No. 22-

In the Supreme Court of the United States

THERESA EAGLESON, DIRECTOR OF THE ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES,
Petitioner,

v.

ST. ANTHONY HOSPITAL,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

PETITION FOR A WRIT OF CERTIORARI

KWAME RAOUL
Attorney General
State of Illinois
JANE ELINOR NOTZ*
Solicitor General
RICHARD S. HUSZAGH
Assistant Attorney General
100 West Randolph St.
Chicago, Illinois 60601
(312) 814-5376
jane.notz@ilag.gov

* *Counsel of Record*

QUESTIONS PRESENTED

In traditional Medicaid fee-for-service programs, States pay healthcare providers directly and must adopt claims payment procedures to ensure that they pay defined percentages of providers' claims within specified time periods. 42 U.S.C. § 1396a(a)(37)(A). Alternatively, States may establish managed care programs, in which they contract with managed care organizations ("MCOs") that in turn enter into contracts with healthcare providers and pay them according to the terms of those contracts. For such programs under a State's Medicaid plan, Section u-2(f) of the Medicaid Act provides that a State must include in its contracts with MCOs a provision—the "Timely Payment Clause"—pursuant to which each MCO agrees to pay providers "on a timely basis consistent with the claims payment procedures described in section 1396a(a)(37)(A) . . . , unless the health care provider and [MCO] agree to an alternate payment schedule." 42 U.S.C. § 1396u-2(f).

The questions presented are:

1. Whether Spending Clause legislation, including Section u-2(f), can impliedly create private rights enforceable under 42 U.S.C. § 1983.

2. Whether, if so, Section u-2(f)'s requirement that States include the Timely Payment Clause in their contracts with MCOs unambiguously gives States a statutory duty, not just a contractual right, to ensure that MCOs pay providers in accordance with that contract provision, and also unambiguously gives providers a private right to enforce that duty.

PARTIES TO THE PROCEEDING

Petitioner is the Director of the Illinois Department of Healthcare and Family Services ("Department"), the state agency that operates Illinois' Medicaid program. Respondent St. Anthony Hospital operates a hospital in Illinois. Meridian Health Plan of Illinois, Inc., IlliniCare Health Plan, Inc., Blue Cross and Blue Shield of Illinois, a division of Health Care Service Corporation, and Cook County Health & Hospitals System are MCOs that intervened in the action.

RELATED PROCEEDINGS

St. Anthony v. Eagleson, No. 21-2325 (7th Cir.) (order denying rehearing and rehearing en banc, Sept. 8, 2022)

St. Anthony v. Eagleson, No. 21-2325 (7th Cir.) (order reversing district court judgment, July 5, 2022)

St. Anthony v. Eagleson, No. 20-cv-2561 (D. Ct. N.D. Ill.) (judgment against plaintiff, July 13, 2021)

St. Anthony v. Eagleson, No. 20-cv-2561 (D. Ct. N.D. Ill.) (order dismissing action, July 9, 2021)

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PETITION FOR A WRIT OF CERTIORARI

Theresa Eagleson, Director of the Illinois Department of Healthcare and Family Services, respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Seventh Circuit. That court, over a dissent by Judge Brennan, held that Section u-2(f) does not just require States to include the Timely Payment Clause in their contracts with MCOs, thereby giving States a contractual right to enforce that provision, but also imposes on States a statutory duty to "ensure" that MCOs comply with the Timely Payment Clause, and gives healthcare providers a private right, enforceable under Section 1983, to force States to comply with that duty.

That interpretation implicates the issues raised in *Health & Hospital Corp. of Marion County v. Talevski* (No. 21-806), now pending before this Court—namely whether, and under what standards, Spending Clause legislation may impliedly create private rights enforceable under Section 1983. In addition, as the dissent below observed, even under existing precedent—including *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1 (1981), and *Gonzaga University v. Doe*, 536 U.S. 273 (2002)—the Seventh Circuit's interpretation of Section u-2(f) violates the Court's strict standards for finding state duties and private rights in Spending Clause statutes.

In these circumstances, the Court should hold this petition pending its decision in *Talevski*, then grant certiorari and either (i) vacate the Seventh Circuit's opinion and remand for further consideration, or (ii) set the case for plenary review on the second question presented.

OPINIONS BELOW

The opinion of the court of appeals on denial of rehearing (App. 11a–77a) is reported at 48 F.4th 737. That court's opinion on the merits (App. 11a–77a) is reported at 40 F.4th 492. The district court's opinion and order (App. 78a–113a) is reported at 548 F. Supp. 3d 721.

JURISDICTION

The court of appeals' judgment on denial of rehearing was entered on September 8, 2022. This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

STATUTE INVOLVED

42 U.S.C. § 1396u-2(f) provides:

> A [State's] contract . . . 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 . . . 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[.]

STATEMENT

1. Medicaid is a Spending Clause program in which participating States, with federal financial support, provide medical assistance to needy individuals. It is authorized by Title XIX of the Social Security Act,

42 U.S.C. §§ 1396 *et seq.* (the "Medicaid Act"), which Congress enacted in 1965 and has since amended from time to time. States originally operated only fee-for-service programs, in which they process claims and pay healthcare providers directly for covered services to eligible individuals. For such programs, Section a(a)(37)(A) requires States to adopt claims payment procedures which ensure that they pay 90 percent of practitioners' "clean claims" (that is, claims for which all necessary information to process the claim is provided) within 30 days, and pay 99 percent of such claims within 90 days. 42 U.S.C. § 1396a(a)(37)(A).

In 1997, Congress amended the Medicaid Act to allow state Medicaid plans to offer medical assistance through managed care programs. Pub. L. No. 105-33, §§ 4701 *et seq*. Such programs, which are commonly used in the private sector and for Medicare benefits, rely on a two-tier system of contracts—between States and MCOs, to whom States pay a fixed fee for each enrolled individual, and then between MCOs and healthcare providers, whose contracts govern how much, and when, the providers are paid for covered services. See *Cmty. Health Care Ass'n of N.Y. v. Shah*, 770 F.3d 129, 137 (2d Cir. 2014).

For such managed care programs, the Medicaid Act directly regulates certain conduct by States and by MCOs, mainly relating to the enrollment and provision of medical care to eligible individuals. See, e.g., 42 U.S.C. §§ 1396u-2(a)(2)–(6), (b)(3)–(8), (c)(1), (d)(1), (2), (4), (6), (e)(1)–(4); 1396b(m)(4). The Medicaid Act also regulates various aspects of the contractual relationship between States and MCOs. See, e.g., 42 U.S.C. §§ 1396u-2(b)(1)–(3), (c)(2), (d)(5), (f), (g), (h).

2. Section u-2(f), at issue here, provides that each state contract with an MCO shall include the Timely Payment Clause, pursuant to which the MCO makes a contractual commitment to the State that it will pay providers "on a timely basis consistent with the claims payment procedures described in section 1396a(a)(37)(A) . . . , unless the health care provider and [MCO] agree to an alternate payment schedule." 42 U.S.C. § 1396u-2(f).

Proceedings Below

1. Respondent St. Anthony Hospital is a private hospital located in Chicago with a large volume of Medicaid patients. App. 16a, 78a. Invoking the district court's jurisdiction under 28 U.S.C. § 1331, respondent brought this Section 1983 action against petitioner, claiming that the Department was violating Section u-2(f) by not ensuring that the MCOs with which respondent has contracts were paying it on a timely basis. App. 79a, 82a–83a, 86a–87a. In support of this claim, respondent asserted that Section u-2(f) does not just give States a contractual right to require MCOs to pay providers on the same schedule that States follow when they pay providers directly in a fee-for-service program (unless an MCO and provider agree to an alternate payment schedule), but also imposes on States a statutory duty to "ensure" that MCOs pay providers according to that schedule. App. 12a, 18a, 87a, 97a, 110a. And instead of seeking relief against the MCOs under its contracts with them, which contain arbitration clauses, respondent sought a federal court order requiring the Department to force the MCOs to promptly pay respondent what it claimed the MCOs owed it. App. 17a–18a, 58a, 79a, 85a–87a.

2. The district court dismissed respondent's action and rejected its interpretation of Section u-2(f), stating: "that's not what the statute says at all." App. 110a–111a. Relying on this Court's holdings in *Pennhurst* and *Gonzaga* that only "clear" and "unambiguous" language in Spending Clause statutes may establish state obligations and private rights to enforce those obligations, the district court held that that the duty respondent attributed to Section u-2(f), under which States must "ensure that MCOs pay providers promptly, . . . simply isn't there." App. 96a–100a, 110a–111a.

3. On appeal, a divided panel of the Seventh Circuit reversed. Over Judge Brennan's dissent, the majority held that Section u-2(f) imposes on States a statutory duty, which providers have a private right to enforce under Section 1983, to "ensure" that MCOs do not "systematically" fail to pay providers on a timely basis. App. 12a, 20a, 33a–43a, 46a, 48a.

At the threshold, both the majority and dissent recognized the importance of the case. The majority acknowledged the "potential magnitude" of its interpretation of Section u-2(f), "with high stakes for the State." App. 48a. And the dissent, noting that no other federal court of appeals had "ever recognized a state's privately enforceable duty to guarantee timely payment under § 1396u-2(f)," stated that the majority's interpretation "threatens to put a tremendous burden on states and the judiciary" and will make "district courts the new Medicaid claims processors for the states." App. 63a, 71a–72a. Among the "few cases recognizing a private right of action under Medicaid," the dissent explained, "none has imposed a duty on the states as broad in scope, ongoing in nature, and

difficult to enforce as the duty the majority opinion concludes exists here." App. 72a (footnote omitted).

Nevertheless, in the majority's view, its reading of Section u-2(f) better fulfilled Congress's goal of having providers timely paid. App. 25a, 33a–39a, 46a–48a. The majority recognized that the Medicaid Act establishes two contractual remedies for delayed MCO payments to providers: "The State can . . . sue MCOs for breach of contract if they fail to pay providers according to the 30/90 pay schedule, and providers are entitled to enforce their own contractual rights as they see fit." App. 34a.[1] But it considered these remedies inadequate, stating that "[t]here is good reason to doubt that contractual remedies alone can vindicate the provider's right to prompt payment." App. 47a. The result, the majority held, is that respondent's interpretation of Section u-2(f) was "more coherent" than a reading that would rely on contractual remedies alone. App. 37a. The majority further held that Section u-2(f) incorporates an additional element: a State's duty is limited to addressing "systemic failures" by MCOs to make timely payments. App. 37a.

Judge Brennan dissented. He explained that the majority's reading violated this Court's precedent regarding the creation of state duties and private rights in Spending Clause statutes. This precedent, he

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[1] The majority admitted that the Department had exercised its contractual right to enforce the Timely Payment Clause in its contract with an MCO operated by the government of Cook County, Illinois, through a corrective action plan, when that MCO delayed payments to providers by using Medicaid funds to pay other obligations. App. 36a; see also App. 45a–46a.

observed, establishes that "'[i]f Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously,'" and that "[b]ecause Medicaid is legislation under the Constitution's Spending Clause, Congress must 'speak with a clear voice' before imposing obligations on the states." App. 60a (quoting *Pennhurst*, 451 U.S. at 17). He added: "[n]othing short of an unambiguously conferred right . . . phrased in terms of the persons benefited can support a section 1983 action." App. 61a (citing, inter alia, *Gonzaga*, 536 U.S. at 283–284, and *Armstrong v. Exceptional Child Ctr., Inc.*, 575 U.S. 320, 332 (2015)).

The majority's reading of the statute, Judge Brennan explained, violated those commands. As to "the text of § 1396u-2(f)," he wrote:

> Congress mandated that a state's "contract" with an MCO "shall provide" that the MCO make payments to healthcare providers on a timely basis consistent with § 1396a(a)(37)(A)'s 30-day/90-day payment schedule, unless healthcare providers and MCOs agree to an alternate payment schedule. But it is clear that is all the text requires. Section 1396u-2(f) is silent on any ongoing governmental duty to monitor MCO payments or otherwise guarantee that MCOs consistently make prompt payments. As other neighboring statutory provisions show, Congress knows how to impose duties requiring state action. Section § 1396u-2(f) contains no such language.

App. 61a–62a (footnote omitted).

Addressing the majority's analysis of Section u-2(f), Judge Brennan described it as "lacking a

textual basis in § 1396u-2(f)" and "pass[ing] over the actual language of § 1396u-2(f) in favor of factors outside the statute." App. 63a, 68a. He also criticized the majority's judgment that "Congress's chosen tools for ensuring prompt payment—private suits and arbitration by healthcare providers against MCOs, along with discretionary enforcement by states—are inadequate." App. 69a. That judgment, he said: overlooked that Congress demonstrated it "knows how to impose duties requiring state action" (App. 61a); incorrectly assumed that the court must "disfavor[]" an interpretation that limits the extent to which Section u-2(f) achieves Congress's purpose to have providers paid on a timely basis (App. 68a–69a); and substituted the majority's "'view of . . . policy for the legislation which has been enacted by Congress'" (App. 69a (quoting *Fla. Dep't of Revenue v. Piccadilly Cafeterias, Inc.*, 554 U.S. 33, 51–52 (2008))). The result, Judge Brennan said, lets providers "bypass" Congress's "chosen tools for ensuring prompt payment," based on contract rights, by bringing Section 1983 actions directly against States. App. 58a, 69a.

Judge Brennan further stated that the Medicaid Act provisions regarding state oversight of MCOs, on which the majority relied, are consistent with giving States contractual rights, not statutory duties, to require MCOs to pay providers on a timely basis. App. 66a. And, he concluded, the statutory duty the majority found in Section u-2(f) not only defeats the managed care program's design "to alleviate the burden on states of managing the 'day-to-day' functions previously performed by states under a fee-for-service system," but also "threatens to put a tremendous burden on states and the judiciary," by opening

the door to "substantial litigation over the timeliness of paying claims." App. 62a–64a.

Judge Brennan also criticized the majority for rewriting Section u-2(f) to include a condition for invoking private rights under it—the "systemic" failure by an MCO to make timely payments—that has "no textual basis." App. 64a; see also App. 64a (Section u-2(f) "never mentions—let alone defines—'systemic' failures to make timely payments."). Federal courts, he explained, will not be able to determine whether an MCO has systemically failed to make payments according to the 30-day/90-day schedule "without reaching the requisite question of whether the disputed claims are clean," "examin[ing] claims for untimely payment on the merits," and "then determin[ing] whether the 'systemic' threshold has been reached." App. 70a.

Noting, finally, that no "other federal circuit ever recognized a state's privately enforceable duty to guarantee timely payment under § 1396u-2(f)," Judge Brennan stated that "[t]o find such an expansive duty under § 1396u-2(f), without any textual support—in the context of Spending Clause legislation, where Congress must speak 'unambiguously' with a 'clear voice'—is a watershed moment." App. 72a–73a.

4. Petitioner sought rehearing on the question of whether Section u-2(f) creates the statutory duty and private right announced by the majority opinion. 7th Cir. Doc. 68. Petitioner also requested that the court hold the rehearing petition pending this Court's decision in *Talevski*. *Id.* at 3, 14–15. The Seventh Circuit declined to hold the petition and denied rehearing, with the panel members again issuing separate majority and dissenting opinions. App. 1a–10a.

For its part, the majority acknowledged both "the potential complexity and challenge of this case for the district court." App. 3a. It also "recognize[d] that the Supreme Court may reshape applicable law in *Talevski*." App. 3a. The majority asserted, however, that its decision "imposes no new duties on . . . State officials" and allows only "injunctive relief to push State officials to comply with duties already imposed by the Medicaid Act." App. 3a.

Judge Brennan, again dissenting, stated that "the proper interpretation of § 1396u-2(f) is a question of extraordinary significance which we should rehear." App. 8a. Panel rehearing was justified, he explained, "[b]ecause this decision will create tremendous burdens and complex practical problems," including for federal courts. App. 8a. He concluded, however, that rehearing en banc was not warranted "[b]ecause of the imminent possibility this area of law will change markedly" as a result of *Talevski*. App. 8a–10a.

REASONS FOR GRANTING THE PETITION

The Court should hold this petition pending its decision in *Talevski* and then either (i) enter an order granting certiorari, vacating the majority's opinion, and remanding for further consideration in light of *Talevski*, or (ii) grant plenary review on the merits of the second question presented.

The Court's upcoming decision in *Talevski* will clarify, if not change, the standards relevant to the proper interpretation of Section u-2(f). Whether Section u-2(f) imposes on States a statutory duty to ensure that MCOs pay providers on a timely basis, and also gives providers a private right to enforce that duty, presents an issue of extraordinary importance

affecting the administration of Medicaid managed care programs in dozens of States involving hundreds of billions of dollars in annual public expenditures. And the decision below departs egregiously from this Court's existing precedent setting strict standards for finding the creation of state duties and private rights in Spending Clause statutes. Further review is thus warranted.

