No. 12-1037

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

RESPONDENTS' BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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COUNTERSTATEMENT OF THE QUESTION PRESENTED

Indiana has elected to provide dental services to qualifying Medicaid participants. The Petitioners ("Indiana") concede that pursuant to Indiana and federal law this creates the obligation to provide reimbursement for medically necessary dental treatment. However, Indiana has imposed an annual cap of $1,000 for dental services covered by Medicaid that results in the refusal of Indiana to provide certain medically necessary dental services. Indiana has filed a petition for certiorari seeking review of a preliminary injunction granted by the District Court that was based on both state and federal law and that was affirmed by the Seventh Circuit. The question presented is whether the Court of Appeals correctly held, consistent with five other circuits, that the federal statute at issue in this case, 42 U.S.C. § 1396a(a)(10), which guarantees that medical assistance will be provided to eligible Medicaid participants, is enforceable through a private action brought pursuant to 42 U.S.C. § 1983?

PARTIES TO THE PROCEEDING

The following individuals and entities were parties to the proceedings in the courts below.

Petitioners: Indiana Family and Social Services Administration; the Secretary of the Indiana Family and Social Services Administration sued in her official capacity, formerly Michael A. Gargano and currently Debra Binott; the Director of the Office of Medicaid Policy and Planning, sued in her official capacity, formerly and currently Patricia A. Casanova.

Respondents: Sandra Bontrager, on her own behalf and on behalf of a certified class of those similarly situated, defined as:

> All past, current and future Indiana Medicaid enrollees age twenty-one and older, who from January 1, 2011 (when the $1,000 cap took effect) forward, need, have needed, or will need coverable dental services that are administratively or judicially determined to be medically necessary, that are routinely provided in a dental office, and that cost more than $1,000 per twelve month period.

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STATEMENT OF THE CASE

"Medicaid is a cooperative federal-state program that provides federal funding for state medical services to the poor. . . . State participation is voluntary; but once a State elects to join the program, it must administer a state plan that meets federal requirements." *Frew ex rel. Frew v. Hawkins*, 540 U.S. 431, 433 (2004) (citing *Wilder v. Virginia Hospital Assn.*, 496 U.S. 498 (1990)). If a state chooses to participate in the Medicaid program it must, in its state plan, "provide . . . for making medical assistance available . . . to all individuals" meeting eligibility standards. 42 U.S.C. § 1396a(a)(10). The statute requires that participating states provide certain mandatory services such as hospital and physician services and it further provides that states may elect to provide dental services. *Id.*; 42 U.S.C. § 1396d(a)(1). Indiana participates in the Medicaid program and has elected to cover a wide range of dental services. 405 IAC 5-14-7.

Indiana law provides that rules concerning Medicaid reimbursement must be "consistent with medical necessity concerning the amount, scope, and duration of the services and supplies to be provided." Ind. Code § 12-15-21-3(3). *See also* 405 IAC 5-2-17. Indiana cases definitively hold that this statute "establishes a precept: medically necessary treatment must be covered." *Thie v. Davis*, 688 N.E.2d 182, 186 (Ind. Ct. App. 1997), *trans. denied. See also Davis v. Schrader*, 687 N.E.2d 370, 372 (Ind. App. 1997) ("Here, we again hold that the State must cover medically necessary

treatments in service areas in which the State opts to provide coverage."); *Coleman v. Indiana Family and Social Services Administration*, 687 N.E.2d 366, 368 (Ind. Ct. App. 1997) ("[O]nce the State chooses to provide coverage within an optional category, the State must cover medically necessary treatments within that category.").

Federal law is also clear that states must in the operation of their Medicaid programs provide coverage for medically necessary services in the areas covered by their programs. *See, e.g.*, *Moore ex rel. Moore v. Reese*, 637 F.3d 1220, 1255 (11th Cir. 2011) (nursing services must be provided when they are medically necessary); *Lankford v. Sherman*, 451 F.3d 496, 511 (8th Cir. 2006) ("While a state has discretion to determine the optional services in its Medicaid plan, a state's failure to provide Medicaid coverage for non-experimental, medically-necessary services within a covered Medicaid category is both per se unreasonable and inconsistent with the stated goals of Medicaid."); *Hope Medical Group for Women v. Edwards,* 63 F.3d 418, 427 (5th Cir. 1995) (ban on Medicaid abortions in cases of rape or incest where the abortion is medically necessary is improper); *Hern v. Beye*, 57 F.3d 906, 910-11 (10th Cir. 1995) (the state's restriction on funding "is inconsistent with the basic objective of Title XIX – to provide qualified individuals with medically necessary care."); *Dexter v. Kirschner*, 984 F.2d 979, 983 (9th Cir. 1992) (Medicaid must pay for "medically necessary inpatient hospital

and physician's services for eligible persons.") (emphasis omitted).

