Honorable Steven C. Seeger: Plaintiff Saint Anthony Hospital's motion for leave to file supplemental complaint (Dckt. No. [101]) is hereby denied. Order to follow. This Court recently granted Defendant's motion to dismiss. (Dckt. No. [108]). Ordinarily, this Court would give a plaintiff leave to amend. But leave to amend is not necessary when an amendment would be futile. See O'Boyle v. Real Time Resolutions, Inc., 910 F.3d 338, 347 (2018); Moore v. Indiana, 999 F.2d 1125, 1128 (7th Cir. 1993). Here, the Court sees no avenue for an amended complaint to state a private right of action against the state. The provisions of the Medicaid Act in question do not create a right enforceable under section 1983. No amendment to the complaint can change that reality. So an amendment would be futile. The case is closed. Civil case terminated. Mailed notice. (jjr,)

ATTENTION: This notice is being sent pursuant to Rule 77(d) of the Federal Rules of Civil Procedure or Rule 49(c) of the Federal Rules of Criminal Procedure. It was generated by CM/ECF, the automated docketing system used to maintain the civil and criminal dockets of this District. If a minute order or other document is enclosed, please refer to it for additional information.

For scheduled events, motion practices, recent opinions and other information, visit our web site at ***www.ilnd.uscourts.gov***.

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

SAINT ANTHONY HOSPITAL,	)	
	)	
Plaintiff,	)	Case No. 20-cv-2561
	)	
v.	)	Hon. Steven C. Seeger
	)	
THERESA EAGLESON, in her official capacity as Director of the Illinois Department of Health and Family Services,	)	
	)	
Defendant.	)	

ORDER

Plaintiff Saint Anthony Hospital's motion under Rule 15(d) for leave to file a supplemental complaint (Dckt. No. [101]) is hereby denied.

The Federal Rules include a few routes for filing a new and improved complaint. Under Rule 15(a), courts "should freely give leave" to amend a complaint "when justice so requires." *See* Fed. R. Civ. P. 15(a)(2). The Federal Rules also provide that a court "may, on just terms, permit a party to serve a supplemental pleading setting out any transaction, occurrence, or event that happened after the date of the pleading to be supplemented." *See* Fed. R. Civ. P. 15(d).

Under Rule 15(d), the district court's decision is discretionary, as confirmed by the use of the verb "may." *Id.* Motions under Rule 15(d) "should be freely granted when doing so will promote the economic and speedy disposition of the entire controversy between the parties, will not cause undue delay or trial inconvenience, and will not prejudice the rights of any of the other parties to the action." *See* 6A Charles Alan Wright & Arthur R. Miller, Federal Practice and Procedure § 1504 (3d ed. 2020) (internal footnotes omitted); *see also Glatt v. Chicago Park*

Dist., 87 F.3d 190, 194 (7th Cir. 1996). The Court can consider the legal sufficiency of the proposed amendment, too. *See* James Wm. Moore, *Moore's Federal Practice* § 1515[3] (3d ed. 2020).

Here, Saint Anthony filed a motion for leave to file a supplemental complaint under Rule 15(d). Saint Anthony seeks to add a claim (Count III) alleging that the state is violating its rights under the Due Process Clause of the Fourteenth Amendment by failing to provide specific information in their remittance advices, and by failing to ensure that managed care organizations ("MCOs") provide that same information in their remittance advices.

The gist of the new claim is that Saint Anthony has a property interest in certain payments (*i.e.*, HAP Claims Payment Increases, and Other Add-On Payments). But the state and the MCOs don't give Saint Anthony enough information for Saint Anthony to be able to tell if it is getting the payments that it is entitled to receive. *See* Supp. Cplt., at ¶ 5 (Dckt. No. [101-1]) (alleging that Saint Anthony is "in the dark as to whether it is being paid moneys to which it is entitled and in which it has a property interest"). In its view, the Due Process Clause gives Saint Anthony a right to greater transparency about what, exactly, the MCOs and the state are paying with each remittance. *Id.* at ¶ 7 ("Without the transparency Saint Anthony has requested . . . Saint Anthony cannot know whether and how much the MCOs have underpaid it.").

The Illinois Medicaid program has two components: a "fee for service" program, which is administered by the state, and a "managed care" program, which is administered by MCOs. The proposed supplemental complaint alleges that the state itself is not providing adequate information when it sends remittances in the fee-for-service program. *Id.* at ¶ 50. And it alleges that the state is not requiring the MCOs to provide enough information in the managed care program. *Id.* at ¶¶ 5, 8, 51, 37, 55; *see also id.* at ¶ 20 ("HFS has refused to require the MCOs to

provide the basic information necessary for Saint Anthony to determine on a regular and accurate basis whether it has been paid all that it is due."). So the state "does not provide notice to Saint Anthony" about what it is paying for the fee-for-service program, and "does not require the MCOs . . . to make that disclosure" under the managed care program. *Id.* at ¶ 49.