I. This Case Should Be Held for *Talevski*.

"Where intervening developments . . . reveal a reasonable probability that the decision below rests upon a premise that the lower court would reject if given the opportunity for further consideration, and where it appears that such a redetermination may determine the ultimate outcome of the litigation, a GVR order is . . . potentially appropriate." *Lawrence v. Chater*, 516 U.S. 163, 167 (1996) (per curiam). The Court "often 'GVRs' a case . . . when it believes that the lower court should give further thought to its decision in light of an opinion of this Court that (1) came after the decision under review and (2) changed or clarified the governing legal principles in a way that could possibly alter the decision of the lower court." *Flowers v. Mississippi*, 136 S. Ct. 2157, 2157 (2016) (Alito, J., dissenting) (cleaned up); see *Lawrence*, 516 U.S. at 168–169. That standard is met here.

All members of the Seventh Circuit panel, as well as respondent, recognized that this Court's decision in *Talevski*, including on the issue of whether Spending Clause statutes can create private rights enforceable under Section 1983 only expressly, not by implication, may affect the outcome of this case. App. 3a, 8a–10a. Section u-2(f) is part of a Spending Clause statute (the

Medicaid Act), and no one contends that it expressly declares the private right the Seventh Circuit majority found in it. A decision on the second question presented in *Talevski*, addressing whether another provision of the Medicaid Act creates private rights enforceable under Section 1983, likewise could change or clarify the applicable standards for finding that Congress intends to create such rights in Spending Clause statutes. Accordingly, the Court should hold this petition pending its decision in *Talevski* and then act on the petition as appropriate, including by entering an order granting the petition, vacating the Seventh Circuit's opinion, and remanding the case for further consideration.

II. If The Court Does Not Grant, Vacate, and Remand After *Talevski*, It Should Grant Plenary Review.

If the Court does not grant the petition and vacate the decision below in light of *Talevski*, it should grant plenary review for two related reasons. First, the Seventh Circuit majority's opinion does not just obviously misinterpret Section u-2(f); it flatly contravenes this Court's precedent regarding the interpretation of Spending Clause statutes. Second, the interpretation of Section u-2(f) has tremendous national importance. The majority's judgment fundamentally transforms the basic structure and operation of managed care programs throughout the country, which involve hundreds of billions of dollars in public spending each year. And review of that decision is critical to ensure that federal courts faithfully follow this Court's precedent establishing strict standards for finding that Spending Clause statutes create state duties and private rights to enforce those duties.

A. The Seventh Circuit's Decision Flatly Contravenes this Court's Precedent on Interpreting Spending Clause Statutes.

Review on the merits of the second question presented, involving the proper interpretation of Section u-2(f), is justified by the Seventh Circuit's manifest failure to follow the Court's well-established precedent concerning the interpretation of Spending Clause legislation. The majority opinion mentioned this precedent but then effectively disregarded it, despite the dissent's repeated charge that the majority was doing just that. This case thus presents an excellent vehicle for the Court to clarify and reaffirm the applicable principles for interpreting a Spending Clause statute that does not unambiguously establish the duty and right asserted by the plaintiff.

1. Interpretation of Spending Clause statutes

Whether a Spending Clause statute establishes a private right enforceable under Section 1983 involves two related issues: whether the statute imposes on a State the duty claimed by the plaintiff, and whether it further gives the class of persons that includes the plaintiff a private right to enforce that duty.

On the first issue, because Spending Clause legislation operates in the nature of a contract, and States voluntarily choose whether to participate based on the terms Congress specified, such legislation creates state duties only when Congress "speak[s] with a clear voice" and establishes such duties "unambiguously." *Pennhurst*, 451 U.S. at 17; see *Cummings v. Premier Rehab Keller, P.L.L.C.*, 142 S. Ct. 1562, 1570 (2022); *Gonzaga*, 536 U.S. at 286 ("If Congress intends to alter

the usual constitutional balance between the States and the Federal Government, it must make its intention to do so unmistakably clear in the language of the statute.") (cleaned up). To determine whether Congress has given such "clear notice," courts "begin with the text" of the statutory provision at issue. *Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006).

If a Spending Clause statute satisfies this first requirement, a court must then determine whether it does not merely confer "benefits" on a specific category of private persons, but "unambiguously" gives them a "right" to enforce the relevant statutory duty, using "explicit rights-creating terms." *Gonzaga*, 536 U.S. at 280–284; see also *id.* at 283 ("*Blessing* [*v. Freestone*, 520 U.S. 329 (2004)),] emphasizes that it is only violations of *rights*, not *laws*, which give rise to § 1983 actions.") (emphasis in original). This inquiry also focuses on the text of the specific statutory provision in question. *Blessing*, 520 U.S. at 342–343; *Cannon v. Univ. of Chicago*, 441 U.S. 677, 689 (1979).

Blessing explained that this second question involves an examination of three factors: whether Congress intended the provision in question to benefit the plaintiff; whether the claimed statutory right is not so "vague and amorphous" that its enforcement would strain judicial competence; and whether the statute unambiguously imposes a binding obligation on the States. 520 U.S. at 340–341. If a Spending Clause statute satisfies all three of these elements, a presumption arises that Congress intended to create a private right, but that presumption is rebutted if the statute contains an enforcement scheme that is inconsistent with that intent. *Id.* at 341; see also *Gonzaga*, 536 U.S.

at 280–284 & n.4.

In *Gonzaga*, the Court refined the *Blessing* analysis in several respects. It held that the relevant statute must be "phrased in terms of the persons benefitted" and establish an "*individual* entitlement," rather than describing duties with an "aggregate focus." 536 U.S. at 284, 288 (emphasis in original, cleaned up). It clarified that only statutes that "unambiguously" establish a "right" to enforce the relevant statutory duty, using "explicit rights-creating terms," create private rights enforceable under Section 1983. *Id.* at 280–284. And it disavowed the suggestion that a less rigorous standard can support finding such rights. *Id.* at 281–283; see also *Armstrong*, 575 U.S. at 330–331 n.* (plurality opinion).

A statute is "unambiguous," and hence can impose on States a particular statutory duty and create a private right to enforce that duty, only if no other interpretation of the statute is "plausible." *Graham Cnty. Soil & Water Conservation Dist. v. U.S. ex rel. Wilson*, 545 U.S. 409, 419 (2005). And, as with all legislation, the interpretation of Spending Clause statutes does not permit courts to read into them terms or conditions that Congress did not enact, *Nat'l Ass'n of Mfrs. v. Dep't of Def.*, 138 S. Ct. 617, 629 (2018); *Return Mail, Inc. v. United States Postal Serv.*, 139 S. Ct. 1853, 1867 n.11 (2019), or to substitute their policy preferences for the text that Congress did enact, *Piccadilly Cafeterias*, 554 U.S. at 51–52. Further, when Congress regulates in an area by prescribing contract terms, rights based on those terms normally are contract rights, not rights "secured by the . . . laws" of the United States that may be enforced under Section 1983. 42 U.S.C. § 1983; *Jackson Transit Auth.*

v. Loc. Div. 1285, Amalgamated Transit Union, AFL-CIO-CLC, 457 U.S. 15, 20–21, 29 & nn.12, 13 (1982); see *Wilson v. Garcia*, 471 U.S. 261, 277 (1985).

2. The Seventh Circuit's opinion disregards the Court's precedent on interpreting Spending Clause legislation.

The Seventh Circuit majority's opinion repeatedly disregarded this established precedent, and often did so without disputing the dissent's protests that it failed to follow this precedent. In particular:

- the majority's interpretation did not "begin with the text" of Section u-2(f), see *Arlington Cent. Sch. Dist. Bd. of Educ.*, 548 U.S. at 296, analyze that text to determine whether it is "unambiguous[],"*Pennhurst*, 451 U.S. at 17, or even identify the specific language in Section u-2(f) that supposedly supports its interpretation;
- the majority did not state that the interpretation of Section u-2(f) adopted by the dissent and the district court, under which the provision simply gives States a contractual right to enforce the Timely Payment Clause in their contracts with MCOs, is not even "plausible," see *Graham Cnty. Soil & Water Conservation Dist.*, 545 U.S. at 419, and instead stated only that its interpretation was "more coherent" (App. 37a);
- the majority substituted its own policy views for what Congress enacted by grounding its conclusion on its views about the comparative effectiveness of contractual and statutory rights and

remedies to achieve the goal of having providers paid on a timely basis, and its assumption about the extent to which Congress intended Section u-2(f) to achieve that goal (App. 34a–38a, 47a–48a), see *Piccadilly Cafeterias*, 554 U.S. at 51–52; *Rodriguez v. United States*, 480 U.S. 522, 525–526 (1987) (per curiam); and

- the majority added an element to its interpretation of Section u-2(f)—that States have a statutory duty only to prevent "systemic" failures by MCOs to pay providers on a timely basis—that is not included in Section u-2(f)'s text, see *Return Mail*, 139 S. Ct. at 1867 n.11.

Remarkably, the majority never responded to the dissent's objections that its opinion "passes over the actual language of § 1396u-2(f) in favor of factors outside the statute" (App. 68a); that the other provisions of the Medicaid Act on which the majority relied are entirely consistent with the view that Congress adopted them for other reasons, including to facilitate a State's exercise of its contractual right to enforce the Timely Payment Clause (App. 65–66a); and that the Medicaid Act, including Section u-2 itself, repeatedly showed that Congress knew how to impose affirmative statutory duties on States when it wanted to (App. 61a–62a & n.3, 65a). Nor did the majority respond to the dissent's criticism that adding the "systemic" element to the duty it found in Section u-2(f)—apparently to minimize the obvious problems that would follow from holding that States must literally "ensure" that MCOs pay providers in accordance with the Timely Payment Clause—has no basis in Section u-2(f)'s text and violates the principle that courts are not free to read into statutes conditions

that Congress itself did not enact. App. 63a–65a.

Individually and collectively, these many serious departures by the Seventh Circuit majority from this Court's established precedent on the interpretation of Spending Clause statutes warrant this Court's review.

B. The Interpretation of Section u-2(f) Is a Question of Exceptional Importance.

Plenary review of the Seventh Circuit's decision is also warranted due to its exceptional importance. The decision has enormous significance for the administration of Medicaid managed care programs nationally. And review is necessary to ensure consistency in lower court jurisprudence concerning the rights and duties created by Congress in Spending Clause statutes.

1. The interpretation of Section u-2(f) has huge consequences for Medicaid managed care programs nationwide.

The proper interpretation of Section u-2(f) has immense practical importance for Medicaid managed care programs throughout the country. Those programs serve more than 50 million individuals in dozens of States and involve annual expenditures of hundreds of billions of dollars in public funds.[2] And the practical differences between the competing interpretations of Section u-2(f) are enormous.

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[2] Ctrs. for Medicare & Medicaid Servs., *Medicaid Managed Care Enrollment and Program Characteristics, 2020* at 6, https://bit.ly/3OXHUwL; Ctrs. for Medicare & Medicaid Servs., *Annual Medicaid & CHIP Expenditures*, https://bit.ly/3XPA5x7 (last visited Dec. 6, 2022).

The Seventh Circuit majority rightly recognized the "potential magnitude" of this question, "with high stakes for the State." App. 48a. The dissent agreed, emphasizing the resulting "tremendous burden" on States and federal courts alike. App. 63a. The massive nationwide consequences of the Seventh Circuit's decision thus justify review by this Court.

Under the interpretation adopted by Judge Brennan in dissent and by the district court, providers have a contractual right to enforce the payment terms in their own contracts with MCOs, and States have a separate contractual right to enforce the Timely Payment Clause in their contracts with MCOs (as the Department has done, see *supra* at 6 n.1), but States do not also have a statutory duty to "ensure" that MCOs pay providers on time, or that MCOs are not guilty of "systemic" payment delays. By contrast, under the majority's interpretation, States must effectively duplicate the MCOs' processing of millions of provider claims and, as the dissent noted, undertake "the same 'day-to-day' administration that a managed care system was supposed to avoid." App. 63a. Under the majority's interpretation, therefore, state Medicaid directors have to decide whether to establish an administrative infrastructure to perform the same claims-processing functions handled by MCOs or risk federal court litigation and liability if they do not.

Further, unless an MCO admits that it is systematically failing to pay providers on a timely basis, a State cannot determine whether an MCO is doing so without itself evaluating, for individual claims, whether the claim was timely paid, which in turn requires evaluating whether the claim was "clean," whether the services were covered by the MCO's plan,

whether the provider obtained any prior authorization required by the plan, when the claim was paid or denied, and, if paid, whether the MCO paid the amount due under its contract with the provider. Performing that analysis for many millions of claims each year represents a monumental task that should not be imposed on States without a thorough analysis of Section u-2(f)'s text in accordance with this Court's governing precedent.

The majority's interpretation of Section u-2(f) also imposes a significant burden on federal courts. As the dissent observed, "a district court can hardly decide if an MCO has systemically underperformed if it does not examine claims for untimely payment on the merits," including "the requisite question of whether the disputed claims are clean," and "then determine whether the 'systemic' threshold has been reached." App. 70a. That determination will just "add to" the "burden on district courts," the dissent explained, "because 'systemic' remains undefined both as a metric (for example, total number of unpaid claims, or a percentage of such claims) and the point at which that numeric threshold is crossed." App. 69a. And this "arduous task" will necessarily "involve some level of adjudicating the nature, timeliness, and merits of payment claims, rendering district courts the new Medicaid claims processors for the states." App. 71a.

Thus, the result of the majority's decision is a wholesale transformation of the regime of contractual rights and remedies governing MCO payments to Medicaid providers into a regime of statutory rights and remedies enforceable in federal court through Section 1983 litigation. Such a massive restructuring of Medicaid managed care programs, with its atten-

dant burdens on both States and federal courts, justifies this Court's review.

2. Correction of the Seventh Circuit's error is necessary to ensure consistency in the interpretation of Spending Clause statutes.

Review by this Court of the second question presented, concerning Section u-2(f)'s meaning, is also warranted to ensure lower courts' faithful adherence to the Court's precedent regarding the interpretation of Spending Clause legislation. As advocates in other litigation before the Court have noted, lower court decisions in this area are characterized by inconsistency and confusion, with conflicting rulings about the meaning of numerous Medicaid Act provisions.[3] That uncertainty undermines the principle that States are entitled to know, based on "unambiguous" statutory text, what duties they have under Spending Clause statutes, and whether those statutes create private rights to enforce those duties. *Gonzaga*, 536 U.S. at 280–286; *Pennhurst*, 451 U.S. at 17.[4] And, as this case illustrates, that uncertainty also leaves room for courts to read into such statutes their own public policy preferences.

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[3] See Brief of Indiana, *et al.* as *Amici Curiae* in Support of Petitioner at 5–6, 8- 9, 14–17 & nn.3–5, *Talevski* (No. 21-806); Brief of 128 Members of Congress as *Amici Curiae* in Support of Certiorari at 2-3, 19-21, *Kerr v. Kerr v. Planned Parenthood S. Atlantic* (No. 21-1431).

[4] See *Talevski* (No. 21-806), Nov. 8, 2022 Oral Arg. Tr. at 46 (Sotomayor, J.) ("So why don't you bring us a case where the right is more ambiguous? This case doesn't seem to present that confusion that you seem to be referring to.").

Against this background, the Seventh Circuit's decision, if left uncorrected, will not just establish a statutory regime subject to federal court enforcement, rather than a contractual regime, to govern MCO payments to Medicaid providers. The decision's many serious departures from the Court's established precedent, conspicuously noted by the dissent, will also send a signal to other courts that this precedent need not be scrupulously observed in cases involving other Spending Clause statutes.

That prospect is unacceptable. Whether Spending Clause statutes unambiguously establish specific state duties and private rights to enforce them is subject to strict standards under this Court's clear precedent. To avoid the Seventh Circuit's approach being followed by other lower courts, and for other Spending Clause statutes, the Court should grant plenary review and clarify the interpretive principles applicable in cases of this kind.

CONCLUSION

The petition for a writ of certiorari should be held pending this Court's decision in *Talevski* (No. 21-806) and then disposed of as appropriate in light of that decision, either by granting, vacating, and remanding for further consideration in light of *Talevski*, or by granting review on the second question presented.

Respectfully submitted,

KWAME RAOUL
Attorney General
State of Illinois
JANE ELINOR NOTZ*
Solicitor General
RICHARD S. HUSZAGH
Assistant Attorney General
100 West Randolph St.
Chicago, Illinois 60601
(312) 814-5376
jane.notz@ilag.gov

* *Counsel of Record*

DECEMBER 2022

APPENDIX A

In the
United States Court of Appeals
For the Seventh Circuit

No. 21-2325

SAINT ANTHONY HOSPITAL,

Plaintiff-Appellant,

v.