Therefore, as the Court of Appeals noted in its decision, "[n]either party disputes that the State is required to provide Medicaid coverage for medically necessary treatments in those service areas that the State opts to provide such coverage (such as dental services)." (App. 8a). However, despite this mandate of medical necessity, Indiana, in the interest of cost-cutting, imposes a $1,000 limit on dental services provided to persons over the age of 21, when the services are those routinely provided in dental offices. 405 IAC 5-14-1(b).

This policy acts as a bar to the provision of a number of medically necessary dental services that cost more than $1,000, all by themselves, let alone in combination with other medically necessary dental services. For example, the cost figures provided by the State for such potentially medically-necessary procedures as a "mandible-closed reduction" procedure or a "mandible-open reduction" procedure exceed $1,000 by themselves. (App. 11a). The $1,000 restriction also means, for example, that while a recipient may receive an upper or lower denture, she cannot receive a complete set of dentures in the same calendar year. Given the inability of an indigent Medicaid recipient to contribute to her health costs, the refusal of Indiana to pay the total cost of a medically necessary dental procedure means that the recipient "will have to go without the procedure." (*Id.*).

Ms. "Bontrager is an Indiana Medicaid recipient in need of significant dental services, including two endosteal implants and two implement abutments for her lower jaw." (*Id.* 3a). It is conceded that these dental services are medically necessary. (*Id.* 3a, 21a). However, given that they exceeded $1,000 in cost, Indiana refused to pay for the services. (*Id.* 3a).

The district court entered a preliminary injunction on behalf of Ms. Bontrager and the class she represents. The court stressed that even if Indiana's action imposing a limit on medically necessary procedures was permissible under federal law, it was not under Indiana law. (*Id.* 42a). However, the district court found that Ms. Bontrager could enforce, through 42 U.S.C. § 1983, the provision of the Medicaid Act mandating that participating states make medical assistance available to all qualified individuals, 42 U.S.C. § 1396a(a)(10), and that Ms. Bontrager was likely to prevail in her claim that Indiana's refusal to pay for medically necessary dental coverage violated this federal law as well as state law. (*Id.* 30a, 54a).

The Seventh Circuit affirmed, finding, consistent with every appellate case to have considered the issue, that 42 U.S.C. § 1396a(a)(10) is enforceable by Medicaid recipients and that Ms. Bontrager is likely to prevail. (*Id.* 15a). The Court of Appeals specifically noted that Ms. Bontrager claimed a "violat[ion of] state and federal Medicaid." (*Id.* 3a).

REASONS FOR DENYING THE WRIT

The petitioners have failed to demonstrate any reason for this Court to grant plenary review. Regardless of any violation of federal law, the refusal of Indiana to provide Medicaid reimbursement for medically necessary dental services violates Indiana law, therefore making this interlocutory appeal an inappropriate vehicle for plenary review. Indiana's contention that state plan requirements under the Medicaid Act can *never* be enforced by Medicaid beneficiaries has not been adopted by any court of appeals, and is directly at odds with a provision of the Social Security Act (that Indiana never cites) expressly acknowledging the permissibility of such actions in appropriate circumstances. Far from there being a circuit split on the question of whether 42 U.S.C. § 1396a(a)(10) is enforceable through 42 U.S.C. § 1983, the Seventh Circuit decision conforms to holdings from five other circuits. Lacking a circuit conflict on the actual question presented, Indiana argues more generally that there is confusion in the lower courts about the proper legal standard to apply in determining whether to permit specific provisions of the Medicaid Act to be enforced through § 1983. The decision below, however, demonstrates no such confusion. It is a straightforward application of this Court's controlling case law – *Blessing v. Freestone*, 520 U.S. 329 (1997), and *Gonzaga University v. Doe*, 536 U.S. 273 (2002) – and thus a poor vehicle for considering whatever confusion may exist (and there is none) regarding the

enforceability through § 1983 of other provisions of the Medicaid Act.

