No. 21-2325

IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

SAINT ANTHONY HOSPITAL,
Plaintiff-Appellant,

v.

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

Appeal from the United States District Court
For the Northern District of Illinois
Hon. Steven C. Seeger
1:20-cv-02561

REPLY BRIEF OF PLAINTIFF-APPELLANT SAINT ANTHONY HOSPITAL

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INTRODUCTION[1]

Medicaid is complex, but this case is simple. Saint Anthony asks HFS to take action to generate prompt and transparent payment of Medicaid billings as required by federal law. HFS and the MCOs seek to avoid accountability for their respective roles in payment delays and the failure to explain what is being paid, and what is not.

HFS argues that if its contracts with MCOs contain certain words, it has delegated to them any duty to comply with federal law, and the systemic problems are not its responsibility.

The MCOs welcome HFS's abdication of duties. HFS pays them billions in capitation payments—indeed, Medicaid constitutes the largest single part of Illinois' budget. MCOs keep what they don't pay providers. Transparency is their enemy, opacity their ally. Unpaid and underpaid claims increase their bottom line. Arbitrations with individual MCOs cannot address systemic problems. Academic studies and press reports establish that the problems presented by this case are important and systemic.[2]

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[1] We use the same nomenclature and quotation conventions as in Saint Anthony's opening brief (Doc. 13, "SAH-Br."). *See* SAH-Br. 2 n.1.

[2] *See* Dunn et al "*A Denial A Day Keeps the Doctor Away*" (University of Chicago Becker Friedman Institute, July 12, 2021), https://bfi.uchicago.edu/insight/finding/a-denial-a-day-keeps-the-doctor-away/

See also Better Government Association, *Insurance Firms Reap Billions in Profits While Doctors Get Stiffed for Serving the Poor*; *Illinois' $16 Billion Health Program Is Riddled with Industry Ties and Potential Conflicts of Interest*; *Illinois Medicaid Companies Rake In Record Profits From Pandemic*, *available at* https://www.bettergov.org/series/milking-medicaid/

Federal law neither endorses HFS's abdication nor requires arbitrations with MCOs to resolve the problems that result from that abdication. Congress gave providers a right to sue HFS for failure to ensure prompt payment. It did not authorize HFS to funnel billions of federal Medicaid dollars to private parties with a quitclaim of its statutory obligations to ensure that providers are paid in compliance with federal law. Due process requires that HFS inform providers how the payments were calculated. That duty does not evaporate with the transfer of government dollars to MCOs. HFS can easily require MCOs to provide such notice through transparent remittances. MCOs know how they calculate their payments. The components should be disclosed to providers.

The arbitration clauses between Saint Anthony and the MCOs are irrelevant to this case. The district court never reached the arbitrability issue, nor should this Court. If this Court finds that Saint Anthony has stated federal claims, the district court can address arbitrability. But arbitrations cannot, in any event, resolve the issues. The worst MCO offender, CountyCare, is admittedly not even subject to mandatory arbitration. Saint Anthony's dispute is with HFS, under federal law. It seeks no relief from MCOs, no adjudication of unpaid claims. It seeks to enforce its federal rights against HFS to ensure that federal law is followed. Only HFS can provide that relief.

If Saint Anthony gets the transparency it seeks, it can determine whether MCOs are paying what they should. If they are not, Saint Anthony could arbitrate,

if necessary. More likely, proper disclosure would force the MCOs to get the payments right in the first place.

ARGUMENT

I. The Complaint Stated a Right to Relief.

A. This is Not a Contract Dispute with MCOs.

HFS and the MCOs misstate Saint Anthony's position to be that,

> Medicaid providers in managed care programs would not have to enforce their contract rights directly against MCOs, but instead would have States to do that for them ....

Doc. 44, HFS-Br. 2; *see also id*. 29. Wrong. Saint Anthony is not suing HFS to enforce contractual rights against MCOs. It is not suing on any claim submitted to MCOs. *See* Part III below. Indeed, the one arbitration filed by an MCO in response to this case was stayed by the arbitrator over a year ago because the MCO could not satisfy the precondition of identifying any Medicaid claim in dispute, R96-1, R97, a deficiency it has not attempted to cure.

Saint Anthony seeks systemic relief based on HFS's failure to comply with its statutory obligation to ensure timely and transparent payment. HFS has oversight responsibility to ensure that for those claims that MCOs determine are "clean" and should be paid, that payment is made on the 30/90-day schedule. HFS does not dispute that separate arbitrations with MCOs cannot address the systemic problems alleged – or that both HFS as well as MCOs have duties with regard to timely payment. *See* SAH-Br. 33.

The question is whether federal law—Sections u-2(f) and (a)(8)—provides the rights that Saint Anthony asserts against HFS. Answering does not involve individual claim disputes with MCOs.

B. Section u-2(f)[3]

1. Section u-2(f) Applies to "Providers."

HFS argues that Section u-2(f)'s text—described by Congress as the "rule for prompt payment of providers"—requires prompt payment only of "practitioners," a word not found in Section u-2(f). HFS-Br. 30-31. HFS ignores the universal acceptance, including by HFS itself before this case, that the Section covers "providers." The district court did not accept HFS's current position.