THERESA A. EAGLESON, in her official capacity as Director of the Illinois Department of Healthcare and Family Services,

Defendant-Appellee,

and

MERIDIAN HEALTH PLAN OF ILLINOIS, INC., et al.,

Intervening Defendants-Appellees.

Appeal from the United States District Court for the Northern District of Illinois, Eastern Division.
No. 1:20-cv-02561 — Steven Charles Seeger, Judge.

On Petitions for Rehearing and Rehearing En Banc

DECIDED SEPTEMBER 8, 2022

Before Wood, Hamilton, and Brennan, *Circuit Judges*.

On consideration of the petitions for rehearing en banc filed August 2, 2022 by Defendant-Appellee and Intervening Defendants-Appellees, no judge in active service has requested a vote on the petitions for rehearing en banc.[*] Judges Wood and Hamilton voted to deny panel rehearing; Judge Brennan voted to grant panel rehearing.

Accordingly, the petitions for rehearing en banc filed August 2, 2022 by Defendant-Appellee and Intervening Defendants-Appellees are DENIED.

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[*] Judge St. Eve did not participate in the consideration of these petitions for rehearing en banc.

Hamilton, *Circuit Judge*, joined by Wood, *Circuit Judge*.

In view of the petitions' exaggerated accounts of the panel's decision, a few comments are in order. First, the panel opinion imposes no new duties on either State officials or managed care organizations. Nor does the panel opinion offer any path toward monetary liability for the State of Illinois or its officials. Only injunctive relief is at stake here: possible injunctive relief to push State officials to comply with duties already imposed by the Medicaid Act.

The panel recognizes the potential complexity and challenge of this case for the district court, but also its importance for plaintiff and other providers of health care to Medicaid patients, as well as for the patients themselves. The panel concluded that the case should not be dismissed on the pleadings but should proceed toward substantial discovery. That course will allow the district court to consider actual facts rather than just allegations in weighing whether injunctive relief is appropriate and what forms it might take.

Finally, the parties and all members of the panel recognize that the Supreme Court may reshape applicable law in *Talevski v. Health and Hospital Corp.*, 6 F.4th 713 (7th Cir. 2021), *cert. granted*, ––– U.S. –––, 142 S. Ct. 2673 (2022). While that case proceeds in the Supreme Court, however, the stakes of this case and the delay plaintiff has already experienced in the courts weigh in favor of allowing the case to proceed in the district court in parallel with the Supreme Court's consideration of *Talevski*. Hence we are not holding these petitions but issue the mandate with this order denying them.

Brennan, *Circuit Judge*, dissenting from the denial of rehearing.

I would grant panel rehearing of this case for the reasons stated in my concurrence in part and dissent in part, as well as those argued in the petitions for panel rehearing filed by the State of Illinois and the intervening managed care organizations (MCOs).

A.

The full context of this dispute shows how far the majority opinion goes.

Saint Anthony has provider contracts with the MCOs in the Illinois managed care program. Those contracts require the Hospital to submit any dispute arising under them to arbitration. So, arbitration is the path for the Hospital to secure relief on its payment terms. Saint Anthony asked to stay the arbitration of its contract and brought this lawsuit, asking that 42 U.S.C. § 1396u-2(f) be interpreted to recognize a new statutory duty. Only then did a route appear outside of the provider contract and the bargained-for dispute resolution of arbitration.

As seen in literature about private enforcement of the Medicaid Act under 42 U.S.C. § 1983,[1] circuit court enforcement of Medicaid provisions since *Gonzaga University v. Doe*, 536 U.S. 273 (2002), has never involved § 1396u-2(f). Now, not only has a private right of action been recognized for the first time as to

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[1] Jane Perkins, NAT'L HEALTH L. PROGRAM, PRIVATE ENFORCEMENT OF THE MEDICAID ACT UNDER 42 U.S.C. § 1983 (2021), https://health-law.org/wp-content/uploads/2021/07/Fact-Sheet-1983-Enforcement.pdf.

§ 1396u-2(f)—a conclusion I agree is compelled under the *Blessing* factors—but the State is obliged under that Medicaid statute to proactively guarantee timely managed care payments to healthcare providers. That obligation is meant to be enforced under the arbitration clause pursuant to the MCO provider contracts.

I will not repeat the reasons why an administrative prerequisite that a managed care contract includes deadlines is so different from a privately enforceable statutory duty to proactively guarantee timely managed care payments. To me, the text of § 1396u-2(f), the silence of its neighboring statutes as to a duty requiring state action, and the statutory incongruence created by the majority opinion's interpretation are revealing. They show that the text-based interpretation of § 1396u-2(f), in which the district court and I engage, is at least plausible.

A statute with more than one plausible interpretation of its text is ambiguous. *Graham Cnty. Soil & Water Conservation Dist. v. United States ex rel. Wilson*, 545 U.S. 409, 419 (2005). And the Supreme Court requires that before Spending Clause statutes impose duties on states, they must do so "unambiguously," "speak[ing] with a clear voice," *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981), and in statutory language that is "unmistakably clear." *Gonzaga*, 536 U.S. at 283 (quoting *Will v. Mich. Dep't of State Police*, 491 U.S. 58, 65 (1989)). Adhering to these Supreme Court pronouncements, I would not conclude that § 1396u-2(f) imposes an enforceable duty.

B.

These two petitions for rehearing articulate well the burdens, practical problems, and changes in decisionmakers resulting from the majority opinion's interpretation of § 1396u-2(f).

The State points out the heavy burdens this decision will place on various players in the complex world of Medicaid. The interpretation of § 1396u-2(f) presents "a question of first impression ... with immense practical importance for Medicaid managed care programs nationwide, involving dozens of States and hundreds of billions of dollars in spending each year." The State fears the majority opinion will "impose on States a huge and unprecedented obligation to duplicate the administrative functions that Congress intended to be fulfilled by MCOs." The State also notes the impact this decision will have on federal courts to resolve the merits of "payment disputes between MCOs and providers as a predicate to determining whether States are liable for failing to ensure the MCOs are making payments on a timely basis." Medicaid managed care programs "serve more than 50 million individuals and involve annual expenditures of hundreds of billions of dollars." The State is concerned that "state Medicaid directors will have to decide whether to establish an administrative infrastructure to duplicate the claims-processing functions performed by MCOs or risk liability" under § 1396u-2(f).

The MCOs are worried that this decision "funnel[s] a subset of MCO-provider payment disputes into litigation, instead of arbitration, [which] will severely burden all interested parties (including

federal courts)." Under this decision, "federal judges will become the arbiters of any MCO-provider disputes that providers can frame as involving 'systemic failure.'" The foundational question of whether providers should address disputes with MCOs through § 1983 claims or arbitration will arise. The MCOs lament the lack of guidance as to "whether and when there is a 'systemic failure' sufficient to justify" a § 1983 claim. Rather than "costly litigation over the nature and scope of claims," the MCOs believe these disputes "could and should have been submitted to cost-effective arbitration."

The MCOs also point out the practical problems with the majority opinion's reading of § 1396u-2(f). For courts to determine if the predicate for State intervention—"systemic failures by MCOs to comply with the 30/90 payment schedule"—is satisfied, they have to determine "which claims (how many? what proportion?) are unpaid, paid late or paid with less transparency." These "determinations fall squarely within the broad arbitration provision in each provider contract," including Saint Anthony's.

To say the majority opinion only provides a new way under § 1983 to enforce existing obligations does not mitigate the substantial changes and alterations to the Medicaid landscape this decision creates. The "new world" of an enforceable duty under § 1396u-2(f) will require a huge amount of adaptation, new systems, and working through unseen problems, as the obligations on various players change and decision-making is shifted away from arbitrators to federal courts.

Because this decision will create tremendous burdens and complex practical problems, and federal courts will now have to consider and decide payment disputes between MCOs and providers that can be framed as involving "systemic failure," the proper interpretation of § 1396u-2(f) is a question of extraordinary significance which we should rehear.

C.

So why not hear this case en banc? Because of the imminent possibility this area of law will change markedly.

This case may well merit rehearing en banc. Given the burdens and change in decisionmakers, it poses "a question of exceptional importance" under Federal Rule of Appellate Procedure 35(a)(2). And under the requirements before Spending Clause legislation imposes a duty on a state, "the panel decision conflicts with a decision of the United States Supreme Court" under Federal Rule of Appellate Procedure 35(b)(1)(A).

But since this case was argued in February, and before it was decided in July, the Supreme Court granted certiorari in another case from our court, *Talevski v. Health & Hosp. Corp. of Marion Cnty.*, 6 F.4th 713 (7th Cir. 2021), *cert. granted*, —— U.S. ——, 142 S. Ct. 2673 (2022), *argument scheduled for* November 8, 2022. *Talevski* held that nursing home residents have privately enforceable rights under 42 U.S.C. §§ 1396r(c)(1)(A)(ii) and (c)(2)(A) to not be chemically restrained for disciplinary or convenience purposes, and to not be transferred or discharged from a facility unless certain criteria are met. 6 F.4th at 720.

Talevski concerned different Medicaid statutes. But one of the two questions presented on which the Supreme Court granted certiorari is broad: "[w]hether, in light of compelling historical evidence to the contrary, the Court should reexamine its holding that Spending Clause legislation gives rise to privately enforceable rights under Section 1983." Petition for a Writ of Certiorari at i, *Health & Hosp. Corp. of Marion Cnty. v. Talevski*, —— U.S. ——, 142 S. Ct. 2673 (2022). The Court can answer this question in ways that will greatly impact the decision in this case. Even Saint Anthony admits in its response to the petitions for rehearing en banc that "[i]f the Supreme Court significantly changes its precedent on Medicaid private rights of action, those changes could affect the majority's opinion in this case."

If our court heard this case en banc, we would proceed parallel with the Supreme Court's consideration of *Talevski* and expend valuable court time and resources. Given the question presented quoted above, we would need to predict how the Supreme Court thinks that issue should come out, a task broader than the arguments before us in this case. So, en banc rehearing here likely would not be an efficient course given the grant of certiorari in *Talevski*.

In the alternative, as the State suggests, I would hold these petitions for rehearing pending the decision in *Talevski*. The non-prevailing parties here may petition the Supreme Court for a writ of certiorari, and even ask that Court for a stay. The Supreme Court may hold such a petition pending the resolution of *Talevski*. Given the broad and deep impact of the majority opinion, it would be best to resolve these

petitions for rehearing with the counsel of *Talevski*, which could significantly change the legal landscape governing the interpretation of § 1396u-2(f).

For these reasons, I respectfully dissent from the denial of panel rehearing. I would grant the petitions for panel rehearing and reconsider this decision, or in the alternative I would hold these petitions for rehearing subject to the outcome of *Talevski*.

APPENDIX B

In the
United States Court of Appeals
For the Seventh Circuit

No. 21-2325

SAINT ANTHONY HOSPITAL,

Plaintiff-Appellant,

v.

THERESA A. EAGLESON, in her official capacity as Director of the Illinois Department of Healthcare and Family Services,

Defendant-Appellee,

and

MERIDIAN HEALTH PLAN OF ILLINOIS, INC., et al.,

Intervening Defendants-Appellees.

Appeal from the United States District Court for the Northern District of Illinois, Eastern Division.
No. 1:20-cv-02561 — Steven Charles Seeger, Judge.

ARGUED FEBRUARY 15, 2022 — DECIDED JULY 5, 2022

Before Wood, Hamilton, and Brennan, *Circuit Judges*.

Hamilton, *Circuit Judge*.

In recent years, Illinois has moved its Medicaid program from a fee-for-service model, where a state agency pays providers' medical bills, to one dominated by managed care, where private insurers pay medical bills. Most patients of plaintiff Saint Anthony Hospital are covered by Medicaid, so Saint Anthony depends on Medicaid payments to provide care to patients. Saint Anthony says it is now in a dire financial state. Over the last four years, it has lost roughly 98% of its cash reserves, allegedly because managed-care organizations (MCOs) have repeatedly and systematically delayed and reduced Medicaid payments to it.

Saint Anthony contends in this lawsuit that Illinois officials owe it a duty under the federal Medicaid Act to remedy the late and short payments. In a thoughtful opinion, the district court dismissed the suit for failure to state a claim for relief. *Saint Anthony Hospital v. Eagleson*, 548 F. Supp. 3d 721 (N.D. Ill. 2021). We see the case differently, however, especially at the pleadings stage. We conclude that Saint Anthony has alleged a viable claim for relief under 42 U.S.C. § 1396u-2(f) and may seek injunctive relief under 42 U.S.C. § 1983 against the state official who administers the Medicaid program in Illinois. We appreciate the potential magnitude of the case and the challenges it may present. Like the district judge and Judge Brennan, we can imagine forms of judicial relief that would be hard to justify. We can also imagine some poor ways to handle this case going forward in the district court. But we need not and should not decide this case by assuming that the worst-case scenarios are inevitable.

The State has tools available to remedy systemic slow payment problems—problems alleged to be so serious that they threaten the viability of a major hospital and even of the managed-care Medicaid program as administered in Illinois. If Saint Anthony can prove its claims, the chief state official could be ordered to use some of those tools to remedy systemic problems that threaten this literally vital health care program. We therefore reverse in part the dismissal of the case and remand for further proceedings.

I. *Factual and Procedural Background*

In reviewing the grant of a motion to dismiss under Federal Rule of Civil Procedure 12(b)(6) for failure to state a claim, we accept all well-pleaded allegations as true and draw all reasonable inferences in Saint Anthony's favor. *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). We are not vouching for the truth of Saint Anthony's account of the facts at this point. Rather, because the defense chose to move to dismiss on the pleadings, it chose to accept for now the truth of Saint Anthony's factual allegations.

A. *The Illinois Medicaid Program*

The federal Medicaid Act established a cooperative arrangement between the federal government and states to provide medical services to poor residents. 42 U.S.C. § 1396 et seq.; *Bria Health Services, LLC v. Eagleson*, 950 F.3d 378, 380 (7th Cir. 2020); see also *National Federation of Independent Business v. Sebelius*, 567 U.S. 519, 541–42 (2012). By agreeing to participate in Medicaid, a state receives financial assistance to help administer the program in exchange for complying with detailed statutory and regulatory

requirements. *Bria Health Services*, 950 F.3d at 380. Those requirements are found in the Medicaid Act itself (Title XIX of the Social Security Act) and in regulations promulgated by the Secretary of the Department of Health and Human Services (HHS). See *id.* at 382; *Rock River Health Care, LLC v. Eagleson*, 14 F.4th 768, 771 (7th Cir. 2021).

Before discussing the relevant statutory requirements at issue here, it is important to understand how Illinois, specifically the Department of Healthcare and Family Services (HFS), administers its Medicaid program. There are two major ways for states to pay providers for services provided to patients covered by Medicaid: fee for service or managed care. In a fee-for-service program, the state pays providers directly based on a set fee for a particular service. See § 1396a(a)(30)(A); Medicaid Program; Medicaid Managed Care: New Provisions, 67 Fed. Reg. 40,989 (June 14, 2002). Under a managed-care program, by contrast, HFS contracts with MCOs (which are private health insurance companies) to deliver Medicaid health benefits to beneficiaries. See 42 U.S.C. § 1396u-2; see also § 1396b(m); 42 C.F.R. § 438 (2020). The state pays the MCO a flat fee per patient per month. The MCO then pays providers for services actually provided to covered Medicaid patients. *Bria Health Services*, 950 F.3d at 381, citing 305 ILCS 5/5-30.1; see *also* 42 U.S.C. §§ 1396u-2, 1396b(m). Like insurance companies, MCOs are generally entitled to keep the difference between the money they receive from the state and the amounts they pay providers for care of covered patients.

In recent years, Illinois has changed from a fee-for-service system to a system dominated by managed care. Illinois introduced managed care in its Medicaid program in 2006. In 2010, the State spent just $251 million on managed care. By 2019, that number had grown to $12.73 billion. In the meantime, the number of MCOs in Illinois has fallen from twelve to seven.

Federal law establishes requirements for timely Medicaid payments for health care providers. When a state pays claims directly, it must pay 90% of so-called "clean claims" within 30 days and 99% within 90 days. See 42 U.S.C. § 1396a(a)(37)(A). (A "clean claim" is one where the provider has given the payor all information needed to determine the proper payments. *Id*.) When a state relies on MCOs to pay providers, federal law requires that the state's contract with an MCO contain a provision that requires the same 30/90 pay schedule for MCO reimbursements to providers. § 1396u-2(f). (MCOs and providers can opt for a different pay schedule, but Saint Anthony has not agreed to a different schedule with any MCOs.)

The focus of this case is the payment schedule provision, § 1396u-2(f). Saint Anthony contends it is also entitled to relief under a separate Medicaid statute requiring a participating state to "provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals." § 1396a(a)(8). As we explain below, however, Saint Anthony is not entitled to relief under that clause.