I. PLENARY REVIEW SHOULD BE DENIED AS INDIANA'S REFUSAL TO PAY FOR NECESSARY MEDICAL CARE VIOLATES INDIANA LAW REGARDLESS OF ANY VIOLATION OF FEDERAL LAW

Regardless of any federal law issue in this case, the denial by Indiana of concededly medically necessary dental services violates Indiana law. Ind. Code § 12-15-21-3(3); *Thie v. Davis*, 688 N.E.2d 182, 186 (Ind. Ct. App. 1997), *trans. denied*; *Davis v. Schrader*, 687 N.E.2d 370, 372 (Ind. Ct. App. 1997); *Coleman v. Indiana Family and Social Services Administration*, 687 N.E.2d 366, 368 (Ind. Ct. App. 1997).[1] The district court so found and the court of appeals affirmed the district court's decision. This Court has not been asked by Indiana to review the lower courts' determinations as to Indiana law, nor would this Court normally do so as it "ordinarily accept[s] the determination of local law by the Court of Appeals." *Ragan v. Merchants Transfer & Warehouse Co.*, 337 U.S. 530, 534 (1949) (citing *Huddleston v. Dwyer*, 322 U.S. 232, 237 (1944)). However, the fact that an independent state law ground exists for affirmance means that even if the holding with respect to the federal claim

[1] This action was originally filed in Indiana state court and was removed to federal court by Indiana.

were reversed the preliminary injunction would stand. This demonstrates that this interlocutory appeal is a particularly poor candidate for plenary review. Plenary review should not be granted to give what is essentially an advisory opinion. *Cf. Herb v. Pitcairn*, 324 U.S. 117, 126 (1945) ("We are not permitted to render an advisory opinion, and if the same judgment would be rendered by the state court after we corrected its views of federal laws, our review could amount to nothing more than an advisory opinion.").

II. INDIANA'S CLAIM THAT STATE PLAN REQUIREMENTS UNDER THE MEDICAID ACT CAN *NEVER* CREATE PRIVATELY ENFORCEABLE RIGHTS IGNORES THE PLAIN AND CONTRARY LANGUAGE OF THE SOCIAL SECURITY ACT

Indiana's threshold position is that the courts below erred in considering whether 42 U.S.C. § 1396a(a)(10), which requires that assistance be provided to qualified individuals, creates privately enforceable rights because, in Indiana's view, a state plan requirement imposed as a condition of the Medicaid Act can *never* create privately enforceable rights. That categorical position has never been adopted by any court of appeals, is directly contrary to the plain language of Congress, and was correctly rejected by the courts below.

Specifically, 42 U.S.C. § 1320a-2 provides that "[i]n an action brought to enforce a provision of this

chapter [of the Social Security Act], such provision is not to be deemed unenforceable because of its inclusion in a section of this chapter requiring a State plan or specifying the required contents of a State plan." This provision, which was adopted as part of the Social Security Act after this Court's decision in *Suter v. Artist M.*, 503 U.S. 347 (1992), was enacted precisely to foreclose the argument being made by Indiana – that no provision of the Social Security Act can ever be enforced through § 1983. Indiana's position that the Medicaid Act does not authorize private actions under any circumstances cannot be reconciled with this clear statutory command. Perhaps recognizing as much, Indiana's petition fails even to mention § 1320a-2.[2]

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[2] Without mentioning them, Indiana's argument would reverse numerous decisions of this Court, both before and after *Gonzaga*, which allowed beneficiaries of programs under the Social Security Act to bring actions claiming violations of particular provisions of the Act. *See Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268, 280-85 (2006) (Medicaid recipient allowed to bring suit that resulted in a decision that Arkansas violated Medicaid state plan requirements); *Shea v. Vialpando*, 416 U.S. 251, 256-57, 265 (1974) (recipients of Aid to Families with Dependent Children ["AFDC"] demonstrated that Colorado regulation violated provision of Social Security Act); *Rosado v. Wyman*, 397 U.S. 397, 401 (1970) (concluding, in litigation by AFDC recipients, that New York statute violated a portion of the Social Security Act); *King v. Smith*, 392 U.S. 309, 311-16 (1968) (affirming, in litigation by AFDC beneficiaries, that Alabama regulation violated a provision of the Social Security Act). While most of these cases were decided long before this Court established the modern parameters for determining congressional intent to allow the private enforcement of

