No. ___

IN THE

Supreme Court of the United States

INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION, MICHAEL A. GARGANO, in his official capacity as Secretary of the Indiana Family and Social Services Administration, and PATRICIA CASANOVA, in her official capacity as Director of Medicaid, Office of Medicaid Policy and Planning,

Petitioners,

v.

SANDRA M. BONTRAGER, ON HER OWN BEHALF AND ON BEHALF OF A CLASS OF THOSE SIMILARLY SITUATED,

Respondents.

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

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

42 U.S.C. § 1396a(a)(10)(A)(i) provides that state Medicaid plans—if they are to remain eligible for full federal reimbursement—must "provide . . . for making medical assistance available . . . to all [eligible] individuals." If a state Medicaid plan does not comport with § 1396a(a)(10)(A)(i), the Secretary of Health and Human Services must decide whether to withhold only part of the state's federal Medicaid reimbursement, or defund the state's Medicaid program in its entirety. *See* 42 U.S.C. § 1396c.

The question presented is:

Does 42 U.S.C. § 1396a(a)(10)(A)(i) create federal "rights" that may be privately enforced under 42 U.S.C. § 1983 by Medicaid beneficiaries?

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PETITION FOR WRIT OF CERTIORARI

The Indiana Family and Social Services Administration; Michael A. Gargano, in his official capacity as Secretary of the Indiana Family and Social Services Administration; and Patricia Casanova, in her official capacity as Director of Medicaid, Office of Medicaid Policy and Planning, respectfully petition the Court to grant a writ of certiorari to the United States Court of Appeals for the Seventh Circuit in this matter.

OPINIONS BELOW

The Opinion of the United States District Court, Northern District of Indiana, is reported as *Bontrager v. Indiana Family & Social Services Administration*, 829 F. Supp. 2d 688 (N.D. Ind. 2011), and is reprinted in the appendix at 18a. The Seventh Circuit's opinion is reported as *Bontrager v. Indiana Family & Social Services Administration*, 697 F.3d 604 (7th Cir. 2012), and is reprinted in the appendix at 1a.

JURISDICTION

The Court of Appeals entered final judgment on September 26, 2012. On Petitioners' Motion, the deadline for filing a Petition for Writ of Certiorari was extended to February 20, 2013. The Court has jurisdiction to review this case under 28 U.S.C. § 1254.

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

42 U.S.C. § 1396

> ***[T]here is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.

For the complete text of this section, *see* Pet. App. 57a.

42 U.S.C. § 1396a(a)(10)

> A State plan for medical assistance must—
>
> **(10)** provide—
> **(A)** for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17), (21), and (28) of section 1396d(a) of this title, to--
> **(i)** all [eligible] individuals

42 U.S.C. § 1396c

> If the Secretary . . . finds—
> (1) that the plan has been so changed that it no longer complies with the provisions of section 1902; ***
>
> the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure) . . . .

For the complete text of this section, *see* Pet. App. 58a.

42 U.S.C. § 1983

> 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. ***

For the complete text of this section, *see* Pet. App. 58a-59a.

STATEMENT

Background

This is a case about whether Indiana's Medicaid program properly reimburses dental providers. The Seventh Circuit concluded it did not, but fundamentally erred in affording the plaintiffs a private right of action to enforce conditions that state Medicaid plans must satisfy to qualify for federal funding.

Medicaid, enacted as Title XIX of the Social Security Act, is a cooperative state and federal joint venture that offers federal reimbursement to states that choose to establish Medicaid programs that comply with federal criteria. Medicaid is not, and constitutionally cannot be, a top-down welfare model where the national government commandeers a state administrative apparatus and instructs the state to provide particular benefits in a particular manner. Instead, the Medicaid Act provides broad discretion for states to design and administer medical assistance plans that qualify for federal reimbursement. A few baseline requirements exist, such as providing coverage to "categorically needy" groups for certain basic services. *See* Barbara S. Klees, Christian J. Wolfe & Catherine A. Curtis, Ctrs. for Medicare & Medicaid Servs., *Brief Summaries of Medicare & Medicaid: Title XVIII and Title XIX of The Social Security Act* 22-26 (Dec. 31, 2012). In virtually all other matters, however, states

can choose the most suitable option; they can, for example, establish eligibility standards, opt to provide coverage for other medical services, define the amount, duration, and scope of services, and determine the payment methodology and payment rate for services. *Id.* at 22-28.

The Medicaid Act comprises 53 sections codified from 42 U.S.C. § 1396 through Section 1396w. In broad outline, the Act authorizes an appropriation and then describes how that appropriation may be spent. In particular, it says that "[t]he sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance." 42 U.S.C. § 1396-1. Importantly, while the Act establishes qualifications for both individuals who wish to receive Medicaid and service providers who wish to be paid by Medicaid, it does this through two principal devices: by establishing the parameters of the "State plans for medical assistance" that qualify for federal reimbursement under 42 U.S.C. § 1396, and by establishing powers and duties of the Secretary of the Department of Health and Human Services.