The proposed supplemental complaint would substantially expand the scope of the case (especially in light of the recent dismissal of the other claims). The original complaint advanced claims about the managed care program only. The supplemental complaint, on the other hand, also makes allegations about the state's fee-for-service program. The supplemental complaint would bring that separate Medicaid program into the case for the first time. It would entail a new theory about a new program, opening up whole new frontiers of discovery. And it would unnecessarily prolong the case because the case is otherwise over.

The theory of the proposed supplemental complaint is much different than the original complaint, too. The original complaint involved claims about the state's duty to ensure that the MCOs were paying Saint Anthony in full and on time. But the supplemental complaint involves claims about the amount of detail that the state and the MCOs must provide when they send remittances to Saint Anthony. Both complaints involve allegations about payments to Saint Anthony under the state's Medicaid program, but there aren't a lot of other similarities, at least when it comes to the nature of the claims. There is a little bit of overlap, but not much. *See* Cplt., at ¶¶ 55–61 (Dckt. No. 1) (alleging a lack of transparency).

The Court also has doubts about the legal sufficiency of Saint Anthony's proposed new claim, especially with respect to the managed care program. Saint Anthony has a contractual relationship with the MCOs. If Saint Anthony is not receiving what it is entitled to receive under those contracts with the MCOs, then the remedy is to pursue its rights under those agreements.

The MCOs are private parties, not state actors. *See generally Am. Mfrs. Mut. Ins. Co. v. Sullivan*, 526 U.S. 40 (1999). The Due Process Clause is about state action, but here, the proposed supplemental complaint at its core is about the conduct of private parties. Saint Anthony cannot get around the state action requirement by blaming the state for the conduct of non-state actors. A lack of information from a private party, without more, is not a deprivation of due process by the government.

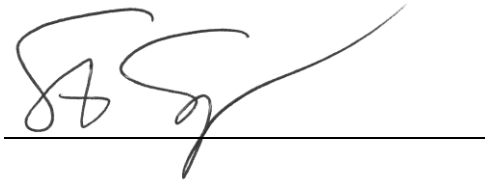
Maybe the state could force the MCOs to provide more information. But the failure to exercise that power does not mean that the state *itself* is violating Saint Anthony's due process rights.

At times, the actions of private parties can constitute state action. But that's not this case. The complaint contains no allegation of a "concerted effort," meaning an agreement between the state and the MCOs to deprive Saint Anthony of information that it is entitled to receive. *See Spiegel v. McClintic*, 916 F.3d 611, 616 (7th Cir. 2019); *Alarm Detection Sys., Inc. v. Village of Schaumburg*, 930 F.3d 812, 825 (7th Cir. 2019). It simply alleges government inaction when the government could do something. *See* Supp. Cplt., at ¶¶ 20, 49.

Finally, the proposed supplemental complaint is an awkward fit, at best, with Rule 15(d). That rule authorizes a party to update a pleading when something "happened," meaning a "transaction, occurrence, or event," "after the date of the pleading to be supplemented." *See* Fed. R. Civ. P. 15(d). That doesn't fit this situation. Saint Anthony doesn't really want to bring the complaint up to date, based on new facts on the ground that happened after the original complaint. Instead, Saint Anthony seeks to expand the case by unveiling a whole new legal theory, and then applying it to a state program that was not at issue in the original complaint.

The supplemental complaint would radically change the scope and nature of the case. It's not remodeling; it's new construction. Saint Anthony is free to build a new claim in a new case, but it's not on the foundation of the original complaint (or even in the same neighborhood), so it doesn't belong here. Motion denied.

Date: July 13, 2021



Steven C. Seeger
United States District Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE
NORTHERN DISTRICT OF ILLINOIS

SAINT ANTHONY HOSPITAL,

Plaintiff(s),

v.

THERESA EAGLESON, in her official capacity as Director of the Illinois Department of Health and Family Services,
Defendant(s).

Case No. 1:20-cv-02561
Judge Steven C. Seeger

JUDGMENT IN A CIVIL CASE

Judgment is hereby entered (check appropriate box):

☐ in favor of plaintiff(s)
and against defendant(s)
in the amount of $,

which ☐ includes pre–judgment interest.
☐ does not include pre–judgment interest.

Post-judgment interest accrues on that amount at the rate provided by law from the date of this judgment.

Plaintiff(s) shall recover costs from defendant(s).

☐ in favor of defendant(s)
and against plaintiff(s)

☒ other: Defendant Eagleson's motion to dismiss is hereby granted. Civil case terminated.

This action was *(check one)*:

☐ tried by a jury with Judge presiding, and the jury has rendered a verdict.
☐ tried by Judge without a jury and the above decision was reached.
☒ decided by Judge Steven C. Seeger on a motion to dismiss (Dckt. No. [16]).

Date: 7/13/2021

Thomas G. Bruton, Clerk of Court

Jessica J. Ramos, Deputy Clerk