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III. THERE IS NO CIRCUIT CONFLICT REGARDING THE ENFORCEABILITY OF § 1396a(a)(10), NOR IS THERE LOWER COURT CONFUSION REGARDING THE APPLICABLE LEGAL STANDARDS

A. There is no Circuit Split and the Seventh Circuit's Decision is Consistent with that of Five Other Circuits

Indiana in its petition does not tarry on what is the salient point – every circuit court both before and after *Blessing* and *Gonzaga* that has considered whether or not § 1396(a)(10) creates rights that Medicaid recipients may privately enforce has indicated that the statute does create such rights. *See Watson v. Weeks*, 436 F.3d 1152, 1159-62 (9th Cir. 2006); *S.D. ex rel. Dickson v. Hood,* 391 F.3d 581, 602-07 (5th Cir. 2004); *Sabree ex rel. Sabree v. Dickson*, 367 F.3d 180, 189-93 (3d Cir. 2004); *Westside Mothers v. Haveman*, 289 F.3d 852, 862-63 (6th Cir. 2002); *Rehabilitation Assn. of Va., Inc. v. Kozlowski*, 42 F.3d 1444, 1449-50 (4th Cir. 1994).[3] No circuit court or state court of last resort has held to the contrary.

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rights, they represent the clear recognition that merely because a requirement is imposed on a state as part of a Social Security state plan requirement does not mean that it is automatically unenforceable.

[3] It is true, as noted by Indiana, that a district court has reached a contrary conclusion. *See Casillas v. Daines*, 580 F. Supp. 2d 235 (S.D.N.Y. 2008). The district court does not explain why it reached a different conclusion than the circuit cases noted above. *Casillas* appears to be an outlier even among district courts that

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B. The Decision Below Does not Reflect any Doctrinal Confusion

Lacking a circuit conflict, Indiana suggests that this Court should grant certiorari to resolve ostensible confusion in the lower courts about the proper standard to apply in determining whether Medicaid rights can be privately enforced. More particularly, Indiana contends that the lower courts have struggled to understand whether and to what extent this Court's decision in *Wilder v. Virginia Hospital Ass'n*, 496 U.S. 498 (1990), remains good law in light of *Gonzaga* and *Blessing*. As evidence of that confusion, Indiana implies that the Seventh Circuit erred in over-relying on *Wilder*.

In answering the question of whether § 1396a(a)(10) creates rights enforceable though § 1983, the Seventh Circuit did not deviate in any way from *Blessing* and *Gonzaga*. The court noted that it had previously held that the section created enforceable rights in *Miller ex rel. Miller v. Whitburn*, 10 F.3d 1315 (7th Cir. 1993), but that *Miller* preceded *Blessing* and *Gonzaga* and accordingly had been analyzed under the standards set forth in *Wilder*. (App. 5a). The court

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have otherwise mostly held that § 1396a(a)(10) creates enforceable rights. *See, e.g.*, *D.W. v. Walker*, 2009 WL 1393818, *6 (S.D. W.Va. May 15, 2009); *Michelle P. ex rel. Deisenroth v. Holsinger*, 356 F. Supp. 2d 763, 766-67 (E.D. Ky. 2005). Indeed, in *Dajour B. v. City of New York*, 2001 WL 830674, *8-*10 (S.D.N.Y. July 23, 2001), the court found the section to create enforceable rights in the context of the Early and Periodic Screening, Diagnostic and Treatment Program.