The operative core of the Act is 42 U.S.C. § 1396a, headed "State Plans for Medical Assistance." It sets forth the main criteria for state plans to qualify for federal reimbursement and also empowers and directs the Secretary to approve or deny state plans and plan amendments of various stripes. In the

main, it requires the Secretary to approve a state plan so long as it (1) fulfills the requirements of Section 1396a(a); and also (2) neither imposes certain prohibited eligibility conditions (enumerated in Section 1396a(b)), nor requires individuals to apply for assistance under a separate state program as a prerequisite to applying for or receiving Medicaid (Section 1396a(c)). Among other things it also restrains the Secretary's authority to limit payments for various reasons (*e.g.,* Sections 1396a(h), (t)), and requires the Secretary to undertake various administrative tasks, such as establishing a system for providing unique identifiers to each physician who furnishes Medicaid services (Section 1396a(x)).

The Act also requires state plans to meet certain criteria with respect to Medicaid providers and recipients. As suggested above, however, these criteria are not cast as stand-alone entitlements or duties, but instead are established as elements of a state plan that qualifies for federal reimbursement. So, for example, the Act provides that "[a] state plan for medical assistance,"—*i.e.* a state program that qualifies for federal payments under Section 1396—must provide medical assistance to "all individuals . . . who are receiving aid or assistance under any plan of the State approved under . . . this chapter." 42 U.S.C. § 1396a(a)(10)(A)(i)(I); *see also* 42 U.S.C. § 1396a(l)(2)(A)(i) (mandating that the state establish a maximum income level "which is a percentage . . . of the income official poverty line . . . applicable to a

family of the size involved"). Under Section 1396a(a)(9)(A), a state plan must ensure that an appropriate state agency will "establish[] and maintain[] health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services[.]" *See also* 42 U.S.C. § 1396a(a)(33)(B) (directing that "the State agency which is responsible for licensing health institutions . . . determin[e] whether institutions and agencies meet the requirements for participation in the program").

The remainder of the Medicaid Act consists largely of variations on this structural theme, *i.e.*, descriptions of what state plans must or may or may not include to qualify for federal payments under various circumstances, coupled with directives to the Secretary to carry out those conditions on payments to states. For example, Section 1396a(q) says that a state plan eligible for federal contribution must provide for a minimum monthly personal needs allowance deduction, Section 1396a(s) requires eligible state plans to adjust payments for hospital services furnished to low-income children under age 6, and Section 1396a(v) defines what standards for disability and blindness a qualifying state plan must use. These are just a few of the many parameters governing the Medicaid program by way of describing conditions states and the Secretary must satisfy if federal reimbursement is to be permitted.

Background of this Lawsuit

While the Medicaid Act requires state plans to cover many services to be eligible for federal matching funds, it does *not* require state plans to cover dental services. 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(10). Nonetheless, Indiana elected to cover certain dental services, *see* 405 Ind. Admin. Code 5-14-1 *et seq.*, but limited that coverage for routine services to $1,000 per year. 405 Ind. Admin. Code 5-14-1(b). The central claim in this case is that this limit contravenes Section 1396a(a)(10)'s provision that a state plan, to qualify for federal matching funds, "provide . . . for making medical assistance available . . . to all [eligible] individuals." 42 U.S.C. § 1396a(a)(10).

1. Sandra Bontrager, a Medicaid recipient, required two endosteal implants and two implant abutments for her mandibular jaw. Pet. App. 21a. The requested services were "'covered services' as defined under 405 IAC 5-2-6 and were 'medically reasonable and necessary services' as defined by 405 IAC 5-2-17." Pet. App. 21a. Indiana's $1,000 cap on Medicaid payments for dental services, however, applies even if the service is medically reasonable and necessary. Thus, Indiana agreed to pay $1,000 toward the total cost of Bontrager's dental care, but no more. On May 5, 2011, Bontrager filed a Verified Class Action Complaint for Mandate to Enforce State and Federal Law and for Declaratory and Injunctive Relief in the Elkhart Superior Court. She

argued that 42 U.S.C. § 1396a(a)(10) and Indiana Code § 12-15-21-3(3) require the State to pay for all medically necessary dental care. Pet. App. 22a. Defendants removed the case to federal court.

Among other things, Defendants argued in the district court that Bontrager had no private right to enforce Section 1396a(a)(10) by virtue of the Medicaid Act itself or through 42 U.S.C. § 1983. To enforce a federal statute under Section 1983, a plaintiff must assert that a defendant has violated a right, not a mere benefit, "unambiguously conferred" by Congress. Section 1396a(a)(10) of the Medicaid Act, however, is part of a larger set of plan requirements that states must meet to be eligible for reimbursement; it affords no individual rights whatever. Indeed, subparagraph 10 is a highly general directive that state plans must "provide . . . for making medical assistance available . . . to all [eligible] individuals." 42 U.S.C. § 1396a(a)(10).