B. *Plaintiff Saint Anthony Hospital*

Saint Anthony is a so-called "safety-net hospital" on the southwest side of Chicago. It provides health care regardless of patients' financial means. See 305 ILCS 5/5-5e.1. Most Saint Anthony patients are on Medicaid. As the Illinois Medicaid system has shifted from fee for service to managed care, the hospital has become ever more dependent on timely payments from MCOs. In recent years, according to Saint Anthony, those payments have repeatedly arrived late, if they arrived at all. As of February 2020, payments of at least $20 million were past due. The impact of late payments can be dramatic. In 2015, Saint Anthony had more than $20 million in cash on hand, which was enough to fund 72 days of operation. As the State increased its reliance on managed care, Saint Anthony saw its cash reserves dwindle. By 2019, Saint Anthony had less than $500,000 cash on hand, enough to cover just two days of operation. Saint Anthony's net revenue per patient also dropped more than 20%.

The MCO payments that eventually arrive are often for less than is owed. Making matters even worse from Saint Anthony's perspective, the payment forms it receives from the MCOs lack the details needed to determine just what is being paid and what is not. The delays and lack of clarity benefit the MCOs: since the State pays the MCOs flat fees per patient and permits them to keep the funds they do not pay out to providers, MCOs have a powerful profit incentive to delay and underpay hospitals like Saint Anthony.

Saint Anthony may not be alone in its experience. Mercyhealth is a regional health-care system and the largest Medicaid provider in Illinois outside of Cook

County. Illustrating the potential gravity of the MCO payment problems, in April 2020, Mercyhealth announced it would stop accepting Medicaid patients covered by four of the seven MCOs in Illinois. Decl. of Kim Scaccia ¶ 6, Dkt. 50-1, Ex. 12. That was a drastic step showing the potential threat to the viability of the managed-care model for Medicaid. Mercyhealth said it took this step because those MCOs were delaying and underpaying it to the point that it was losing $30 million per year on Medicaid patients. See also David Jackson & Kira Leadholm, Insurance Firms Reap Billions in Profits While Doctors Get Stiffed for Serving the Poor, Better Government Ass'n (Nov. 8, 2021, 12:00 PM), https://www.bettergov.org/news/insurance-firms-reap-billions-in-profits-while-doctors-get-stiffed-for-serving-the-poor/.[1]

Faced with this dire financial situation, Saint Anthony had two paths to seek legal relief from what it sees as systemic defects in the Illinois Medicaid program. One path would be to sue MCOs individually for violating Saint Anthony's contractual right to timely payment. Arbitration provisions in those contracts would likely require arbitration for each individual claim in dispute, which could easily involve many thousands of individual claims each year. This

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[1] We may consider the Mercyhealth information in evaluating a Rule 12(b)(6) motion, without converting the motion into one for summary judgment, because the information elaborates on and illustrates factual allegations in the complaint. E.g., *Geinosky v. City of Chicago*, 675 F.3d 743, 745 n.1 (7th Cir. 2012). Mercyhealth also reportedly worked out a compromise with one MCO, Molina, under which it continued to care for Molina-covered Medicaid patients. Decl. of Kim Scaccia ¶ 9, Dkt. 50-1, Ex. 12.

suit represents the second path, seeking a court order to require Illinois to enforce the MCOs' contractual obligations to make timely and transparent payments.

C. *Procedural History*

Saint Anthony filed a two-count complaint under 42 U.S.C. § 1983 against Theresa A. Eagleson, the Director of HFS, in her official capacity. (We refer to Director Eagleson here as HFS or the State.) As relevant here, Count I alleges that HFS is violating the Medicaid Act, including section 1396u-2(f), by failing to ensure that MCOs meet the timely payment requirements. Count II alleges that HFS is violating section 1396a(a)(8) by failing to ensure that the MCOs furnished medical assistance with reasonable promptness. Saint Anthony seeks injunctive relief directing HFS to require the MCOs to comply with the 30/90 payment rule, to use transparent remittance forms, and if necessary, to require the State to cancel a contract with an MCO that continues to fail to comply with the timely payment requirements.[2]

HFS moved to dismiss Saint Anthony's complaint under Federal Rule of Civil Procedure 12(b)(6) for failure to state a claim. Its chief argument was that none of the statutory provisions grant Saint Anthony any rights enforceable under section 1983, and that even if they did, the factual allegations failed to state a plausible claim for relief. The district court agreed and

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[2] Saint Anthony also moved for a preliminary injunction. The district court granted limited discovery before suspending in part actions related to the preliminary injunction motion while it resolved a discovery dispute. The court then granted the motion to dismiss and denied the preliminary injunction motion as moot.

dismissed the case. 548 F. Supp. 3d 721 (N.D. Ill. 2021).

While the motion to dismiss was pending, Saint Anthony moved to supplement its complaint by adding a due process claim. HFS responded to Saint Anthony's request, arguing that the new claim would fail on the merits. The district court denied Saint Anthony the opportunity to file a reply to defend its proposed claim on the merits. Then, four days after granting the motion to dismiss, the district court denied the motion to supplement as futile, and also because the judge thought the entire case should be concluded by the grant of the motion to dismiss.

In the district court, four MCOs also sought and were granted leave to intervene in the suit. The MCOs asked the court to stay the lawsuit and compel arbitration. One MCO (Meridian) demanded arbitration with Saint Anthony, but that proceeding was stayed because Meridian had not followed the proper procedures to invoke arbitration. The district court later denied the MCOs' motions as moot after granting the motion to dismiss.

Saint Anthony has appealed the court's dismissal of its section 1396u-2(f) and 1396a(a)(8) claims, as well as the denial of the motion to supplement. We first address Saint Anthony's asserted right to timely payment under section 1396u-2(f). To evaluate Saint Anthony's claim, we walk through each of the so-called Blessing factors. Each factor supports Saint Anthony here. We then analyze three remaining issues: Saint Anthony's claim under section 1396a(a)(8), the district court's denial of the motion to supplement, and the intervening MCOs' motion to stay the proceedings in favor of arbitration.

II. *A Right to Timely Payment*

The central issue here is whether section 1396u-2(f) grants a right to providers like Saint Anthony that is privately enforceable through section 1983. We conclude that the State's duty is to try to ensure that the MCOs actually pay providers in accord with the 30/90 pay schedule—not merely that the contracts between the MCOs and HFS include clauses that say as much on paper. Providers like Saint Anthony have a right under section 1396u-2(f) that is enforceable under section 1983, at least to address systemic failures to provide timely and transparent payments.

A. *Legal Standard*

We again emphasize that we are reviewing the grant of a motion to dismiss under Federal Rule of Civil Procedure 12(b)(6) for failure to state a claim, so we begin by accepting all well-pleaded allegations as true and drawing all reasonable inferences in Saint Anthony's favor. *Iqbal*, 556 U.S. at 678.

The analysis for possible enforcement of federal statutory rights under section 1983 is familiar. "Section 1983 creates a federal remedy against anyone who, under color of state law, deprives 'any citizen of the United States ... of any rights, privileges, or immunities secured by the Constitution and laws.'" *Planned Parenthood of Indiana, Inc. v. Commissioner of Indiana State Dep't of Health*, 699 F.3d 962, 972 (7th Cir. 2012) (omission in original), quoting 42 U.S.C. § 1983. This language "means what it says," *Maine v. Thiboutot*, 448 U.S. 1, 4 (1980), and "authorizes suits to enforce individual rights under federal statutes as well as the Constitution." *City of Rancho Palos Verdes*

v. Abrams, 544 U.S. 113, 119 (2005).

Yet not all statutory benefits, requirements, or interests are enforceable under section 1983. A plaintiff seeking redress for an alleged violation of a federal statute through a section 1983 action "must assert the violation of a federal right, not merely a violation of federal law." *Blessing v. Freestone*, 520 U.S. 329, 340 (1997) (remanding for further consideration whether federal statute on child-support obligations created rights enforceable under section 1983); see also *Gonzaga University v. Doe*, 536 U.S. 273, 286 (2002) ("[W]here the text and structure of a statute provide no indication that Congress intends to create new individual rights, there is no basis for a private suit."). Congress must have "*intended to create a federal right*," *Gonzaga*, 536 U.S. at 283, and "the statute 'must be phrased in terms of the persons benefited' with 'an *unmistakable focus* on the benefited class.'" *Planned Parenthood of Indiana*, 699 F.3d at 973, quoting *Gonzaga*, 536 U.S. at 284. It is thus not enough to fall "within the general zone of interest that the statute is intended to protect" to assert a right under section 1983. *Gonzaga*, 536 U.S. at 283.

To aid in this analysis, courts apply the three "*Blessing* factors" to the statutory text and structure:

> 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.

Talevski v. Health & Hospital Corp. of Marion County, 6 F.4th 713, 717 (7th Cir. 2021) (Federal Nursing Home Reform Act granted individual rights enforceable under section 1983, quoting *Blessing*, 520 U.S. at 340–41), cert. granted, No. 21-806, —— U.S. ——, 142 S. Ct. 2673 (U.S. May 2, 2022).

If these three factors are satisfied, "the right is presumptively enforceable under section 1983." *Id*. at 720. The defendant may overcome this presumption by demonstrating that "Congress shut the door to private enforcement." *Gonzaga*, 536 U.S. at 284 n.4. Congress may foreclose a remedy under section 1983 "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." *Id*. (internal quotation marks and citations omitted); see also *Talevski*, 6 F.4th at 721 (collecting just three cases where the Supreme Court determined that a statutory scheme implicitly foreclosed section 1983 liability).

One final background note: The Medicaid Act is an exercise of Congress's power under the Spending Clause. The Supreme Court has found that section 1983 can be used to enforce rights created in the exercise of the spending power. *Wilder v. Virginia Hospital Ass'n*, 496 U.S. 498, 508–12 (1990) (finding a now-defunct amendment to the Medicaid Act granted plaintiff a private right enforceable under section 1983). Since *Wilder*, the Court has cautioned against

finding rights in that context. See *Armstrong v. Exceptional Child Center, Inc.,* 575 U.S. 320, 330 n* (2015) ("[Plaintiffs] do not assert a § 1983 action, since our later opinions plainly repudiate the ready implication of a § 1983 action that *Wilder* exemplified."); see also *Gonzaga*, 536 U.S. at 283. We made this observation in *Nasello v. Eagleson*: "In the three decades since *Wilder* [the Court] has repeatedly declined to create private rights of action under statutes that set conditions on federal funding of state programs." 977 F.3d 599, 601 (7th Cir. 2020).

But as we clarified most recently in *Talevski*, this trend does not mean that Spending Clause legislation never creates rights enforceable under section 1983. 6 F.4th at 723–26. On the contrary, the Court has not overruled *Wilder*. The later Spending Clause cases in which it has declined to find private rights simply did not satisfy the standards we have discussed. *Id*. at 724. As we said in *Talevski*, "[t]he Court could have saved itself a great deal of time [in *Armstrong*] if it had wanted to establish an unbending rule that Spending Clause legislation never supports a private action." *Id*. at 725. Spending Clause legislation or not, the relevant question is the same: "do we have the necessary rights-creating language to support a private right of action?" *Id*. To answer that question, apply the *Blessing* factors.[3]

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[3] While this case involves a right under section 1983, not an implied private right of action, *Gonzaga* clarified that "the inquiries overlap in one meaningful respect—in either case we must first determine whether Congress *intended to create a federal right*." 536 U.S. at 283.

B. *Rights Analysis*

With this background in mind, here is the text of section 1396u-2(f), the provision central to this appeal:

> 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....

42 U.S.C. § 1396u-2(f). The statutory language cross-references sections 1396b(m) and 1396a(a)(37)(A). Section 1396b(m) describes the State's contract with an MCO. Section 1396a(a)(37)(A) declares that a "State plan for medical assistance must"

> (37) provide for claims payment procedures which
>
> (A) 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.

§ 1396a(a)(37)(A).

We agree with Saint Anthony that section 1396u-2(f) grants providers a right to timely payment from the MCOs that the State must safeguard because the right satisfies all three *Blessing* factors. Also, there is no alternative remedy that would be incompatible with individual enforcement under section 1983. As we explain next in applying the *Blessing* factors, providers are the intended beneficiaries of section 1396u-2(f), enforcing the 30/90 pay schedule would not strain judicial competence, and the statute unambiguously imposes a binding obligation on the State. In addition, while private contract remedies may offer an alternative path to enforcement for individual claims, that path does not foreclose enforcement under section 1983. It is also far from clear that contract remedies, including arbitration, could provide systemic relief that may be sought more sensibly from state officials under section 1983. We address each point in turn.

1. *Factor One: Intended Beneficiaries*

The first *Blessing* factor asks whether Congress intended section 1396u-2(f) to benefit providers like Saint Anthony and whether it intended that benefit to be a *right*, as distinct from a generalized entitlement. We conclude that both answers are yes.

First, providers are the intended beneficiaries of section 1396u-2(f). The text requires MCOs to contract that they "shall make payment to health care *providers* ... on a timely basis." § 1396u-2(f) (emphasis added). No one benefits more directly from a requirement for timely payments to providers than the

providers themselves. Cf. *BT Bourbonnais Care, LLC v. Norwood*, 866 F.3d 815, 821 (7th Cir. 2017) ("Who else would have a greater interest than the [nursing facility operators] in the process 'for determination of rates of payment under the [State] plan for ... nursing facility services'"? (second alteration and omission in original)).

To resist this conclusion, HFS asserts that the term "health care providers" includes *practitioners* but not *hospitals*. The district judge did not adopt this argument, nor do we. Section 1396u-2(f) cross-references section 1396a(a)(37)(A), which requires that states pay "practitioners" on the 30/90 pay schedule. See *Illinois Council on Long Term Care v. Bradley*, 957 F.2d 305, 306, 308 (7th Cir. 1992). "Practitioners" in that context means individual providers as opposed to institutional ones like Saint Anthony. HFS thus argues that since section 1396u-2(f) requires states to ensure MCOs pay providers "consistent with the claims payment procedures described in section 1396a(a)(37)(A)," section 1396u-2(f) adopts the 30/90 pay schedule requirement only as to "practitioners." In the State's view, holding that section 1396u-2(f) applies to hospitals as well would exceed rather than be consistent with what section 1396a(a)(37)(A) requires.

The argument is not persuasive. HFS reasons that Congress implicitly and indirectly defined "providers" narrowly—just for purposes of section 1396u-2(f)—through a cross-reference to section 1396a(a)(37)(A) that describes a state's payment obligations to practitioners in a fee-for-service program. That is an improbably subtle reading. A more persuasive reading

of the statutory text is that Congress invoked only the payment *procedures* in section 1396a(a)(37)(A), not the *beneficiaries* of that provision. The statutory text explains that payment must be made "on a timely basis *consistent with the claims payment procedures* described in section 1396a(a)(37)(A) of this title." § 1396u-2(f) (emphasis added). Those procedures include the 30/90 pay schedule.

Congress knows how to use cross-references for a definitional purpose in the Medicaid Act. See, e.g., § 1396u-2(a)(1)(B)(i) ("[A] medicaid managed care organization, as defined in section 1396b(m)(1)(A) of this title...."); § 1396u-2(b)(2)(A)(i) ("[T]o provide coverage for emergency services (as defined in sub-paragraph (B))...."). That is not what occurred here. The language is sufficiently plain here, *United States v. Melvin*, 948 F.3d 848, 851–52 (7th Cir. 2020), and the plain meaning of "health care provider" includes hospitals. Cf. 42 U.S.C. § 1395w–25(d)(5) (enacted as part of the Balanced Budget Act of 1997).

HFS's position is also inconsistent with the provision's purpose as shown in additional statutory language. Section 1396u-2(f) was part of the same Balanced Budget Act of 1997. See Pub. L. No. 105-33, 111 Stat. 251 § 4708(c) (1997). Section 4708(c) is entitled: "Assuring Timeliness of Provider Payments." This language signals that Congress intended section 1396u-2(f) to assure, i.e., to guarantee, timely payment to providers. That understanding is consistent with later congressional action. In 2009 Congress enacted 42 U.S.C. § 1396u-2(h) as part of the American Recovery and Reinvestment Act of 2009. See Pub. L. No. 111-5, 123 Stat. 115, § 5006(d) (2009). That

subsection established special rules for "Indian enrollees, Indian health care providers, and Indian managed care entities." § 1396u-2(h). Relevant to our purposes, section 1396u-2(h)(2)(B) cross-references section 1396u-2(f) and describes it as the "rule for prompt payment of providers":

> (2) Assurance of payment to Indian health care providers for provision of covered services
>
> Each contract with a managed care entity under section 1396b(m) of this title or under section 1396d(t)(3) of this title shall require any such entity, as a condition of receiving payment under such contract, to satisfy the following requirements:
>
> ...
>
> (B) Prompt payment
>
> To agree to make prompt payment (*consistent with rule for prompt payment of providers under section 1396u–2(f) of this title*) to Indian health care providers that are participating providers with respect to such entity....