acknowledged that *Blessing* demands that the focus be on whether the plaintiff has asserted the violation of a right, not merely a law. (*Id.* 4a [citing *Blessing*, 520 U.S. at 340]). The court further acknowledged that *Gonzaga* "'may have taken a new analytical approach'" to the question of whether an enforceable right is created, while noting that *Wilder* had not been overruled by this Court. (*Id.* 6a [quoting *Bertrand ex rel. Bertrand v. Maram*, 495 F.3d 452, 456 (7th Cir. 2007)]). Accordingly, the court looked to other circuit court cases decided *after Blessing* and *Gonzaga*, each of which had found that § 1396a(a)(10) creates enforceable federal rights by following the analysis of *Blessing* and *Gonzaga*. (*Id.* [citing *Watson v. Weeks*, *supra*; *Sabree ex rel. Sabree v. Richman*, *supra*; *S.D. ex rel. Dickson v. Hood*, *supra*]).[4] The court found the

[4] In *Watson*, the court stated that *Blessing* establishes the current three-part test for determining whether a statutory section is enforceable through § 1983 and the court further noted that the first prong of the test was clarified in *Gonzaga*. 436 F.3d at 1157-62. *Wilder* is cited as part of the historical antecedent to the *Blessing* test and to support the conclusion that the availability of state administrative remedies does not foreclose a § 1983 remedy. *Id.* at 1157, 1162. In *Sabree* the court specified that *Blessing* and *Gonzaga* must be satisfied to determine if enforceable rights were created. 367 F.3d at 189, 192. The court correctly noted, as did the Seventh Circuit, that *Gonzaga* did not overrule *Wilder* and that *Wilder* found that a statute that was similar or identical to those found in Sections 1396a(a)(8) and (10), and 1396d(a)(15), created enforceable rights. *Id.* at 192. In *S.D.* the court applied the *Blessing* analysis while noting the need, as stressed in *Gonzaga*, for the statute to contain rights-creating language. 391 F.3d at 602-05. *Wilder* is cited to support

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reasoning of these courts, applying *Gonzaga* and *Blessing*, not *Wilder*, to be "persuasive." (*Id.* 6a.) The Seventh Circuit's decision therefore does not deviate from the standard set by *Blessing* and *Gonzaga* and committed no error as to the significance of *Wilder*.

To the extent that there may be confusion about how these standards apply to other provisions of the Medicaid Act, this is not the case to resolve it. This case involves only one particular provision in that lengthy Act, the provisions of which vary widely. As this Court cautioned in *Blessing*, 520 U.S. at 340, each statutory section must be analyzed independently. In any event, Indiana's claim of doctrinal confusion is significantly overstated. The cases cited by Indiana in its Petition in an attempt to demonstrate this confusion (Pet. 18-20) actually demonstrate the opposite. Each case cited by Indiana that actually determines whether a right is created is explicit that it is utilizing *Blessing* and/or *Gonzaga*, not *Wilder*, to determine whether an enforceable right is present.[5]

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the argument that the statutory language was not too vague or amorphous for judicial enforcement. *Id.* at 605.

[5] *See Bryson v. Shumway,* 308 F.3d 79, 88 (1st Cir. 2002) (citing *Wilder* to support the point that some Medicaid Act provisions support a § 1983 claim, but noting that not all do and the test of *Blessing* must be satisfied); *Rabin v. Wilson-Coker*, 362 F.3d 190, 202 (2d Cir. 2004) (analyzing provision under *Gonzaga* and post-*Gonzaga* precedent); *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 189, 192 (3d Cir. 2004) (noting that *Blessing* and *Gonzaga* must be satisfied in determining whether the statute created enforceable rights); *Doe v. Kidd*, 501 F.3d 348, 355-56

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Then, Indiana characterizes two circuit cases as rejecting the approach of these other circuits and in some way creating a conflict. (Pet. 20). Yet, these cases do nothing different – they also hold that *Blessing* and *Gonzaga* establish the prevailing test.[6] The