The district court expressed hesitation about whether, indeed, the plaintiffs had a cause of action. The court stated that if not bound by Seventh Circuit precedent, it would have followed the analysis set forth in *Casillas v. Daines*, 580 F. Supp. 2d 235 (S.D.N.Y. 2008), which held "that § 1396a(a)(10)(A) was not sufficiently definitive to be read to have unambiguously conferred a private right of action." Pet. App. 27a-28a. Ultimately, however, the district court concluded it was bound by *Miller ex rel. Miller v. Whitburn*, 10 F.3d 1315, 1319-21 (7th Cir. 1993),

which afforded Medicaid recipients a cause of action to enforce Section 1396a(a)(10) via 42 U.S.C. § 1983. Pet. App. 27a-30a. The district court granted Bontrager's motion for preliminary injunction requiring Defendants "to provide Medicaid payments for coverable dental services that are administratively or judicially determined to be medically necessary and that are routinely provided in a dental office, including such services in excess of $1,000 annually." Pet. App. 56a.

The Seventh Circuit affirmed, also based on *Miller*. The court explained that there was no reason to revisit circuit precedent because this Court had already held in *Wilder v. Virginia Hospital Association*, 496 U.S. 498 (1990), that Medicaid providers may generally sue to enforce the plan provision requirements of the Medicaid Act. Pet. App. 5a-6a. The court recognized that since *Wilder* was decided, *Gonzaga University v. Doe*, 536 U.S. 273 (2002), and *Blessing v. Freestone*, 520 U.S. 329 (1997), had changed the "analytical approach" required in cause of action cases, but further held that it was still bound by *Wilder* since this Court had not expressly overruled that case. Pet. App. 6a (quoting *Bertrand ex rel. Bertrand v. Maram*, 495 F.3d 452, 456 (7th Cir. 2007)).

On the merits, the Seventh Circuit ruled that because some dental services cost more than $1,000, those services would never be completely covered by Indiana's Medicaid plan. Pet. App. 11a. Thus, while

"[t]he purpose of Medicaid dental services is to provide reimbursement for routine dental treatments to medically needy, indigent individuals" some of those services are "completely excluded from coverage" because of the cap. Pet. App. 13a. And "when a service goes completely unprovided, it has obviously not been provided in an amount sufficient to achieve its purpose." Pet. App. 13a (quoting Pet. App. 51a).

REASONS FOR GRANTING THE PETITION

I. The Court Should Take this Case to Address the Important Federal Question of the Extent to Which Medicaid Recipients May Enforce Medicaid Plan Requirements Via Section 1983

It is no secret that the Medicaid Act is "among the most completely impenetrable texts within human experience" and "dense reading of the most tortuous kind[.]" *Rehabilitation Ass'n of Va., Inc. v. Kozlowski,* 42 F.3d 1444, 1450 (4th Cir. 1994). Yet it is abundantly clear that the Medicaid Act itself creates no private right of action for recipients or providers, so any cause of action for private enforcement must come through 42 U.S.C. § 1983. Section 1983 affords no relief for a mere violation of federal *law*, however, only federal *rights*. *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 106 (1989) ("Section 1983 speaks in terms of

'rights, privileges, or immunities,' not violations of federal law.").

Over the past fifteen-plus years, the Court has substantially narrowed private enforcement of conditions on federal Spending Clause legislation. To be enforceable through Section 1983, a federal statute must create an "unambiguously conferred" right that the defendant has allegedly violated. *Gonzaga Univ. v. Doe*, 536 U.S. 273, 283 (2002). In the wake of *Gonzaga*, lower federal courts have struggled to determine when, if ever, Medicaid providers and recipients can enforce the Medicaid Act against states. The Court should take this case (as well as *Planned Parenthood of Indiana, Inc. v. Commissioner of Indiana State Department of Health*, 699 F.3d 962 (7th Cir. 2012), *petition for cert. filed*) to decide the extent to which the Medicaid Act, and in particular the plan requirements it sets forth for federal reimbursement, meet this standard, and indeed to consider overruling *Wilder v. Virginia Hospital Association*, 496 U.S. 498 (1990), if necessary.

A. The Court in *Wilder* did not examine whether the Medicaid Act's plan requirements confer individual rights

1. In *Wilder v. Virginia Hospital Association*, 496 U.S. 498, 524 (1990), the Court held that a now-repealed state plan provision known as the Boren Amendment was enforceable by providers through

Section 1983. *Wilder* continues to provide the template for private enforcement of the Medicaid Act in lower courts, yet the rationale underlying its holding is inconsistent with the Court's more recent decisions narrowing the circumstances where private parties may enforce federal spending criteria. What is more, Congress has now repealed the Boren Amendment and in so doing has expressed the intention of overruling *Wilder*.