§ 1396u-2(h)(2)(B) (emphasis added).

Given this evidence, it would seem odd to construe a provision Congress intended to assure timeliness of provider payment as not applying to many providers, as HFS advocates. That would appear to defeat the statute's evident purpose in most cases. We decline to read the text in such a manner. *Quarles v. United States*, —— U.S. ——, 139 S. Ct. 1872, 1879 (2019) ("We should not lightly conclude that Congress enacted a

self-defeating statute."). If the text required such a result, that would be one thing, but we should not adopt such an improbable reading of the text to reach such an odd result.

In applying the first *Blessing* factor, we next conclude that section 1396u-2(f) grants providers a right, not merely a generalized benefit. It is here that we disagree with the district court. In granting the motion to dismiss, the court determined that section 1396u-2(f) failed the first *Blessing* factor. The court invoked *Gonzaga*, asserting that providers received only "a generalized 'benefit'" from section 1396u-2(f), which "isn't good enough" to constitute a right enforceable under section 1983. *Saint Anthony Hospital*, 548 F. Supp. 3d at 734, quoting *Gonzaga*, 536 U.S. at 283. The district court concluded that section 1396u-2(f) "itself does not entitle providers to much of anything, and does not contain any 'explicit rights-creating terms.'" *Id*., quoting *Gonzaga*, 536 U.S. at 284.

We read the statute differently. *Gonzaga* provides a useful contrast regarding rights-creating language. In *Gonzaga*, a former student sued Gonzaga University and an employee under section 1983 for allegedly violating his rights under the Family Educational Rights and Privacy Act (FERPA). Part of the statutory language at issue directed the Secretary of Education that "[n]o funds shall be made available' to any 'educational agency or institution' which has a prohibited 'policy or practice'" of permitting the release of education records without parents' written consent. *Gonzaga*, 536 U.S. at 287 (alteration in original), quoting 20 U.S.C. § 1232g(b)(1); see also

§ 1232g(b)(2). That prohibited activity is allegedly what occurred in the case.

The Supreme Court concluded that Congress did not grant an individual whose interests were violated under FERPA a right enforceable through section 1983. Because the statutory provisions did not have an individualized focus, they failed *Blessing* factor one: "[The] provisions further speak only in terms of institutional policy and practice, not individual instances of disclosure. Therefore, as in *Blessing*, they have an 'aggregate' focus, they are not concerned with 'whether the needs of any particular person have been satisfied,' and they cannot 'give rise to individual rights.'" *Gonzaga*, 536 U.S. at 287–88 (internal citation omitted), quoting *Blessing*, 520 U.S. at 343–44. The Court also highlighted that the Secretary of Education could take away funds only if the university did not *substantially* comply with the statutory requirements. This fact contributed to the understanding that the focus was on systemwide performance rather than individual instances of improper disclosure. Finally, since FERPA's provisions spoke only to the Secretary and directed him to withdraw funding from schools that had a "prohibited 'policy or practice,'" the Court determined that their focus was "two steps removed from the interests of individual students and parents." *Id*. at 287 (citation omitted). The provisions therefore failed to confer an individual right enforceable under section 1983.

The opposite is true here. Section 1396u-2(f) is concerned with whether the needs of particular persons and entities—providers like Saint Anthony—have been satisfied. The statutory text specifies that

the State "shall provide" that MCOs "shall make payment to health care providers ... on a timely basis." 42 U.S.C. § 1396u-2(f). The focus of section 1396u-2(f) is not "two steps removed" from the interest of providers. Its focus is directly on the interest Saint Anthony asserts here: ensuring that providers receive timely payment from MCOs. And the provision is not concerned only with whether MCOs in the aggregate pay providers on the 30/90 pay schedule, but whether *individual* providers are receiving the payments in the timeframe promised.

We see this in the provision's close attention to provider-specific exemptions from the 30/90 pay schedule. Section 1396u-2(f) says that its mandate applies "unless the health care provider and the organization agree to an alternate payment schedule." It establishes a personal right to timely payment, which all providers are entitled to insist upon. C*f. Planned Parenthood of Indiana*, 699 F.3d at 974 (Medicaid state plan requirement permitting all eligible recipients to receive medical assistance from the provider of their choice established a personal right "to which all Medicaid patients are *entitled*" but, implicitly, need not accept (emphasis added)). Either way, the focus is on the individual provider. The focus is not on whether MCOs in the aggregate substantially comply with the timely payment requirement. Section 1396u-2(f) is thus not just a benchmark for aggregate performance.

That conclusion finds support in our precedents under the Medicaid statutes. Section 1396a(a)(10)(A) provides that "[a] State plan for medical assistance must ... provide ... for making medical assistance

available ... to all [eligible] individuals." We have held that the provision confers private rights to individuals enforceable under section 1983. See *Miller v. Whitburn*, 10 F.3d 1315, 1319–20 (7th Cir. 1993); accord, *Bontrager v. Indiana Family & Social Services Admin.*, 697 F.3d 604, 607 (7th Cir. 2012) (reaffirming Miller's rights analysis after *Blessing* and *Gonzaga*). In *Miller*, we found it significant that the State was required to provide medical assistance to all eligible individuals. The same is true here, but with respect to timely payments to providers that do not opt out of the 30/90 pay schedule. And in *Wilder*, the statute, like the statute here, required states to provide for payment to health care providers: "a state plan" must ensure "'payment ... of the *hospital services, nursing facility* services, and services in an *intermediate care facility* for the [recipients] under the plan.'" 496 U.S. at 510 (omission in original), quoting 42 U.S.C. 1396a(a)(13)(A) (1982 ed., Supp. V). The Supreme Court concluded that this statutory language granted rights to health care providers enforceable under section 1983. See *id.* at 524. *Wilder* may lie close to the outer edge of the line for section 1983 cases under Spending Clause legislation, but recognizing the rights-creating language in section 1396u-2(f) does not push that logic any further.

At bottom, section 1396u-2(f) defines the minimum terms of the provider's right to timely payment and is provider-specific. It uses "individually focused terminology," *Gonzaga*, 536 U.S. at 287, unmistakably "phrased in terms of the persons benefited," *id.* at 284, quoting *Cannon v. University of Chicago*, 441 U.S. 677, 692 n.13 (1979), and satisfies

Blessing factor one.

2. *Factor Two: Administration*

Blessing factor two requires a plaintiff to show that "the right assertedly protected by the statute is not so vague and amorphous that its enforcement would strain judicial competence." *Talevski*, 6 F.4th at 719. HFS does not appear to contest whether section 1396u-2(f) satisfies this standard, nor could it. Saint Anthony argues that the State violated its right to timely payment by failing to abide by section 1396u-2(f)'s statutory mandate of trying to ensure that the MCOs are paying providers in line with the 30/90 pay schedule. Determining whether payments met the 30/90 pay schedule is "administrable," "fully capable of judicial resolution," and "falls comfortably within the judiciary's core interpretative competence." *Planned Parenthood of Indiana*, 699 F.3d at 974.

3. *Factor Three: Obligation*

The third *Blessing* factor asks whether section 1396u-2(f) unambiguously imposes a binding obligation on HFS. This requires answering two questions: (1) what is HFS's duty under the statute, and (2) is that duty mandatory?

In a typical private right dispute, the emphasis is on the second question. See, e.g., *BT Bourbonnais Care*, 866 F.3d at 822. Section 1396u-2(f) contains mandatory language, however: "A [State contract] ... with a medicaid managed care organization *shall* provide that the organization *shall* make payment to health care providers ... on a timely basis...." 42 U.S.C. § 1396u-2(f) (emphasis added). The double use of "shall" rebuts the notion that the State's obligation is

anything less than mandatory. But what exactly is the State's obligation here?

Section 1396u-2(f) requires the State's contracts with the MCOs to require that the MCOs pay providers on the 30/90 pay schedule. HFS asserts, and the partial dissent agrees, that section 1396u-2(f) does not impose a duty on the State even to try to ensure that MCOs actually do what their contracts say. HFS's theory is that the statute requires only that a provision in the paper contract specify the timely payment obligation. The State can then sue MCOs for breach of contract if they fail to pay providers according to the 30/90 pay schedule, and providers are entitled to enforce their own contractual rights as they see fit. In HFS's view, nothing in section 1396u-2(f) requires the State itself do anything more to ensure prompt payment. Put differently, if the contract between an MCO and the State contains a clause ensuring timely payment for providers on the 30/90 pay schedule, the State contends it has met its duty under section 1396u-2(f), regardless of actual performance.

We do not read section 1396u-2(f) as permitting such a hands-off approach. Nor would a reasonable state official deciding whether to accept federal Medicaid money have expected she could take that hands-off approach to MCO payments to providers. When interpreting statutes, often the "meaning—or ambiguity—of certain words or phrases may only become evident when placed in context." *King v. Burwell*, 576 U.S. 473, 486 (2015), quoting *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 132 (2000). We must read texts "in their context and with a view to their place in the overall statutory scheme."

Id., quoting *Brown & Williamson*, 529 U.S. at 133; see also *Davis v. Michigan Dep't of Treasury*, 489 U.S. 803, 809 (1989) ("[S]tatutory language cannot be construed in a vacuum. It is a fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme."). And to the extent possible, we must "ensure that the statutory scheme is coherent and consistent." *Ali v. Federal Bureau of Prisons*, 552 U.S. 214, 222 (2008).

Interpreting section 1396u-2(f) as only a "paper" requirement conflicts with these principles of statutory interpretation. HFS is correct that Congress intended MCOs to "assume day-to-day functions previously performed by States under a traditional fee-for-service model." Appellee's Br. at 30. But Congress did not intend for MCOs to go unsupervised. It has long been obvious to all that under the managed-care system of Medicaid, MCOs have a powerful incentive to delay payment to providers for as long as possible and ultimately to underpay to maximize their own profits. It's a classic agency problem: MCOs are expected to act in the providers' interests, but their interests are not the same. Regarding timely payments, they are in direct conflict. The Medicaid Act contains several provisions to counteract that problem in addition to section 1396u-2(f). They help inform our understanding of the particular provision in dispute here.

The statute also imposes reporting and oversight responsibilities on states. For example, section 1396b(m)(2)(A)(iv) requires a state's contract with an MCO to permit the state "to audit and inspect any

books and records" of an MCO related to "services performed or determinations of amounts payable under the contract." Section 1396u-2(c)(2)(A)(i) further specifies that a state's contract with an MCO must provide for an "annual (as appropriate) external independent review" of the "timeliness" of MCO "services for which the organization is responsible," including payments. The Medicaid Act thus requires HFS to take steps to monitor MCO payment activities to gather performance data and to understand how the system is functioning.

The Medicaid Act further specifies actions a state can take when an MCO underperforms. See § 1396u-2(e). The State can put an MCO on a performance plan, for example. As discovery in this case revealed, HFS took this step recently with CountyCare, an MCO, after CountyCare paid only 40% of claims within 30 days and only 62% of claims within 90 days. The CountyCare case turned up evidence of the agency problem in action. The State found that CountyCare's Medicaid money was improperly diverted from the Medicaid program to pay other county government bills rather than health care providers.[4]

In such a case, if an MCO has "repeatedly failed to meet the requirements" of its contract with the State and the requirements in section 1396u-2, "the State

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[4] As with the information mentioned above about Mercyhealth, we may also consider the CountyCare information in evaluating the Rule 12(b)(6) motion without converting the motion into one for summary judgment. The information elaborates on (and illustrates) factual allegations in the complaint. E.g., *Geinosky*, 675 F.3d at 745 n.1.

shall (regardless of what other sanctions are provided) impose the sanctions described in subparagraphs (B) and (C) of paragraph (2)." § 1396u-2(e)(3). Subparagraph (B) details the appointment of temporary management to oversee the MCO, and subparagraph (C) permits individuals enrolled with the MCO to terminate enrollment without cause. § 1396u-2(e)(2)(B)–(C).

Federal Medicaid regulations add to the State's responsibilities here. For instance, 42 C.F.R. § 438.66(a) (2016) provides: "The State agency must have in effect a monitoring system for all managed care programs." Section 438.66(b)(3) specifies that the State's monitoring system "must address all aspects of the managed care program, including the performance of each MCO ... in ... [c]laims management." It's hard to imagine a more central aspect of claims management than timely payments. Saint Anthony alleges here that HFS is simply failing to collect the required data on the timeliness of MCO payments.

These responsibilities support the conclusion that Congress intended for states to try to ensure that the right to timely payment in section 1396u-2(f) is honored in real life. The timely payment rule is more than a paper requirement. The more coherent reading of the statute as a whole is that Congress intended the State to engage in these reporting and oversight responsibilities, and if it becomes evident that MCOs are systematically not paying providers on a timely basis, then the State would have an obligation to act under section 1396u-2(f) to secure providers' rights. These mandatory oversight responsibilities would make little sense if that were not the case. The

provision's mandatory language, coupled with the additional oversight and reporting responsibilities, supports the reading that section 1396u-2(f) must be doing more than imposing merely the formality of contract language. Providers' right to timely payment must exist in practice.

HFS counters, and the partial dissenting opinion agrees, that the duty imposed by section 1396u-2(f) is at the very least ambiguous. HFS points to *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1, 17 (1981), which taught that Congress can impose conditions on grants of federal money only if it does so "unambiguously" and "with a clear voice." In HFS's view, if Congress wanted to impose the significant duty on states that Saint Anthony advocates, it should have done so more explicitly. Section 1396u-2(f) is not a clear statement, it's ambiguous, and therefore cannot carry the weight Saint Anthony gives it. So says HFS.

We appreciate the point, but we think Congress spoke sufficiently clearly here. The clear-statement rule explains that "States cannot knowingly accept conditions of which they are 'unaware' or which they are 'unable to ascertain.'" *Arlington Central School District Board of Education v. Murphy*, 548 U.S. 291, 296 (2006), quoting *Pennhurst*, 451 U.S. at 17. To determine whether Congress spoke clearly in this case, we "must view [section 1396u-2(f) and the Medicaid Act] from the perspective of a state official who is engaged in the process of deciding whether the State should accept [Medicaid] funds and the obligations that go with those funds." *Id*. Any state official planning to launch a managed-care program would have understood that the state would have to try to

ensure that providers receive prompt payment from MCOs. Such an official would not reasonably have concluded that Congress intended that the "rule for prompt payment of providers" would be only a proverbial paper tiger. See § 1396u-2(h)(2)(B) (describing section 1396u-2(f) as the "rule for prompt payment of providers"). That position conflicts with the State's oversight and reporting obligations and its enforcement duties under the Medicaid Act.

HFS also argues that section 1396u-2(f) cannot impose this duty on the State because it "would negate[] section 1396u-2(e)'s express grant to States of discretion to seek termination of an MCO's contract for violating section 1396u-2[f] or its contract with the State." Appellee's Br. at 27. The argument highlights a key issue in this appeal and one that helps explain our disagreement with the district court and the partial dissent.

Saint Anthony requested several forms of relief in its complaint. One of those was canceling a contract with an MCO that fails to pay on time after State intervention. HFS argues that forcing it to cancel a contract with an MCO because it did not meet the 30/90 pay schedule would infringe on the State's discretion to decide when it will terminate such a contract, which is expressly preserved by the statute. See § 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...."). In HFS's view, that means section 1396u-2(f) cannot impose a duty on the State to ensure providers receive timely

payment because it might require the State to take action that is expressly reserved to its discretion.

We are inclined to agree with HFS that a district court could not force the State to cancel a contract with an MCO. Canceling a contract with any one of the seven MCOs in Illinois might well cause a "massive disruption" to the State's Medicaid program. Appellee's Br. at 28. HFS and only HFS has the discretion to decide when and why it will invite that type of disruption. Section 1396u-2(e)(4)(A) is clear on that point. See also 42 C.F.R. §§ 438.708 (when states can terminate an MCO contract), 438.730 (CMS can sanction an MCO by denying payment). To the extent that Saint Anthony requests such relief, we doubt the district court has authority to impose it, though we need not answer that question definitively at this stage, on the pleadings. Perhaps sufficiently egregious facts might convince us otherwise, but that question about a worst-case scenario can be addressed if and when it actually arises and matters.

Continuing with the theme of assuming the worst, HFS and the partial dissent also argue that reading this duty into section 1396u-2(f) would lead to the district court acting effectively as the Medicaid claims processor for the State. In a parade of horribles, that's the prize-winning float. Given the practical difficulties in judicial enforcement that would come with recognizing a duty here, HFS contends, such a duty could not be what Congress intended. We agree that any form of retail-level relief, i.e., requiring the district court to adjudicate issues at the claim-by-claim level, would strain judicial resources and seem to conflict with the arbitration clauses in the contracts between

the MCOs and Saint Anthony. A process that required a district judge to micro-manage claims would be inappropriate here.