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(4th Cir. 2007) (citing the *Blessing* factors and the point, articulated in *Gonzaga*, that only rights can be enforced through § 1983, and citing *Wilder* for the proposition that Medicaid Act provisions are not necessarily precluded from enforcement through § 1983); *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 602-05 (5th Cir. 2004) (applying the *Blessing* test and noting the need, as stressed in *Gonzaga*, that the statute contain rights creating language); *Westside Mothers v Haveman*, 289 F.3d 852, 862 (6th Cir. 2002) (applying the *Blessing* test after citing *Wilder* for the point that the Supreme Court has held that in some circumstances a provision of Medicaid is enforceable through § 1983); *Bertrand ex rel. Bertrand v. Maram*, 495 F.3d 452, 456-57 (7th Cir. 2007) (assuming a private right of action, without deciding issue, in order to deny plaintiffs' claim on the merits); *Pediatric Specialty Care, Inc. v. Arkansas Dep't of Human Servs.*, 443 F.3d 1005, 1014-15 (8th Cir. 2006), *cert. granted and vacated in part and remanded with instructions to dismiss claims as moot*, 551 U.S. 1142 (2007) (in the portion of the case subsequently vacated by this Court on other grounds, analyzing claim under *Gonzaga*, and citing *Wilder* merely for the "proposition" – unanimously supported by the circuits – "that the Medicaid Act may create enforceable rights"); *Watson v. Weeks*, 436 F.3d 1152, 1157-62 (9th Cir. 2006) (analyzing claim under *Blessing* and *Gonzaga*, and citing *Wilder* merely as support for its conclusion that the availability of state administrative remedies does not foreclose a § 1983 claim).

[6] *See Mandy R. ex rel. Mr. & Mrs. R. v. Owens*, 464 F.3d 1139, 1146-47 (10th Cir. 2006) (noting that, while *Gonzaga* tightened the test for finding an enforceable right, it did not overrule *Wilder*); *Martes v. Chief Executive Officer of South Broward Hosp. Dist.*, 683 F.3d 1323, 1326 (11th Cir. 2012) (without mention of *Wilder*, analyzing provision under *Blessing* and *Gonzaga*,

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circuits are thus united in their understanding of the appropriate standard to apply in deciding whether specific provisions of the Medicaid Act can be privately enforced.

Applying the test set forth in *Blessing* and *Gonzaga*, moreover, the lower courts have reached a broad consensus regarding which provisions of the Medicaid Act can be privately enforced. At pages 22-23 of its Petition and in a table beginning at page 60a of its Appendix, Indiana attempts to demonstrate that courts have split on their interpretations of whether particular portions of the Medicaid Act may be enforced through § 1983. In fact, however the list of cases demonstrate remarkable unanimity among courts as to whether particular provisions of the Medicaid Act are or are not judicially enforceable, which in turn demonstrates that courts are carefully heeding this Court's requirement that analysis must be made of "the provision in question." *Blessing*, 520 U.S. at 340.[7] In the small number of circumstances

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and concluding that provision was not focused on the individual beneficiary so as to create a right).

Indiana also cites to *Jones v. District of Columbia*, 996 A.2d 834 (D.C. App. 2010) as a prime example of a court that rejects *Wilder*. But in *Jones* the plaintiffs argued that, under *Wilder, any* provision of the Medicaid Act was enforceable through § 1983, *id.* at 845, an erroneous argument quickly and properly rejected.

[7] The chart does describe a single seeming circuit disagreement concerning the enforceability of 42 U.S.C. § 1396a(a)(30), which requires that states safeguard against unnecessary utilization of Medicaid services and insure that payments are sufficient

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where courts have differed over the enforceability of a particular position, the majority of courts have reached one conclusion with a lone district court adhering to the contrary position.

IV. THE CIRCUIT COURT PROPERLY FOUND THAT § 1396a(a)(10) CREATES RIGHTS THAT MEDICAID RECIPIENTS MAY ENFORCE THROUGH § 1983

Indiana does not argue that Ms. Bontrager is not an intended beneficiary of § 1396a(a)(10). Nor does it generally disagree that the right created by the statute is mandatory in nature.[8] Instead it argues that