The Boren Amendment required participating states' Medicaid programs to reimburse providers at "reasonable and adequate rates." *Wilder*, 496 U.S. at 511. It was enacted in 1981 to counteract the inflationary pressure of centralized national reimbursement rates. *Id.* at 506 (citing Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, 95 Stat. 808 (1981)). The intent was to delegate the responsibility for determining "reimbursement methodologies" to the states, which until then were required to use a particular algorithm to calculate reimbursements as a condition of receiving federal funds. *Id.* Accordingly, the Boren Amendment provided that a state had to pay providers "according to rates that it 'finds, and makes assurances satisfactory to the Secretary,' are 'reasonable and adequate' to meet the costs of 'efficiently and economically operated facilities.'" *Id.* at 507. The Secretary would "review[] only the reasonableness of the assurances provided by a State and not the State's findings themselves." *Id.* at 507-08 (citing 42

C.F.R. § 447.256(2) (1989); 48 Fed. Reg. 56051 (1983)).

To determine whether the Boren Amendment was privately enforceable, the Court chiefly considered whether "the provision in question was intend[ed] to benefit the putative plaintiff." *Id.* at 509. It relied for this test on *Wright v. City of Roanoke Redevelopment & Housing Authority*, 479 U.S. 418 (1987), where the Court held that public housing tenants could sue under Section 1983 to enforce the so-called Brooke Amendment, which precluded federally funded local housing authorities from charging rent that exceeded 30 percent of the tenant's income. *Id.* at 430-32. While the Court's opinion discusses a hesitancy to infer congressional preclusion of a Section 1983 remedy where a federal right has been infringed, the only basis it cited for finding a federal right in the Brooke Amendment was that a statutory "intent to benefit tenants is undeniable." *Id*. at 430.

In accord with this test, the Court observed in *Wilder* that, notwithstanding the counter-inflationary roots of the Boren Amendment, "[t]here can be little doubt that health care providers are the intended beneficiaries of the Boren Amendment." *Wilder*, 496 U.S. at 510. From this premise the Court inferred that (1) a state participating in Medicaid was required to adopt "reasonable and adequate" reimbursement rates; and (2) providers

could sue if they disputed the reasonableness of the rates. *Id.* at 512-15.

Congress, however, repealed the Boren Amendment as part of the Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4711(a), 111 Stat. 251, 507-08 (1997), and in support of doing so the House Committee on the Budget conveyed its intent to undo *Wilder*: "It is the Committee's intention that, following enactment of this Act, neither this nor any other provision of Section 1902 will be interpreted as establishing a cause of action for hospitals and nursing facilities relative to the adequacy of the rates they receive." H.R. Rep. No. 105-149, at 591 (1997).

2. The Court's subsequent decision in *Gonzaga University v. Doe*, 536 U.S. 273 (2002), has further undermined *Wilder*'s supporting rationale. The Court in *Gonzaga* made it clear that in order for a federal statute to be enforceable through Section 1983, it must "unambiguously confer[]" a right. *Id.* at 283. A mere intention to benefit the plaintiff is not enough.

The Court in *Gonzaga* understood that its "unambiguously confer" test created tensions with *Wilder*, and indeed went out of its way to discuss and limit *Wilder*. The Court observed that the Boren Amendment was an exceptional case because it conferred a specific entitlement upon the plaintiff providers. *Id.* at 280. More specifically, the Boren

amendment was exceptional because it "explicitly conferred specific *monetary* entitlements upon the plaintiffs." *Id.* (emphasis added). The Court did not, however, explain why the monetary nature of the benefit accruing to providers transformed a condition of federal funding into an "unambiguous" right. Nor did the Court in *Gonzaga* seem fully convinced of its own attempt to distinguish *Wilder*. "[M]ore recent decisions," the Court observed, "have rejected attempts to infer enforceable rights from Spending Clause statutes." *Id.* at 280-81 (noting only two occasions in which the Supreme Court has found a private right of action related to the spending clause).

Plainly, *Gonzaga* left *Wilder* hanging by a thread.

B. In the wake of *Gonzaga*, the Circuits are in conflict over whether *Wilder* controls Medicaid Act claims

The need for review of the private-right-of-action issue is especially acute because while nine circuits expressly adhere to *Wilder* in Medicaid cases, two (the Tenth and Eleventh) do not, and a third jurisdiction, the D.C. Court of Appeals, has expressly rejected reliance on *Wilder* in view of *Gonzaga*.

Put another way, in nine circuits every private action seeking to enforce the Medicaid Act in effect begins not with the Act itself, but with *Wilder*'s holding that at least *some* provisions of the Act are

privately enforceable through Section 1983. Accordingly, most lower courts in effect do not analyze whether plan requirements may generally be privately enforced consistent with *Gonzaga*, but only whether the particular plan requirement in question can plausibly be construed to benefit individual recipients. Instead of "reading the whole statutory text, [and] considering the purpose and context of the statute" as a whole as the Court more recently has required, *Dolan v. U.S. Postal Service*, 546 U.S. 481, 486 (2006), most lower courts have considered each subsection individually as if a few magic words could convert a spending condition into an individual right. The result is an entire category of federal spending statutes whose private enforcement cannot be reconciled with *Gonzaga*, except in the Tenth and Eleventh Circuits and in the District of Columbia.