These two limits on remedies in a section 1983 action do not persuade us, however, that we should affirm dismissal on the theory that the State has no duty at all to ensure timely payment under section 1396u-2(f). HFS can take other steps at the system level to address chronic late and/or short payments by MCOs. Those actions would neither force the State to cancel an MCO contract nor turn the district court into a claims processor. If Saint Anthony can prove its claims of systemic delay and/or underpayment, we are confident that the district court could craft injunctive relief to require HFS to do *something* to take effective action.

We draw helpful guidance on these issues of potential equitable relief from *O.B. v. Norwood*, 838 F.3d 837 (7th Cir. 2016). There, we affirmed a preliminary injunction against Illinois officials in a suit brought by Medicaid beneficiaries who sought to enforce different sections of the Medicaid Act requiring the State to find nurses to provide home nursing for children enrolled in Medicaid. HFS argued in *O.B.* that it had no obligation to find nurses (or to act at all). We *rejected* that argument:

> Certainly the defenses thus far advanced by HFS are weak. The primary defense is that nothing in the Medicaid statute "required [HFS] to ensure that Plaintiffs would receive medical care from nurses in their homes." But it was HFS that decided that home nursing was the proper treatment for O.B., the other named

plaintiffs, and the other members of the class.

Id. at 840 (alteration in original).

We recognized in *O.B.* the difficulties state officials faced in providing the needed nurses. There was no guarantee that compliance with the injunction would solve the plaintiffs' problems. In affirming the preliminary injunction, though, we explained that the injunction "should be understood simply as a first cut: as insisting that the State do *something* rather than nothing to provide in-home nursing care for these children." *Id.* at 842; see also *id.* at 844 (Easterbrook, J., concurring) ("All a district court can do in a situation such as this is require [the State] to start trying."). If Saint Anthony can prove its claims of systemic delay and/or underpayment, the same is true here. The State decided to switch to a Medicaid program dominated by managed care. The State cannot now claim it has no obligation to ensure that Medicaid providers serving patients under that program receive timely payment. *O.B.* instructs that where HFS has a duty, a district court may order it to do something when that duty is not being met, at the first cut. The court may then need to supervise the effects of the injunction and the State's response and adjust the court's orders as circumstance and equity may require. The district court should not let the perfect become the enemy of the good, nor should the possibility that a first cut at an injunction might not work sufficiently justify a denial of any relief at all.

To be clear, we are not suggesting that an injunction ordering the State officials literally to do only "something" would be sufficient. Federal Rule of Civil Procedure 65(d)(1) requires an injunction to

"describe in reasonable detail ... the act or acts restrained or required." At the same time, we have often recognized that district courts have substantial equitable discretion in crafting injunctions so that they are both understandable by those enjoined and effective to accomplish their purposes. *Eli Lilly & Co. v. Arla Foods, Inc.*, 893 F.3d 375, 384–85 (7th Cir. 2018); *H-D Michigan, LLC v. Hellenic Duty Free Shops S.A.*, 694 F.3d 827, 843 (7th Cir. 2012), *citing Russian Media Group, LLC v. Cable America, Inc*., 598 F.3d 302, 307 (7th Cir. 2010). If Saint Anthony can prove systemic failures by MCOs to comply with the 30/90 payment schedule with reasonably transparent payment information, we would expect the district court to explore with the parties what steps the State officials could reasonably be expected to take to correct those systemic failures before framing an appropriate and effective injunction. And if such an injunction later needed to be modified based on experience, the district court would have ample power to do so at the request of a party or on its own motion.

O.B. also makes clear that a district court can craft injunctive relief within its equitable powers and discretion even in circumstances where some more drastic remedial measures may be off the table. See *O.B.,* 838 F.3d at 844 (Easterbrook, J., concurring) (identifying certain forms of relief that were off limits while also instructing the district judge to try different things and to "keep tabs on what is happening and adjust the injunction as appropriate" to secure relief for plaintiffs); accord, *Rizzo v. Goode*, 423 U.S. 362, 376–77 (1976) ("Once a right and a violation have been shown, the scope of a district court's equitable powers

to remedy past wrongs is broad, for breadth and flexibility are inherent in equitable remedies." (internal quotations and citation omitted)). Federal Rule of Civil Procedure 54(c) offers relevant guidance here, providing that any final judgment other than a default judgment "should grant the relief to which each party is entitled, even if the party has not demanded that relief in its pleadings." The converse is also true, of course. If a party demands relief in its pleadings that is not available, such a demand does not poison the well to defeat relief to which the party is otherwise entitled. If Saint Anthony succeeds on the merits of its claims, we believe the district court here will be able to craft a remedy to push the State toward complying with its duty to provide for timely and transparent payments to Saint Anthony.

We recognize that part of the rationale for adopting the managed-care model was to ease the State's administrative burden. Measures that would force HFS to take a more aggressive oversight role could reduce some of the administrative benefits the State hoped to gain by the switch to managed care. As we have explained, however, the Medicaid Act permits states to shift major Medicaid duties to MCOs but does not allow States to wash their hands of effective oversight. On the contrary, the Medicaid Act shows that Congress recognized the troubling financial incentives inherent in a managed-care system and the need for effective oversight. Recall that the Medicaid Act requires the State to audit and inspect MCO books and records, to perform annual external reviews of payment timeliness, and to implement sanctions if an MCO is underperforming.

Saint Anthony alleges here that HFS is falling far short on those oversight and monitoring duties. HFS cannot avoid those duties altogether on the theory that Saint Anthony also asked for certain remedies that might not be available in this section 1983 action. If the State cannot manage to carry out those oversight and monitoring duties, an effective remedy to enforce the requirements would honor the bargain struck when Illinois accepted funding for Medicaid in the first place.

The partial dissent also criticizes our focus on systemic failures and judicial relief to address such failures, arguing that there is no textual basis for that focus. The partial dissent portrays the choice as an either-or: either the district court must prepare to take over day-to-day claims management, or no judicial relief is available at all. The case is difficult, but the judicial options are not so limited. First, the Medicaid statute and the relevant contracts recognize that perfection is not required. That much is clear from the 30/90 pay schedule itself: pay 90% of clean claims within 30 days and 99% within 90 days. Second, HFS itself seems to be able to tell the difference between minor problems and systemic ones, and there is reason to think it can identify systemic measures that can be effective without having HFS (let alone the district court) take over day-to-day claims management. As noted above, for example, HFS took action against CountyCare based on data showing that CountyCare "was not regularly meeting" the 30/90 pay schedule. Decl. of Robert Mendonsa ¶ 16, Dkt. 86-10. HFS investigated, demanded that CountyCare adopt a "Corrective Action Plan," and reported that a few

months after adopting such a plan, CountyCare "significantly reduced the number of outstanding claims that [were] older than 90 days." *Id*. ¶¶ 17–21. We need not and should not adopt a mathematical definition of "systemic" failures at the pleadings stage. That problem can await further factual development. (To use a metaphor often used in the law, a person can *usually* tell the difference between being in mountains, in foothills, or on a plain even if there are no sharp boundaries between mountains, foothills, and plains.)

For these reasons, we conclude that section 1396u-2(f) satisfies the third *Blessing* factor because the State has a binding obligation to try to ensure prompt payment for providers from MCOs.

4. *Alternative Remedial Scheme*

Since section 1396u-2(f) satisfies the three *Blessing* factors, the right to prompt payment is presumptively enforceable under section 1983. *Talevski*, 6 F.4th at 720. HFS can rebut this presumption 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[.]" *Id.* (alteration and omission in original), quoting *Gonzaga*, 536 U.S. at 284 n.4. HFS has not identified any express language in the Medicaid Act foreclosing private rights enforcement. HFS relies instead on the implicit approach, which is a "difficult showing." *Blessing*, 520 U.S. at 346.

If the MCOs are failing to abide by the contractual terms, says HFS, Saint Anthony should just enforce its

own contracts with them. And providers like Saint Anthony are "in the best position" to "enforce their right to timely payment directly under their contracts with MCOs." Appellee's Br. at 29. As HFS sees the matter, there is no need to permit section 1983 actions to "achieve Congress's goal of enabling Medicaid providers to receive timely payment." *Id*.

A contractual remedy may offer some prospect of relief to a provider like Saint Anthony. But HFS has not convinced us that "allowing [section 1983] actions to go forward in these circumstances 'would be inconsistent with'" a "carefully tailored [Congressional] scheme.'" *Blessing*, 520 U.S. at 346, quoting *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 107 (1989). Rather, Congress intended the State's Medicaid plan to ensure timely payment to providers. If, as Saint Anthony alleges, the plan has been failing to meet this requirement, repeatedly and systematically, we would not be surprised if provider-MCO arbitrations would do little to correct that problem on a systemic basis.

There is good reason to doubt that contractual remedies alone can vindicate the provider's right to prompt payment. Saint Anthony files many thousands of Medicaid claims each year. If most claims are not paid on time, Saint Anthony's option under the contract is to sue the MCO and/or to submit each claim for arbitration. Many other Medicaid providers across Illinois might need to do the same with each of the seven MCOs. That avenue represents a claim-by-claim adjudication on the individual provider-MCO level, across many thousands of claims, all in their own arbitrations. It's not immediately obvious that this

dispute-resolution system would even be manageable, let alone superior to a systemic solution implemented by HFS. At the very least, we are not persuaded that Congress, implicitly through the contractual model, created "a comprehensive enforcement scheme that is incompatible with individual enforcement under [section 1983]." *Gonzaga*, 536 U.S. at 285 n.4.

For these reasons, we conclude that section 1396u-2(f) satisfies *Blessing* and contains a right to timely payment that is enforceable under section 1983. Saint Anthony has plausibly alleged a violation of such a right that would support a claim for relief. We therefore reverse the district court's dismissal of this claim.

We emphasize that this decision is based on the pleadings. This is a hard case with high stakes for the State, Medicaid providers, and Medicaid beneficiaries. We also recognize the potential magnitude of the case and the challenges it may present to the district court. If it turns out that resolving this dispute would actually require the district court to analyze each late claim, effectively taking on the role of the State's Medicaid claims processors, or that effective relief could come only by canceling a contract with an MCO, then we may face a different situation. But we do not know at this point what direction the course of this litigation will take. HFS has not convinced us that we must decide whether Saint Anthony has alleged a viable claim today by assuming only the worst-case scenarios will emerge down the line. If Saint Anthony can support its factual allegations about systematically late and inadequate payments, we believe the district court could exercise its equitable discretion to fashion

effective relief. The corrective action plan that HFS demanded from CountyCare may provide a starting point, adaptable to the circumstances of different MCOs.

III. *Additional Issues*

We have three issues left to discuss: Saint Anthony's claim in Count Two under section 1396a(a)(8), the district court's denial of Saint Anthony's motion to supplement the complaint, and a possible stay in favor of arbitration. We address each in turn.

A. *Count Two*

Unlike Saint Anthony's claim under section 1396u-2(f), its claim under section 1396a(a)(8) is not viable. Section 1396a(a)(8) does not provide Saint Anthony any enforceable rights under section 1983 because it does not contain any rights-creating language for *providers*. In the jargon of this niche in the law, it fails to satisfy *Blessing* factor one.

Recall that the first *Blessing* factor requires Congress to have intended the plaintiff to be the beneficiary of the provision in question. *Blessing*, 520 U.S. at 340. Section 1396a(a)(8) requires a state to "provide that all individuals wishing to make application for medical assistance under [the state's Medicaid system] shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals." 42 U.S.C. § 1396a(a)(8). The key language in this provision is "individuals," used in two places. At the beginning, the text specifies that "all *individuals* wishing to make application for medical assistance" must have the

opportunity to do so. At the end, it says that "all eligible *individuals*" must receive that assistance promptly. We agree with other circuits that have concluded that individuals are the intended beneficiaries of this provision. See, e.g., *Romano v. Greenstein*, 721 F.3d 373, 378–79 (5th Cir. 2013) (concluding that individuals were the "clearly" intended beneficiaries of section 1396a(a)(8) and that the provision gave individuals a private right of action); *Doe v. Kidd*, 501 F.3d 348, 356–57 (4th Cir. 2007) (same); see also *Nasello*, 977 F.3d at 602 (collecting cases).[5]

Saint Anthony asserts that "individuals" could also include providers. It argues that dictionary definitions of "individual" include a "single ... thing, as opposed to a group," which includes a single provider. Appellant's Br. at 39, quoting *Individual*, Black's Law Dictionary (11th ed. 2019). Medical assistance is also defined in the statute to include "payment." 42 U.S.C. § 1396d(a). Saint Anthony puts these pieces together to argue that section 1396a(a)(8) includes requiring MCOs to furnish "medical assistance" (defined as including "payment" for medical services) to "individuals" (defined as including "hospitals") with "reasonable promptness."

The argument is not convincing. For one, interpreting "individual" to include a "hospital" is a long stretch of the language. Saint Anthony's argument is also inconsistent with other parts of section

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[5] We declined to decide this issue in *Nasello* but accepted the premise for the sake of argument. 977 F.3d at 602.

1396a(a)(8) and surrounding statutory provisions. Section 1396a(a)(8) says that states must "provide that all individuals wishing to make application for medical assistance" can do so. (Emphasis added.) Providers do not make *application* for medical assistance; individuals do. See 42 C.F.R. § 435.4 (2015) ("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."). As the district court correctly identified, the texts surrounding section 1396a(a)(8) use "individuals" repeatedly to refer to natural persons. See *Saint Anthony Hospital*, 548 F. Supp. 3d at 738 (collecting provisions).

Given this statutory evidence, Congress did not speak "with a clear voice" and manifest an "unambiguous[]" intent to confer rights to providers like Saint Anthony under section 1396a(a)(8) through the word "individuals." See *Pennhurst*, 451 U.S. at 17. Section 1396a(a)(8) thus fails the first *Blessing* factor and does not confer a private right to providers that can be enforced under section 1983.

B. *Saint Anthony's Motion to Supplement the Complaint*

While the motion to dismiss was pending, Saint Anthony moved to supplement its complaint with a claim for deprivation of property without due process of law. Saint Anthony alleged HFS violated its due process rights in two ways, both related to payment transparency: (1) by failing to notify Saint Anthony of the amounts being paid for services provided to Medicaid beneficiaries in the fee-for-service program;

and (2) by failing to require MCOs to provide such notice in the managed-care program. Four days after the district court dismissed the existing complaint, the court denied Saint Anthony's motion to supplement.

As a preliminary matter, there is an academic question whether this request should be construed as a motion to supplement under Federal Rule of Civil Procedure 15(d) or a motion to amend under Rule 15(a). Saint Anthony's motion sought to add allegations concerning both post-complaint events (most appropriate as a 15(d) supplement) and some pre-complaint events that came to light in discovery (most appropriate under 15(a)). The distinction between 15(a) amendments and 15(d) supplements is not important here. District courts have essentially the same responsibilities and discretion to grant or deny motions under either subsection. See *Glatt v. Chicago Park District*, 87 F.3d 190, 194 (7th Cir. 1996) ("[T]he standard is the same."); see also 6A Wright & Miller, Federal Practice and Procedure § 1504 (3d ed.) (explaining that a lack of formal distinction between the two is "of no consequence," and that leave should be freely granted when doing so will promote economic and speedy disposition of entire controversy and will not cause undue delay or unfair prejudice to other parties).

Ordinarily, "a plaintiff whose original complaint has been dismissed under Rule 12(b)(6) should be given at least one opportunity to try to amend her complaint before the entire action is dismissed. We have said this repeatedly." *Runnion ex rel. Runnion v. Girl Scouts of Greater Chicago & Northwest Indiana*, 786 F.3d 510, 519 (7th Cir. 2015) (collecting cases).

The decision to deny the plaintiff such an opportunity "will be reviewed rigorously on appeal." *Id*. "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." *Id*. at 519–20, quoting *Barry Aviation Inc. v. Land O'Lakes Municipal Airport Commission*, 377 F.3d 682, 687 (7th Cir. 2004). Reasons for denying leave to amend include "futility, undue delay, prejudice, or bad faith." *Kreg Therapeutics, Inc. v. VitalGo*, Inc., 919 F.3d 405, 417 (7th Cir. 2019).