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to enlist providers. (App. 67a). However, the only case cited as finding that the provision is enforceable under § 1983 by Medicaid recipients is the *Pediatric Specialty Care* case that was vacated by this Court. *See* n.5, *supra* and 551 U.S. 1142 (2007). All other circuits that have reached the issue since *Gonzaga* have determined that Section 1396a(a)(30) is not enforceable through § 1983. *Equal Access for El Paso v. Hawkins,* 509 F.3d 697,703 (5th Cir. 2007); *Mandy R. ex rel. Mr. & Mrs. R. v. Owens*, 464 F.3d 1139, 1147-48 (10th Cir. 2006); *Westside Mothers*, 454 F.3d at 542-43; *Sanchez v. Johnson*, 416 F.3d 1051, 1062 (9th Cir. 2005); *Long Term Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 57-59 (1st Cir. 2004). Prior to *Gonzaga*, the First Circuit had suggested that Section 1396a(a)(30) was enforceable by recipients. *Visiting Nurse Ass'n v. Bullen,* 93 F.3d 997, 1004 n.7 (1st Cir. 1996). The circuit court's contrary decision in *Ferguson*, after applying *Gonzaga*, is a further demonstration of the lack of doctrinal confusion in the lower courts.

[8] Indiana does argue that § 1396a(a)(10) does not "create specific rights to the dental procedures that [Ms.] Bontrager has requested." (Pet. 30). It appears that this argument may be more appropriately characterized as an argument on the merits of

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the statute is too vague and amorphous for judicial enforcement. Even without the significant precedent that holds the opposite, *supra*, this argument is unavailing.

Although Indiana insists that the mandate of § 1396a(a)(10) – that participating states "provide . . . for making medical assistance available . . . to all [eligible] individuals" – is "about as general as it gets" (Pet. 30), it ignores the fact that the term "medical assistance" is statutorily defined at great length, *see* 42 U.S.C. § 1396d(a). Nor did the Seventh Circuit err in turning to the authoritative interpretation of the statute promulgated by the U.S. Department of Health and Human Services. (App. 8a-10a). After all, "[l]anguage in a regulation may invoke a private right of action that Congress through statutory text created, but it may not create a right that Congress has not. . . . Agencies may play the sorcerer's apprentice, but not the sorcerer himself." *Alexander v. Sandoval*, 532 U.S. 275, 291 (2001). It was for this interpretive purpose that the Seventh Circuit relied on the language of 42 C.F.R. § 440.230, and this regulation is certainly entitled to deference under *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). The argument that a statute is

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Ms. Bontrager's Medicaid claims than as an argument concerning the statute's general enforceability: after all, a statute either is enforceable or is not enforceable, and cannot be enforceable as to some substantive claims but not enforceable as to others. Indiana has not sought certiorari on the merits of the respondents' claims.

unenforceably vague simply because interpretive authority has been offered finds no support whatsoever in jurisprudence from this Court or from the lower courts.[9]

Nor can the use of a purportedly amorphous term in the *regulation* – "utilization control procedures" – sound the death-knoll for the private enforceability of the *statute*. This is a novel argument for which Indiana finds little support, and is fatally flawed on two levels. First, the inquiry into whether a statute is so vague that its enforcement would strain judicial competence is one that understandably and necessarily focuses on the language of the *statute*, not of interpretive regulations. *See, e.g.*, *Blessing*, 520 U.S. at 340-41. Indeed, given that the focal point of the *Blessing* analysis is on congressional intent, *see, e.g.*, *Gonzaga*, 536 U.S. at 283-84, Indiana's argument would permit administrative agencies to unilaterally undermine the duly passed legislative enactments of Congress. This obviously is not so.

And second, Indiana's argument mistakenly confuses a *vague* term with an *undefined* one (as did the district court in *Casillas v. Daines*, 580 F. Supp. 2d 235 (S.D.N.Y. 2008), on which Indiana relies heavily). While Indiana focuses on the term "utilization control procedures," which it believes susceptible to "multiple

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[9] Indiana has not argued, either in seeking certiorari or in the lower courts, that the U.S. Department of Health and Human Services exceeded its statutory authority in promulgating 42 C.F.R. § 440.230.

plausible interpretations" (Pet. 31), the Seventh Circuit detailed the manner in which courts have applied this term to include "a prior authorization process, or similarly designed to control access, prevent fraud, or streamline efficiency." (App. 15a). Once this term is properly applied, any alleged vagueness immediately dissipates. As is clear from the Seventh Circuit's decision, courts have had no difficulty in applying § 1396a(a)(10), and a lone district court decision standing in diametric opposition to the holdings of six circuits certainly does not warrant plenary review.

CONCLUSION

The petition for a writ of certiorari should be denied.

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