1. Notwithstanding the Court's brief attempt in *Gonzaga* to reconcile *Wilder*, lower courts have understood *Gonzaga* to represent a significant doctrinal shift. *See, e.g.*, *Bertrand ex rel. Bertrand v. Maram*, 495 F.3d 452, 456 (7th Cir. 2007) (acknowledging that *Gonzaga* "may have taken a new analytical approach"); *Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 59 (1st Cir. 2004) ("Whether *Gonzaga* is a tidal shift or merely a shift in emphasis, we are obligated to respect it[.]"); *Sabree ex rel. Sabree v. Richman*, 367 F. 3d 180,182 (3d. Cir. 2004) ("The [*Gonzaga*] Court, no doubt, has set a high bar for plaintiffs."); *D.G. ex*

rel. Stricklin v. Henry, 594 F. Supp. 2d 1273, 1276 (N.D. Okla. 2009) ("In [*Gonzaga*], the Supreme Court tightened the first requirement [of the *Blessing* test.]"); *Mendez v. Brown*, 311 F. Supp. 2d 134, 140 (D. Mass. 2004) (recognizing that after *Gonzaga* private cause of action claims must survive "heightened analysis").[1]

Yet in Medicaid cases, nine circuits continue to rely on *Wilder* to justify private enforcement of various Medicaid provisions by way of Section 1983. *See, e.g.*, *Bryson v. Shumway*, 308 F.3d 79, 88-89 (1st Cir. 2002) (citing *Wilder* to establish private enforceability of the Medicaid Act under Section 1983); *Rabin v. Wilson-Coker*, 362 F.3d 190, 202 (2d Cir. 2004) (citing *Wilder* to support private enforcement of Medicaid Act provisions through Section 1983); *Sabree ex rel. Sabree v. Richman*, 367

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[1] *See also* Devi M. Rao, *"Making Medical Assistance Available": Enforcing the Medicaid Act's Availability Provision Through § 1983 Litigation*, 109 Colum. L. Rev. 1440, 1454 (2009) ("*Gonzaga* represents a departure from prior case law addressing the enforceability of federal statutes through § 1983."); Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements*, 42 U.C. Davis L. Rev. 413, 434 (2008) (*Gonzaga* "narrowed, and attempted to clarify" *Blessing* and "expressed deep skepticism regarding private parties enforcing federal conditions on spending against states"); Brian J. Dunne, *Enforcement of the Medicaid Act Under 42 U.S.C. § 1983 After* Gonzaga University v. Doe*: The "Dispassionate Lens" Examined*, 74 U. Chi. L. Rev. 991, 999 (2007) (noting *Gonzaga* "marked [a] departure from the more broad-based inquiry into legislative intent demonstrated in *Wilder* and other Court precedent").

F.3d 180, 192 (3d Cir. 2004) ("[T]he Court has refrained from overruling *Wright* and *Wilder*, which upheld the exercise of individual rights under statutes that contain similar (or, in the case of *Wilder,* identical) provisions to 42 U.S.C. § 1396."); *Doe v. Kidd*, 501 F.3d 348, 356 (4th Cir. 2007) (citing *Wilder* and stating that the "Medicaid Act does not explicitly forbid recourse to § 1983."); *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 605 (5th Cir. 2004) (finding that the "provisions at issue are no more 'vague and amorphous' than other statutory terms that this court, as well as other courts, have found capable of judicial enforcement" such as in *Wilder*); *Westside Mothers v. Haveman*, 289 F.3d 852, 862 (6th Cir. 2002) (citing *Wilder* for the proposition that "in some circumstances a provision of the Medicaid scheme can create a right privately enforceable against state officers through § 1983"); *Bertrand ex rel. Bertrand v. Maram*, 495 F.3d 452, 456-57 (7th Cir. 2007) (observing that *Wilder* "held that one portion of the Medicaid Act may be enforced via § 1983, and that *Gonzaga University* did not overrule *Wilder*") (internal citation omitted); *Pediatric Specialty Care, Inc. v. Arkansas Dep't of Human Servs.*, 443 F.3d 1005, 1015 (8th Cir. 2006) (noting that *Wilder* "has already considered whether (now-repealed) provisions of the Medicaid Act . . . conferred a § 1983 right of action on behalf of health care providers . . . [and a]lthough *Gonzaga* takes a more restrictive view of rights-creating statutes, it did not overrule *Wilder*"); *Watson v. Weeks*, 436 F.3d 1152, 1157-58 (9th Cir. 2006) (invoking *Wilder* to

permit private enforcement of the Medicaid Act through Section 1983).

Two other circuits, the Tenth and Eleventh, reject this approach, however. In *Mandy R. ex rel. Mr. & Mrs. R. v. Owens*, 464 F.3d 1139, 1148 (10th Cir. 2006), the court found no enforceable rights under Section 1396a(a)(30)(A) because "[e]ven though *Wilder* addressed a similar statute, our approach is controlled by *Gonzaga*[.]" Similarly, in *Martes v. Chief Executive Officer of South Broward Hospital District*, 683 F.3d 1323 (11th Cir. 2012), the court did not cite *Wilder* but instead employed *Gonzaga*'s "unambiguously conferred right" test exclusively and held that Section 1396a(a)(25)(C) does not create individual rights because it "is formulated as a requirement of a Medicaid State plan as it relates to third party liability for payment of Medicaid patients' medical expenses." *Id.* at 1328-30. Plainly this method of analyzing whether Section 1396a(a) of the Medicaid Act bestows individual rights cannot be reconciled with the decision below, which gave no account of the plan requirement context when deducing whether an individual right exists under the statute. Pet. App. aa-6a.