The district court used a procedure here that ran a high risk of error. Saint Anthony requested leave to add the due process claim after minimal discovery and before the court ruled on the pending motion to dismiss. The court entered a minute order recognizing that "Rule 15(a)(2) provides that the 'court should freely give leave when justice so requires.'" It then ordered HFS to respond, even permitting an oversized brief. HFS responded by arguing the merits of the due process claim, saying in essence that the proposed amendment or supplement would be futile. Futility could be a good reason to deny the amendment or supplement, but then the district court took a wrong turn. It denied Saint Anthony an opportunity to file a reply defending the merits of its proposed due process claim. The court then denied Saint Anthony's motion on futility grounds. This unusual procedure thus denied Saint Anthony a fair opportunity to defend the merits of its supplemental claim—only to lose on the supposed lack of merit. That procedure amounted to an abuse of discretion.

Other aspects of the district court's decision on that motion also point toward reversal. For instance, Saint Anthony's request to supplement the complaint occurred early in the lawsuit. See *Abu-Shawish v. United States*, 898 F.3d 726, 738 (7th Cir. 2018) ("The usual standard in civil cases is to allow defective pleadings to be corrected, *especially in early stages*, at least where amendment would not be futile." (emphasis added)). The district court did not find bad faith by Saint Anthony or prejudice to HFS.

The district court denied the motion in part because it concluded the new claim would expand the scope and nature of the case, which the court thought was "otherwise over." We do not find this rationale persuasive, especially after we have concluded that the case is not otherwise over. The due process claim against the State pertains to the lack of transparency in the Medicaid remittances, based at least in part on new information produced in the limited discovery. Saint Anthony alleged problems with the remittances in its original complaint, as HFS acknowledges. The new claim added issues related to the fee-for-service aspects of Illinois Medicaid, but that fact alone was not reason enough to deny leave so early in the life of a case and before discovery was in full swing. Courts should not be surprised, and should not respond rigidly, when discovery in a complex case turns up evidence to support a new theory for relief or defense.

In addition, by denying the motion to amend or supplement, the district court put Saint Anthony at risk of serious and unfair prejudice. To the extent the district court might have thought that the due process claim should be presented in a separate lawsuit, Saint

Anthony could face serious problems with claim preclusion. See *Arrigo v. Link*, 836 F.3d 787, 798–800 (7th Cir. 2016).[6]

At this stage of the proceedings, the only arguable ground for denying Saint Anthony's request to supplement its complaint would have been futility on the merits. The district court did say that it "ha[d] doubts about the legal sufficiency of Saint Anthony's proposed new claim." As noted above, the denial of a

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[6] In Arrigo, the first district court denied plaintiff's motion to amend the complaint to add a related claim, and we affirmed. Then, when the plaintiff tried to bring the claim in a new action, the second district court dismissed it. We upheld that decision, asserting that "allowing Arrigo to proceed here would result in the very prejudice and inefficiency that the denial of the untimely amendment, which we upheld, was intended to avoid." 836 F.3d at 800. We also stressed that "[t]o rule otherwise would undermine the principles animating the doctrines of res judicata and claim splitting, as well as our decision upholding on appeal the denial of the motion for leave to amend." *Id.* In that sense, by prohibiting the supplemental claim here, the district court might have also prevented Saint Anthony from bringing that claim in a future case, all without the opportunity for Saint Anthony to defend the merits of the claim. HFS argues that Saint Anthony's concerns are misplaced because the district court implied that Saint Anthony could bring its due process claim in a future action. It is true that a district court can expressly reserve a claim for future adjudication, *see, e.g., Sklyarsky v. Means-Knaus Partners, L.P.,* 777 F.3d 892, 896 (7th Cir. 2015); 18 Wright & Miller § 4413, but such an exception requires the second court to conclude the first court adequately preserved the claim. One could understand why such assurances from HFS, including its post-argument letter promising to forgo a claim preclusion defense in a separate lawsuit, might provide Saint Anthony limited comfort, especially since the district court's stated rationale was based at least in part on a supposed lack of merit.

plaintiff's first attempt at leave to amend or supplement "will be reviewed rigorously on appeal." *Runnion*, 786 F.3d at 519. Doubts on the merits do not show futility. See, e.g., *id*. at 519–20; *Bausch v. Stryker Corp*., 630 F.3d 546, 562 (7th Cir. 2010) ("Generally, if a district court dismisses for failure to state a claim, the court should give the party one opportunity to try to cure the problem, even if the court is skeptical about the prospects for success."). We thus reverse the denial of Saint Anthony's motion to supplement its complaint.

C. *Arbitration?*

The remaining issue is whether we should stay the case in favor of arbitration, as the intervening MCOs request. A necessary aspect of Saint Anthony's claim against HFS is showing that the MCOs systematically miss the 30/90 pay schedule. The MCOs dispute that allegation, however. They argue that under the contracts, each allegedly late claim presents a factual dispute that must be resolved in arbitration before Saint Anthony's case against HFS can proceed on the merits.

The district court did not address this issue, and we decline to do so here as well. Both HFS and the MCOs have their distinct obligations to ensure timely payment for providers. While factual issues related to the MCOs appear intertwined with Saint Anthony's claim against HFS, they do not foreclose Saint Anthony's section 1983 action. Faced with chronic late payments, Saint Anthony is entitled to seek relief against HFS as well as against the MCOs.

* * *

To sum up, Saint Anthony has alleged a viable right under 42 U.S.C. § 1396u-2(f) to have HFS act to try to ensure timely payments from MCOs, and that right is enforceable in this section 1983 action against HFS Director Eagleson in her official capacity. We REVERSE the district court's dismissal of Count One. Saint Anthony does not have any rights under section 1396a(a)(8). We AFFIRM the district court's dismissal of Count Two. We REVERSE the district court's denial of Saint Anthony's motion to supplement, decline to stay the proceedings in favor of arbitration, and REMAND for proceedings consistent with this opinion.

Brennan, *Circuit Judge*, concurring in part and dissenting in part.

I join my colleagues in concluding that 42 U.S.C. § 1396a(a)(8) does not support a private right of action for healthcare providers. And while I agree that under the *Blessing* factors, 42 U.S.C. § 1396u-2(f) creates a private right of action, I part ways with them on the breadth and substance of the State's duty under that statute. An administrative prerequisite that a managed care contract includes deadlines is fundamentally different from a privately enforceable statutory duty to proactively guarantee timely managed care payments to healthcare providers. I also conclude that the district court did not abuse its discretion in denying Saint Anthony's Federal Rule of Civil Procedure 15(d) motion to supplement its complaint.

I

Saint Anthony is a hospital in Chicago serving impoverished patients that relies heavily on Medicaid for its funding. Saint Anthony maintains that it has not received timely Medicaid payments from multiple managed care organizations ("MCOs"). Rather than pursue any claims against the MCOs directly through arbitration or litigation as provided for in the Hospital's contracts,[1] Saint Anthony has attempted to bypass the MCOs altogether by suing Illinois under 42 U.S.C. § 1396u-2(f).

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[1] Saint Anthony has contracts with all seven MCOs in the Illinois managed care program. Each of the four MCOs that intervened in this case has a contract with the Hospital that contain arbitration provisions, three of which are binding.

Section 1396u-2(f) governs contracts between states and managed care organizations under a managed care system. The provision states in relevant part:

> 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 ... 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). The provision that § 1396u-2(f) incorporates—42 U.S.C. § 1396a(a)(37)(A)—lists the payment procedures which apply to a state's fee-for-service system, requiring payment for 90% of clean claims within 30 days and 99% of clean claims within 90 days.

The parties substantially disagree about § 1396u-2(f)'s requirements. They agree that states have a duty to include contractual provisions with MCOs, and there is no dispute that such provisions exist in the underlying contracts here.[2] They also agree that states have a right to enforce that provision. But the parties diverge as to whether states have a privately enforceable duty to guarantee that all MCO payments

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[2] Saint Anthony might have had an actionable claim under § 1396u-2(f) if it had pleaded that the State's MCO contracts failed to include the required 30-day/90-day payment schedule. But the Hospital admits that the State's contracts do include the necessary payment provisions.

are timely paid to healthcare providers. According to the State, § 1396u-2(f) mandates only that MCO contracts with healthcare providers include payment schedules that conform to § 1396a(a)(37)(A)'s 30-day/90-day payment requirement. Saint Anthony believes the statute requires more: states must proactively enforce MCO payments to ensure they are issued on a timely basis.

Before determining the extent of a state's duty under § 1396u-2(f), it is crucial to remember, "if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously." *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981). Because Medicaid is legislation under the Constitution's Spending Clause, Congress must "speak with a clear voice" before imposing obligations on the states. *Id.* This ensures states exercise their choice to participate in Medicaid knowingly, "cognizant of the consequences of their participation." *Id*. "A state cannot knowingly accept the conditions of the federal funding if that state is unaware in advance of the conditions or unable to ascertain what is expected of it, and therefore we insist that Congress must speak with a clear voice." *City of Chi. v. Barr*, 961 F.3d 882, 907 (7th Cir. 2020). We have described this requirement, which is rooted in federalism concerns, as "rigorous." *Planned Parenthood of Ind., Inc. v. Comm'r of Ind. State Dep't Health*, 699 F.3d 962, 973 (7th Cir. 2012). Indeed, the Court has shown great reluctance to recognize private rights of action under 42 U.S.C. § 1983 for beneficiaries of federally funded state programs. Since *Wilder v. Virginia Hospital Ass'n*, 496 U.S. 498 (1990), decided over three decades

ago, the Court "has repeatedly declined to create private rights of action under statutes that set conditions on federal funding of state programs." *Nasello v. Eagleson*, 977 F.3d 599, 601 (7th Cir. 2020); *see Talevski v. Health & Hosp. Corp. of Marion Cnty.*, 6 F.4th 713, 718 (7th Cir. 2021), *cert. granted sub nom. Health & Hosp. Corp. v. Talevski*, No. 21-806, —— U.S. ——, 142 S. Ct. 2673 (U.S. May 2, 2022) ("[N]othing 'short of an unambiguously conferred right ... phrased in terms of the persons benefited' can support a section 1983 action." (quoting *Gonzaga Univ. v. Doe*, 536 U.S. 273, 283–84 (2002))); *see, e.g., Armstrong v. Exceptional Child Ctr., Inc.*, 575 U.S. 320, 332 (2015).

With this legal backdrop, consider the text of § 1396u-2(f). Congress mandated that a state's "contract" with an MCO "shall provide" that the MCO make payments to healthcare providers on a timely basis consistent with § 1396a(a)(37)(A)'s 30-day/90-day payment schedule, unless healthcare providers and MCOs agree to an alternate payment schedule. But it is clear that is all the text requires. Section 1396u-2(f) is silent on any ongoing governmental duty to monitor MCO payments or otherwise guarantee that MCOs consistently make prompt payments. As other neighboring statutory provisions show, Congress knows how to impose duties requiring state action.[3]

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[3] See, e.g., 42 U.S.C. § 1396u-2(a)(3)(A) ("A State must permit an individual to choose a managed care entity from not less than two such entities...."); 1396u-2(a)(4)(B) ("The State shall provide for notice to each such individual of the opportunity to terminate (or change) enrollment under such conditions."); § 1396u-2(a)(4)(C) ("[T]he State shall establish a method for establishing enrollment priorities in the case of a managed care entity that does not have sufficient capacity to enroll all such individuals seeking

Section § 1396u-2(f) contains no such language. Rather, its text describes the contract provision that must be included—for timely payments consistent with deadlines set out in a different statute—not the State's ongoing enforcement duty. This is not surprising given that § 1396u-2(f) pertains to managed care systems, rather than traditional fee-for-service arrangements. As the majority opinion notes, the managed care structure was designed to alleviate the burden on states of managing the "day-to-day" functions previously performed by states under a fee-for-service system.

Review of the Medicaid Act as a whole confirms this reading of § 1396u-2(f). *See* ANTONIN SCALIA & BRYAN A. GARNER, READING LAW 167 (2012) ("The text must be construed as a whole."); *id*. at 180 ("The provisions of a text should be interpreted in a way that renders them compatible, not contradictory."). In 42 U.S.C. § 1396u-2(e)(4)(A), the statute sets forth "[s]anctions for noncompliance" that states can impose against MCOs who commit enumerated offenses. Among the tools at a state's disposal is the

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enrollment...."); § 1396u-2(a)(4)(D) ("[T]he State shall establish a default enrollment process...."); § 1396u-2(a)(5)(C) ("A State that requires individuals to enroll with managed care entities under paragraph (1)(A) shall annually (and upon request) provide ... to such individuals a list identifying the managed care entities...."); § 1396u-2(c)(1)(A) ("[T]he State shall develop and implement a quality assessment and improvement strategy...."); § 1396u-2(d)(1)(B)(i) ("[T]he State ... shall notify the Secretary of such noncompliance."); § 1396u-2(d)(6)(A) ("[A] State shall require that ... the provider is enrolled consistent with section 1396a(kk) of this title with the State agency administering the State plan under this subchapter.").

power to terminate a contract with a noncompliant MCO. As the majority opinion admits, the text of § 1396u-2(e)(4)(A) reserves this punitive measure to the discretion of the states. Yet under Saint Anthony's reading of the statute, if an MCO fails to make timely payments to healthcare providers, a state could be *required* to terminate the MCO's contract as a last resort if, as the majority opinion rules, the state has a duty to ensure compliance with the contractual payment schedule. Saint Anthony's only response is that states can "choose the tools to generate compliance" with the payment schedule. But even the Hospital admits—as it must—that terminating an MCO's contract may become "necessary" as a "final draconian remedy" if other remedial measures prove ineffective.[4]

In addition to lacking a textual basis in § 1396u-2(f), and creating statutory incongruences within the Medicaid Act, Saint Anthony's interpretation threatens to put a tremendous burden on states and the judiciary. Unsuspecting states will be surprised to learn that now they must manage MCOs to guarantee that all payments to healthcare providers are made on a timely basis—the same "day-to-day" administration that a managed care system was supposed to avoid. The duty the Hospital would read into § 1396u-2(f) would obligate trial courts to become de facto Medicaid claims processors for states. Courts will be charged with resolving disputes about which claims are clean and which are not, as well as substantial litigation over

[4] Oral Arg. at 43:51–44:22.

the timeliness of paying claims.

Aware of these problems, the majority opinion endorses a third reading of § 1396u-2(f), distinct from either of the interpretations for which the parties advocate. Healthcare providers "have a right under section 1396u-2(f) that is enforceable under section 1983, at least to address systemic failures to provide timely and transparent payments," per the majority opinion. My colleagues hope that qualifying the state's duty to ensure timely payment only when MCO's are *systemically* late in paying healthcare providers will lessen the burden on the states and district courts.

But the majority opinion's interpretation is even further removed from the text of § 1396u-2(f). That provision never mentions—let alone defines—"systemic" failures to make timely payments. While Saint Anthony's position that states must always ensure timely payment is incorrect, its reading at least acknowledges that the statutory text contains no limiting principle—that is, states either have a privately enforceable duty to ensure prompt payment, or they do not. By contrast, the majority opinion introduces a new standard under which victims of the worst MCO offenders may pursue federal claims, but disputes not deemed "systemic"—presumably about a comparatively small number of untimely payments—are not actionable. There is no textual basis for such a conditional duty under § 1396u-2(f), let alone text that is "unambiguous[]" and spoken with a "clear voice." *Pennhurst*, 451 U.S. at 17.

Instead of grounding its interpretation in the text of § 1396u-2(f), the majority opinion looks elsewhere. For example, it states that "Congress did not intend

for MCOs to go unsupervised." But that is a false dilemma. By requiring contractual provisions that MCOs make timely payments, § 1396u-2(f) enables a healthcare provider like Saint Anthony to privately enforce their contractual rights against MCOs directly through arbitration or litigation. Recall that Saint Anthony is not without a vehicle to press its arguments about nonpayment of claims. The Hospital has contracts with MCOs, each of which contains a bargained-for arbitration clause. The arbitration with one of the MCOs, Meridian, is currently stayed at the Hospital's request. Further, it is undisputed that states have the authority to intervene and to penalize noncompliant MCOs. The question is not whether Congress intended that MCOs go unsupervised, but whether Congress intended in § 1396u-2(f) that MCOs be supervised via a privately enforceable legal duty, found in that statute, and now recognized in the majority opinion.

As evidenced throughout § 1396u-2, Congress knows how to impose duties requiring state action when it wants to. But language imposing a duty is absent from § 1396u-2(f). "We do not lightly assume that Congress has omitted from its adopted text requirements that it nonetheless intends to apply, and our reluctance is even greater when Congress has shown elsewhere in the same statute that it knows how to make such a requirement manifest." *Jama v. Immigr. & Customs Enf't*, 543 U.S. 335, 341 (2005). And as referenced above, unspoken Congressional intent should be an oxymoron when examining whether Spending Clause legislation contains a private right of action.

When the majority opinion does turn to the actual language of the statute, tellingly, it looks only to unrelated provisions in the Medicaid Act, rather than "start[ing] with the specific statutory language in dispute"—here, the text of § 1396u-2(f). *Murphy v. Smith*, —— U.S. ——, 138 S. Ct. 784, 787 (2018); *see King v. Burwell*, 576 U.S. 473, 500–01 (2015) (Scalia, J., dissenting) ("[S]ound interpretation requires paying attention to the whole law" as "a tool for understanding the terms of the law, not an excuse for rewriting them"). My colleagues note that elsewhere in the Act, Congress authorized states to audit MCOs and to conduct annual reviews, some of which relate to MCO payment activities. The Medicaid Act also specifies remedial measures a state can take against noncompliant MCOs, such as putting them on performance plans and imposing sanctions. These "reporting and oversight responsibilities" are proof positive, according to the majority opinion, that states are legislatively required to enforce prompt payment provisions.

This rationale proves too little. State oversight of MCOs serves a wide array of purposes, any one of which could plausibly explain Congress's imposition of managerial responsibilities. For example, as the majority opinion highlights, these oversight measures recently served to unearth an MCO's misallocation of funds. But the imposition of reporting and oversight responsibilities does not show that Congress imposed a privately enforceable duty on states to guarantee healthcare providers are timely paid. The majority opinion's rationale also proves too much. If Congress's only purpose in authorizing state audits and oversight

was to require states to guarantee timely payments by MCOs to healthcare providers, why is that purpose limited to *systemic* MCO noncompliance? No reason is offered for limiting the state's mandatory enforcement duties to only the widest or worst offenders.

As a final measure, the majority opinion notes that elsewhere in the Medicaid Act, § 1396u-2(f) is referenced as the "rule for prompt payment of providers." 42 U.S.C. § 1396u-2(h)(2)(B). My colleagues suppose that such a title implies a binding obligation on states to enforce MCO payment schedules. "But headings and titles are not meant to take the place of the detailed provisions of the text. Nor are they necessarily designed to be a reference guide or a synopsis." *Brotherhood of R. R. Trainmen v. Balt. & O. R. Co.*, 331 U.S. 519, 528 (1947). This title is especially unhelpful because it does not clarify whether § 1396u-2(f) is an administrative requirement that a managed contract include deadlines, or a rule that imposes a privately enforceable, managerial duty on states to guarantee all MCO payments are timely (or at least when there is "systemic" untimeliness). A passing reference in § 1396u-2(h)(2)(B) to the provision in dispute fails to alter the plain meaning of § 1396u-2(f)'s text.

The broader structure of Medicaid also shows how the majority opinion's approach conflicts with § 1396u-2(e)(4)(A). If a state is unable to resolve an MCO's "systemic" failure to timely pay healthcare providers using lesser measures, the state must terminate its contract with the MCO because the majority opinion holds that states "have an obligation to act under section 1396u-2(f) to secure providers' rights." My

colleagues state that "a district court could not force the State to cancel a contract with an MCO." But that attempts to have it both ways, as that is the unavoidable consequence of this holding. If states have a privately enforceable duty to ensure prompt payment —at least when MCOs have systemically failed to comply with the provided payment schedule—states would be obligated to terminate MCO contracts as a measure of last resort.[5] My colleagues acknowledge as much by suggesting that "sufficiently egregious facts" could warrant such extreme measures. In other words, the majority opinion nods to the statutory tension that its broad rule creates, but then moves on without resolving it, content with the knowledge that the statutory conflict is not realized here because Saint Anthony has not *yet* sought termination of MCO contracts. That is not a tenable solution for the statutory conflict created. Even if the "worst-case scenario" existed only in the abstract, the fact that § 1396u-2(e)(4)(A) cannot be reconciled with my colleagues' construction of § 1396u-2(f) shows this is not a sound approach to statutory interpretation.

Overall, the majority opinion passes over the actual language of § 1396u-2(f) in favor of factors outside the statute and references to Congress's overall intent. But "[i]t is not a proper use of the [whole act] canon to say that since the overall purpose of the statute is to achieve x, any interpretation of the text that limits the achieving of x must be disfavored." SCALIA & GARNER, *supra*, at 168. "[N]o legislation

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[5] Again, as the Hospital's counsel conceded repeatedly at oral argument. Oral Arg. at 43:51–44:22.

pursues its purposes at all costs." *Rodriguez v. United States*, 480 U.S. 522, 525–26 (1987) (per curiam). The majority opinion suggests Congress's chosen tools for ensuring prompt payment—private suits and arbitration by healthcare providers against MCOs, along with discretionary enforcement by states—are inadequate. *See e.g.,* Majority Op. at 509, 511 (referencing § 1396u-2(f)'s mandate that state contracts include prompt payment schedules with MCOs as a "'paper' requirement" and "a proverbial paper tiger"). But "it is not for us to substitute our view of ... policy for the legislation which has been passed by Congress." *Fla. Dep't of Revenue v. Piccadilly Cafeterias, Inc.*, 554 U.S. 33, 52 (2008) (quoting *In re Hechinger Inv. Co. of Del., Inc.*, 335 F.3d 243, 256 (3d Cir. 2003)).

Paradoxically, the attempt to limit this holding to systemic MCO noncompliance, designed to alleviate the burden on district courts, will add to it. Now courts will have to make preliminary determinations on whether healthcare providers have pleaded "systemic" failures by MCOs to determine if claims are actionable. That determination must be made without statutory or judicial guidance, because "systemic" remains undefined both as a metric (for example, total number of unpaid claims, or a percentage of such claims) and the point at which that numeric threshold is crossed.

The majority opinion suggests this determination is intuitive, as evidenced by a solitary instance of the State acting against one noncompliant MCO, CountyCare. This example, my colleagues posit, shows that the State "seems to be able to tell the difference between minor problems and systemic ones." As an

initial matter, if Saint Anthony's allegations of State inaction in the face of rampant untimeliness by MCOs are true, this case proves the State cannot intuit the difference between "systemic" and "minor" failures. Even more, before the majority opinion, labels like "systemic" and "minor" were without legal significance. So, an example of the State acting against an MCO does not show that the State—much less district courts—can determine which MCOs are systemically underperforming, and which are not. Tens of thousands of untimely payments might signal a "systemic" problem while a handful of unpaid claims might not, but between these extremes lies a vast expanse of undefined terrain.

District courts are also promised that they will not need to "adjudicate issues at the claim-by-claim level"—a task my colleagues concede "would strain judicial resources and seem to conflict with the arbitration clauses in the contracts between the MCOs and Saint Anthony." But a district court can hardly decide if an MCO has systemically underperformed if it does not examine claims for untimely payment on the merits, and then determine whether the "systemic" threshold has been reached. And a district court cannot decide whether the payment schedule even applies to a group of payment claims without reaching the requisite question of whether the disputed claims are clean. Moreover, without inspecting whether individual claims are being paid on time, a district court has no metric by which to gauge the effectiveness of, or a State's compliance with, injunctions designed to ensure timely payment. Pointing to *O.B. v. Norwood*, 838 F.3d 837 (7th Cir.

2016), the majority opinion insists that all the district court must do is require the State to do "something." But my colleagues recognize that such a remedy is appropriate only "[i]f Saint Anthony can prove its claims of systemic delay and/or underpayment," which necessarily involves adjudicating the underlying claims on the merits.[6]

In sum, the majority opinion's interpretation of § 1396u-2(f) finds no support in that statute's text and contravenes other provisions of the Medicaid Act. The attempt to limit a privately enforceable duty to "systemic" untimeliness by MCOs appears nowhere in that statute. This interpretation requires district courts to perform the arduous task of deciphering whether a healthcare provider has proved systemic abuse. That evaluation will involve some level of adjudicating the nature, timeliness, and merits of payment claims, rendering district courts the new Medicaid claims processors for the states. And as a consequence, "day-to-day" functions and enforcement are returned to the states—the precise type of fee-for-service management that MCOs were designed to

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[6] *O.B.* is also distinguishable. There, the statutory text of 42 U.S.C. § 1396a(a)(10)(A) imposed a duty on the State to make "medical assistance" available, which this court determined included providing nurses for children. 838 F.3d at 842–43. Here, there is no textual mooring for this holding that states have a privately enforceable duty to ensure healthcare providers are timely paid in instances where MCOs are systemically delaying payments. *See also id.* at 843–44 (Easterbrook, J., concurring) (noting the district court's injunctive order requiring the states to do something to find nurses "does not supply any detail," and "[t]he Supreme Court has reversed injunctions that read like this one").

avoid. This court has not previously read an implied right of action against the states under Medicaid so expansively. Of this court's few cases recognizing a private right of action under Medicaid, none has imposed a duty on the states as broad in scope, ongoing in nature, and difficult to enforce as the duty the majority opinion concludes exists here.[7] Nor has any other federal circuit ever recognized a state's privately enforceable duty to guarantee timely payment under § 1396u-2(f). Jane Perkins, *Private Enforcement of the Medicaid Act Under Section 1983*, NAT'L. HEALTH L. PROGRAM 5–7 (July 30, 2021), https://bit.ly/2XaCtDY. To find such an expansive duty under § 1396u-2(f),

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[7] *See, e.g., Talevski*, 6 F.4th at 720 (holding that nursing home residents have privately enforceable rights under 42 U.S.C. §§ 1396r(c)(1)(A)(ii) and (c)(2) to not be chemically restrained for disciplinary or convenience purposes, and to not be transferred or discharged from a facility unless certain criteria are met); *BT Bourbonnais Care, LLC v. Norwood*, 866 F.3d 815, 824 (7th Cir. 2017) (holding that 42 U.S.C. § 1396a(a)(13)(A) creates a privately enforceable duty on states to provide a public process with notice and opportunity to comment as outlined in § 1396a(a)(13)(A)); O.B., 838 F.3d at 842–43 (holding that provisions in the Medicaid Act impose a privately enforceable duty on states to take affirmative steps to locate and provide home nurses for children that the Illinois Department of Healthcare and Family Services have approved for home nursing); *Planned Parenthood of Ind., Inc.*, 699 F.3d at 974 (holding that 42 U.S.C. § 1396a(a)(23) creates a privately enforceable "right to receive reimbursable medical services from any qualified provider"); *Bontrager v. Ind. Fam. & Soc. Servs. Admin.*, 697 F.3d 604, 607–08 (7th Cir. 2012) (reaffirming *Miller v. Whitburn*, 10 F.3d 1315, 1318 (7th Cir. 1993), which held that Medicaid recipients have a right of action to "challenge the reasonableness of a state's decision regarding the medical necessity of a life saving procedure" under 42 U.S.C. § 1396a(a)(10)(A)).

without any textual support—in the context of Spending Clause legislation, where Congress must speak "unambiguously" with a "clear voice"—is a watershed moment.

II

I also part ways with my colleagues on whether the district court abused its discretion in denying Saint Anthony's motion to supplement its complaint.

Federal Rule of Civil Procedure 15(d), which governs motions to supplement pleadings, provides in relevant part that "[o]n motion and reasonable notice, the 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." FED. R. CIV. P. 15(d). This court has emphasized "that there is no absolute right to expand the case in this way," and that "the district court has substantial discretion either to permit or to deny such a motion." *Chi. Reg'l Council of Carpenters v. Vill. of Schaumburg*, 644 F.3d 353, 356 (7th Cir. 2011); *see In re Wade*, 969 F.2d 241, 250 (7th Cir. 1992) (noting that a Rule 15(d) motion is reviewed for abuse of discretion); *Otis Clapp & Son, Inc. v. Filmore Vitamin Co.*, 754 F.2d 738, 743 (7th Cir. 1985) (same). Under an abuse of discretion standard of review, we will reverse "only if no reasonable person would agree with the decision made by the trial court." *Lange v. City of Oconto*, 28 F.4th 825, 842 (7th Cir. 2022) (quoting *Smith v. Hunt*, 707 F.3d 803, 808 (7th Cir. 2013)).

On appeal Saint Anthony points to Rule 15(a), which governs a motion to amend pleadings. Rule

15(a) includes the familiar language that courts "should freely give leave when justice so requires." FED. R. CIV. P. 15(a). But Saint Anthony did not file a motion to amend under Rule 15(a); rather, it expressly filed a motion to supplement under Rule 15(d).[8] That the Hospital could have filed a motion under Rule 15(a) is not relevant. Rule 15(d) does not contain or otherwise invoke Rule 15(a)(2)'s mandate that courts freely grant motions to amend.

The difference between Rule 15(a) and Rule 15(d) is substantive.[9] A supplemental complaint filed under Rule 15(d) is to embrace only events that have happened since the original complaint; that is, to "bring[] the case up to date." *6A* CHARLES ALAN WRIGHT & ARTHUR R. MILLER, FEDERAL PRACTICE AND PROCEDURE § 1504 (3d ed.) Saint Anthony argues its supplemental complaint alleged facts discovered after the filing of the original complaint. But that is only partially correct. The Hospital states in its supplemental complaint that its allegations are only "based in part on events that have occurred since" the original complaint. (emphasis added). The supplemental complaint references Saint Anthony's earlier allegations about lack of transparency on MCO payments from January and February 2020, predating the April 2020 original complaint. Indeed, the original complaint included an entire section challenging the lack of transparency in the MCOs dealing with

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[8] Dist. Ct. D.E. 101 ("Motion for Leave to File Supplemental Complaint").

[9] Contra Oral Arg. at 45:20–25.

providing hospitals.

Saint Anthony also added a new claim in its supplemental complaint. The original complaint alleged statutory violations for the State's failure to ensure timely payments from MCOs. The supplemental complaint alleged violation of the Fourteenth Amendment's Due Process Clause and requested transparency in the calculations and variables used in making payments under the managed care program and Illinois's separate fee-for-service program—the latter of which was not previously part of this action.

Given this case's subject matter, scope, and procedural posture, the district court was well within its discretion to decide against a massive increase in the scale of this litigation. Saint Anthony's original complaint was limited to the State's managed care program—an enormous undertaking itself. The supplemental complaint, filed nine months later after the parties had engaged in expedited discovery, added a new due process count which, as the district court correctly observed, would have entailed "whole new frontiers of discovery." That characterization is modest. The case would have expanded to include the Hospital's claim involving, for the first time, the $7 billion Medicaid fee-for-service program.[10] When a

[10] For FY 2020, Illinois paid nearly $15 billion to managed care organizations, and nearly $6.9 billion in fee-for-service payments, according to statistics compiled by the Medicaid and CHIP Payment and Access Commission, a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and related programs.

proposed supplemental complaint seeks to add a claim that will unduly delay and alter the scope of litigation, a district court may deny leave to supplemental the complaint. *See Clean Water Action v. Pruitt*, 315 F. Supp. 3d 72, 84–85 (D.D.C. 2018).

For my colleagues, if the district court's decision denying the motion to supplement is affirmed, "Saint Anthony could face serious problems with claim preclusion." But shortly after oral argument in our court, the State submitted a post-argument memorandum in which it stated:

> [I]f the Court affirms the district court's orders denying [Saint Anthony] leave to file its proposed supplemental complaint and [Saint Anthony] seeks to assert that additional claim in a separate action, [the State] will not assert, and accordingly waives, the defense of claim preclusion as to the additional claim alleged in plaintiff-appellant's proposed supplemental complaint.[11]

So, Saint Anthony would have been able to assert its additional claim against the State in a separate case. The State affirmatively waived any argument to the contrary.

MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION, MACSTATS: MEDICAID AND CHIP DATA BOOK 48 (2021), https://bit.ly/3NbGn3P. The Commission's authorizing statute is 42 U.S.C. § 1396.

[11] D.E. 59.

As the district court reasoned and concluded—a decision that warrants deference under our standard of review—allowing this supplementation would not promote the economic and speedy disposition of the controversy between the parties and would cause undue delay. A reasonable person could take the view that the Hospital's motion to supplement, coming when it did, expanding the litigation to the scale that it would, and including facts Saint Anthony previously knew, should be denied. Therefore, I cannot join my colleagues in their conclusion that the district court abused its discretion in denying that motion.

For these reasons, I respectfully concur in part and dissent in part.

APPENDIX C

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

SAINT ANTHONY HOSPITAL,

Plaintiff,

v.

THERESA A. EAGLESON, in her official capacity as Director of the Illinois Department of Healthcare and Family Services,

Defendant.

No. 20-cv-02561

Steven Charles Seeger, Judge.

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, 321 Ill. Dec. 175, 888 N.E.2d 694. 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

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[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).

about it. *Id*. at ¶ 65.

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 ¶ 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

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[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);

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 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

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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.

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, —— U.S. ——, 140 S. Ct. 735 (2020); *Ziglar v. Abbasi*, —— U.S. ——, 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 Hospital*, 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 at 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*., —– U.S. ——–, 141 S. Ct. 2298, 2306–07 (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,* ––– U.S. ––––, 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

/s/ *Steven Seeger*
Steven C. Seeger
United States District Judge