Furthermore, the D.C. Court of Appeals has rejected the vitality of *Wilder* in particularly direct terms. In *Jones v. District of Columbia*, 996 A.2d 834, 845 (D.C. 2010), the court found no enforceable rights among several sections of the Medicaid Act and rejected plaintiffs' reliance on *Wilder* because

"the Court's *Gonzaga* decision in 2002 was a game-changer for § 1983 suits." Moreover, said the court, "to the extent that *Wilder* retains any validity, whatever it said 'as a general matter' about the Medicaid Act is not—indeed under *Blessing*, cannot be—particularly instructive as to the enforceability of the specific provisions [in the Medicaid Act]." *Id.* "Finally," said that court, "plaintiffs' reliance on *Wilder* is undermined by the fact that Congress repealed the provision at issue in *Wilder* not long after the Court held that that provision was privately enforceable." *Id.*

In short, while the Court has otherwise reigned in the circumstances where beneficiaries of federal spending may sue to enforce conditions on that spending, nine circuits continue to rely on the old permissive doctrine represented by *Wilder* when it comes to Medicaid. And they do this despite the fact that Congress expressly repealed the Boren Amendment and a House Committee suggested a desire to overturn *Wilder*. The extent to which the Medicaid Act may properly be enforced through Section 1983 in the wake of *Gonzaga* is a nationally important question, particularly in view of the circuit conflict that has developed. The Court should therefore grant certiorari to review this question.

2. What is more, lower federal courts have split with respect to whether some individual plan-requirement sections are privately enforceable. For starters, as discussed more below, *see infra* Part III,

Casillas v. Daines, 580 F. Supp. 2d 235, 243 (S.D.N.Y. 2008), ruled that Section 1396a(a)(10) does *not* provide a private right of action, in conflict with the Seventh Circuit's decision below. Similarly, with regard to Section 1396a(a)(23), at issue in the companion case to this one, *Planned Parenthood of Indiana, Inc. v. Comm'r of Indiana State Dep't of Health*, 699 F.3d 962, 974 (7th Cir. 2012), *petition for writ of certiorari filed*, the Seventh Circuit ruled that this provider choice requirement "unambiguously gives Medicaid-eligible patients an individual right" enforceable through 42 U.S.C. § 1983. In *M.A.C. v. Betit*, 284 F. Supp. 2d 1298, 1307 (D. Utah 2003), however, the court held that it did "not contain the unambiguous rights-creating language of *Gonzaga,* and consequently, there is no private right of action" to enforce Section 1396a(a)(23).

Other sections of the Medicaid Act that have generated disagreement include at least the following:

Section 1396a(a)(1): *Compare Sobky v. Smoley*, 855 F. Supp. 1123, 1133-34 (E.D. Cal. 1994) (privately enforceable), *with Boatman v. Hammons*, 164 F.3d 286, 290-92 (6th Cir. 1998) (not privately enforceable);

Section 1396a(a)(17): *Compare Mendez v. Brown*, 311 F. Supp. 2d 134, 137-40 (D. Mass. 2004) (privately enforceable), *with Watson v. Weeks*, 436

F.3d 1152, 1162-63 (9th Cir. 2006) (not privately enforceable);

Section 1396a(a)(25): *Compare Mallo v. Pub. Health Trust of Dade County, Florida*, 88 F. Supp. 2d 1376, 1379-91 (S.D. Fla. 2000) (privately enforceable), *with Martes v. Chief Executive Officer of S. Broward Hosp. Dist.*, 683 F.3d 1323, 1325-30 (11th Cir. 2012) (not privately enforceable);

Section 1396a(a)(30): *Compare Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Servs.*, 443 F.3d 1005, 1015-16 (8th Cir. 2006) (privately enforceable), *with Sanchez ex rel. Hoebel v. Johnson*, 416 F.3d 1051, 1062 (9th Cir. 2005) (not privately enforceable).

In all, the plan requirements enumerated in Section 1396a(a) comprise 83 subparts, 32 of which lower courts have addressed for purposes of deducing individual rights. A table in the appendix to this Petition lists each of these plan requirement sections and cites at least one case, if any could be found, that permit or refuse enforcement via Section 1983. Pet. App. 60a. A separate table similarly cites other provisions of the Medicaid Act whose private enforceability has been the subject of litigation. Pet. App. 69a. It is clear from these tables that, notwithstanding *Gonzaga*, widespread (but not universal) reliance on *Wilder* has led to a patchwork of lower court decisions permitting private enforcement of some Medicaid plan requirements

but not others. The Court needs to address the extent to which Medicaid plan requirements are enforceable through Section 1983.

3. The Court has otherwise been interested recently in the implications of *Gonzaga* for private enforcement of Medicaid. Last term, in *Douglas v. Independent Living Center of Southern California, Inc.*, 132 S. Ct. 1204, 1212 (2012), the Court issued a writ of certiorari to consider whether 42 U.S.C. § 1396a(a)(30)(A) can be enforced via the Supremacy Clause where it was *undisputed* "that there is no statutory private right of action to enforce 42 U.S.C. § 1396a(a)(30)(A), either under 42 U.S.C. § 1983 or directly under the Medicaid Act." Brief for the United States as Amicus Curiae Supporting Petitioner at 9, *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 132 S. Ct. 1204 (2012) (Nos. 09-958, 09-1158, 10-283), 2011 WL 2132705 at *9.

The Court, however, never reached the issue whether the Supremacy Clause affords a private right of action to enforce Medicaid plan requirements. Instead, the Court voted 5-4 to remand after a decision from CMS changed the posture of the case. Chief Justice Roberts dissented from the remand, and would have decided the case because the Court's precedents had "emphasized that 'where 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, whether under § 1983 or under an implied right

of action.'" *Douglas*, 132 S. Ct. at 1213 (Roberts, C.J., dissenting) (quoting *Gonzaga*, 536 U.S. at 286). The Chief Justice said that when "the law established by Congress is that there is no remedy available to private parties to enforce the federal rules against the State[,]" but courts grant an equitable right to enforce the statute anyway, it "raise[s] the most serious concerns regarding both the separation of powers (Congress, not the Judiciary, decides whether there is a private right of action to enforce a federal statute) and federalism (the States under the Spending Clause agree only to conditions clearly specified by Congress, not any implied on an ad hoc basis by the courts)." *Id.* (Roberts, C.J., dissenting).

In terms of enabling orderly development of the law, it may have been fortuitous that the Court remanded *Douglas* without deciding whether the Supremacy Clause affords a last-ditch mechanism for private enforcement of Medicaid plan requirements. The logically antecedent question is whether, and to what extent, those plan requirements may be enforced through Section 1983. The Court has not addressed that question apart from *Wilder*, which *Gonzaga* was careful to limit to its facts. In the wake of *Gonzaga*, the Court would be well advised to revisit the private enforceability of Medicaid plan requirements via Section 1983 more generally before taking another case presenting the Supremacy Clause enforcement issue. Both this case and its companion, *Planned Parenthood of*

Indiana, Inc. v. Comm'r of Indiana State Dep't of Health, 699 F.3d 962 (7th Cir. 2012), *petition for writ of certiorari filed*, provide the Court with suitable opportunities to do just that.

II. The Medicaid Act's Plan Requirements Do Not Confer Individual Rights

The Medicaid Act was not written to confer private rights on individuals. Instead, the Act created a voluntary program enabling states to seek federal matching funds for qualifying state healthcare benefits programs. *See Harris v. McRae*, 448 U.S. 297, 308 (1980). Congress enacted Medicaid pursuant to its spending power and, as such, it does not directly impose any duties or restraints on state or local governments. *See South Dakota v. Dole*, 483 U.S. 203, 211-12 (1987); *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981). Indiana is free to opt out of eligibility for federal Medicaid funds and is in no way obligated to structure its Medicaid program in accordance with the conditions required for federal funding. Furthermore, when a state is participating in Medicaid, it remains free to amend its program, even if that means the United States will deny federal funding as a consequence. *See* 42 U.S.C. § 1396c; 42 C.F.R. § 430.12(c).

By its own terms, the Medicaid Act imposes a legal obligation on *only* one individual—the United States Secretary of Health and Human Services.

The Secretary is obligated to ensure that states substantially comply with plan requirements before approving federal matching funds. *See* 42 U.S.C. § 1396c. If the Secretary finds that a state plan "has been so changed that it no longer complies with the provisions of section 1396a" or that "in the administration of the plan there is a failure to comply substantially with any such provision[,]" then the Secretary "shall notify [the] State . . . that further payments will not be made to the State[.]" *Id.* Payments will then be discontinued "until the Secretary is satisfied that there will no longer be any such failure to comply." *Id.* Or, rather than cutting off payments completely, the Secretary may, in her discretion, "limit payments to categories under or parts of the State plan not affected by [the] failure [to comply]." *Id.* If a state chooses not to meet the conditions of Section 1396a—which is its prerogative—42 U.S.C. § 1396c explicitly dictates the appropriate remedy: rejection or discontinuation of some portion of federal funding. *See* 42 U.S.C. § 1396c.

All of this underscores what the Court has been saying for over thirty years. As explained in *Pennhurst*, this virtual dearth of enforceable individual rights linked to Spending Clause legislation is due to the fact that "[i]n 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." *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 28 (1981). The Court explained that "[t]he legitimacy of Congress' power to legislate under the spending power [] rests on whether the State voluntarily and knowingly accepts the terms of the 'contract.'" *Id.* at 17; *see also Ind. Prot. & Advocacy Servs. v. Ind. Family & Soc. Servs. Admin.*, 603 F.3d 365, 389 (7th Cir. 2010) (Easterbrook, C.J., dissenting) ("What a state anticipates when it accepts a federal grant is that enforcement rests in the hands of the grantor, which can either turn off the spigot or sue in its own name[.]").

The Medicaid plan requirements serve only as partial instructions to states choosing to participate in Medicaid *and* to the Secretary, who is charged with administering it. Further, the statute does not place the state under any mandatory obligation. Indeed, the contrary is true—its participation is optional. Indiana's participation in Medicaid and the creation of a state plan that conforms with 42 U.S.C. § 1396a(a)(10) is completely voluntary, as is its continued participation. The only catch is that failure to comply with the requirements of this voluntary program may result in the loss of federal funds.

A financial incentive to comply with a voluntary federal program does not create a mandatory federal obligation. In *South Dakota v. Dole*, 483 U.S. 203, 211-12 (1987), for example, the Court held that

authorizing expenditure of a percentage of federal highway monies only to states that maintain their drinking ages at twenty-one has no effect on the authority of a state to set a lower drinking age; a state merely risks the loss of federal highway funds for noncompliance. The authority to create or maintain a state plan and participate in Medicaid likewise remains fully within the province of states, even after they choose to participate in Medicaid. *See id*. Indiana has the unfettered right to fully or partially withdraw from the program described in 42 U.S.C. § 1396a(a)(10)—it just risks losing federal funding that Congress has conditioned on compliance if it chooses to do so. The transformation of Medicaid from a voluntary program into a mandatory one for purposes of Section 1983 lawsuits runs afoul of principles that underlie the program and all legislation enacted pursuant to Congress's spending power. As 42 U.S.C. § 1396a(a)(10) creates no unambiguous rights and indeed places no mandatory conditions upon states, no private right of action exists.

III. Section 1396a(a)(10) Is Particularly Unsuited to Private Enforcement

The vague and amorphous funding conditions provided by Section 1396a(a)(10) underscore why courts should not infer private enforcement rights for Medicaid plan provision requirements. Section 1396a(a)(10) does not deal with "the needs of any particular person," but with "the aggregate services

provided by the State." *Blessing v. Freestone,* 520 U.S. 329, 343 (1997); *see also Gonzaga Univ. v. Doe*, 536 U.S. 273, 281 (2002).

Section 1396a(a)(10) says that a state plan for medical assistance must "provide . . . for making medical assistance available . . . to all [eligible] individuals." 42 U.S.C. § 1396a(a)(10). Such text is as general as it gets. It cannot pass the *Blessing* test explaining that conditions on federal spending are privately enforceable only if the right allegedly protected is not so "vague and amorphous" that its enforcement strains judicial competence. *Blessing*, 520 U.S. at 340-41.

As noted by the Southern District of New York, Section 1396a(a)(10) "does not unambiguously confer the right that this plaintiff asserts. Alternatively, enforcement of the right would require the application of vague and amorphous standards and, therefore, would strain judicial competence." *Casillas v. Daines*, 580 F. Supp. 2d 235, 243 (S.D.N.Y. 2008). And in no way does it create specific rights to the dental procedures that Bontrager has requested.

To find greater specificity that would lend itself to enforcement, the Seventh Circuit cited federal regulations, and in particular 42 C.F.R. § 440.230, which says that, in light of Section 1396a(a)(10), a state's Medicaid plan must "specify the amount, duration, and scope of each service that it

provides[.]" 42 C.F.R. § 440.230(a); Pet. App. 8a. Also, "[e]ach service must be sufficient in amount, duration, and scope to reasonably achieve its purpose." 42 C.F.R. § 440.230(b); Pet. App. 9a. However, the state "may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures." 42 C.F.R. § 440.230(d); Pet. App. 9a.

The regulations—which cannot separately confer an enforceable individual right in any event—provide no real guidance as to the Executive Branch's interpretation of what Section 1396a(a)(10) actually requires. The regulations suggest that because "there are a limited number of hospital beds and a limited number of physicians and nurses within a state[,]" a state may control "the use of these resources[.]" *Casillas*, 580 F. Supp. 2d at 243. However, "the phrase ["utilization control procedures] is susceptible to multiple plausible interpretations and lacks a fixed meaning." *Id.* As noted by the district court in grappling with the "multiple plausible interpretations" of "utilization control procedures," such an interpretive struggle itself "is compelling evidence that 'the right assertedly protected by' section 1396a(a)(10)(A) is 'so vague and amorphous that its enforcement . . . strain[s] judicial competence.'" Pet. App. 30a (quoting *Blessing,* 520 U.S. at 340-41).

Accordingly, the Seventh Circuit has erred in concluding that Section 1396a(a)(10) confers an

individual right enforceable through Section 1983. The Court should take this case first to consider overruling *Wilder*, but even short of that to elucidate the proper standard for deducing individual rights from Medicaid plan requirements.

CONCLUSION

The petition should be granted.

Respectfully submitted,

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