Section u-2(f) means "providers" because it says "providers," not "practitioners." MCOs "shall make payment to health care *providers* … on a timely basis …." 42 U.S.C. §1396u-2(f). Plain meaning controls. *United States v. Melvin*, 948 F.3d 848, 851 (7th Cir. 2020) ("[W]e start with the text of the statute to ascertain its plain meaning.") (cleaned up). If Congress intended to restrict u-2(f) to "practitioners," it would have said so, as it did in Section 1396a(a)(37)(A). *See Maine Cmty. Health Options v. United States*, 140 S. Ct. 1308, 1323 (2020) ("[W]hen Congress includes particular language in one section of a statute but omits it in another, Congress intended a difference in meaning.") (cleaned up). *See also*, *e.g.*, *KM*

[3] Saint Anthony has not "abandoned" claims to enforce Sections 1396a(a)(37)(A) and 1396b(m). HFS-Br. 21 n.2. It consistently invokes those provisions in Count I (*see* R1:¶81), which seeks to enforce Section u-2(f). *E.g.*, SAH-Br. 20, 28-29.

Enter., Inc. v. Glob. Traffic Techs., Inc., 725 F.3d 718, 728 (7th Cir. 2013). HFS improperly excises the key word.

HFS ignores that after adopting u-2(f), Congress added u-2(h), stating special rules for Indian healthcare systems, including a payment schedule incorporating u-2(f), which Congress described as the "rule for prompt payment of providers." 42 U.S.C. § 1396u-2(h)(2)(B) (*see* SAH-Br. 23-24). HFS ignores this fact.

Section u-2(f)'s legislative history confirms that "providers" means "providers." SAH-Br. 24-25; *see also* R26:5-6. HFS dismisses the history as "minimal." HFS-Br. 41. It simply ignores Congress's repeated references to prompt payment of "providers" (not just "practitioners"). SAH-Br. 24-25.

Saint Anthony's interpretation is universally accepted:

- Courts agree that Section u-2(f) applies the 30/90-day rule to "providers." *See Appalachian Reg'l Healthcare v. Coventry Health & Life Ins. Co.*, 970 F. Supp. 2d 687, 699 (E.D. Ky. 2013) ("*Every provider* is entitled to be paid a specific percentage of claims within a definite period of time."); *Medevac MidAtlantic, LLC v. Keystone Mercy Health Plan*, 817 F. Supp. 2d 515, 526 (E.D. Pa. 2011) ("[L]egislative history available suggests that Congress was attempting to extend the reach of Section 1396a(a)(37)(A) to *all types of providers*."); *Nat'l Med. Care, Inc. v. Rullan*, No. Civ. 04-1812(HL), 2005 WL 2878094, at *8 (D.P.R. Nov. 1, 2005) (clinic provider can enforce payment schedule of (a)(37)(A) incorporated into u-2(f)).

- The responsible federal agency repeatedly stated that u-2(f) applies Section (a)(37)(A)'s payment deadlines to "providers" paid through MCOs. *See* SAH-Br. 27 n.11; R26:6-7.

> To be consistent with section 1902(a)(37)(A) of the Act [42 U.S.C. §1396a(a)(37)(A)], *the Medicaid MCO's contract must ensure* that 90 percent 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 contract and furnished by *health care providers* are paid within 30 days of receipt and that 99 percent of such claims are paid within 90 days of receipt.

63 Fed. Regis. 52,022, 52,063-64 (Sept. 29, 1998).[4] HFS relies only on agency comments made *two decades before* u-2(f) was enacted that concerned Section (a)(37)(A)'s then-focus on individual "practitioners." HFS-Br. 30-31 & n.4. When Congress later applied Section (a)(37)(A)'s prompt-payment rules to "providers" paid through MCOs, it used the word "providers" in u-2(f).

- Commentators agree. *See, e.g.*, *Medicaid Managed Care*, 2018 Health Law Handbook 6 (Alice G. Gosfield ed.) ("Through the incorporation of the … (37)(A) standards, *all providers* operating under a comprehensive Medicaid managed care plan are entitled to be paid" on the 30/90-day schedule).

- HFS's own manual telling providers how to navigate Illinois' MCO system states that MCOs must make payments on the timetable of 42 U.S.C.

[4] *Available at* https://www.federalregister.gov/documents/1998/09/29/98-26068/Medicaid-program-medicaid-managed-care

§1396a(a)(37)(A). *See* R26:9.[5] HFS Manual Section 2.80 adds that HFS applies the 30/90-day timelines to "all clean claims from *Providers*." *Id.*

All these sources rebut HFS's present argument.

HFS seeks to limit Section u-2(f) to "practitioners" by arguing that the reference to "practitioners" in (a)(37)(A) overrides u-2(f)'s express application to "providers." HFS-Br. 30-34. But the primary requirement of Section u-2(f) is that contracts between HFS and MCOs "shall provide" that MCOs "shall make payment to health care providers" "on a timely basis." Section (a)(37)(A) states the rule for the timeliness. When drafted long before u-2(f), it applied only to practitioners in fee-for-service programs. Section u-2(f), adopted later, then kept (a)(37)(A)'s definition of timeliness, but applied it to a broader class – all providers – for MCO programs. That is the only reasonable reading of Section u-2(f)'s incorporation of Section (a)(37)(A)'s "procedures" – to provide the timetable on which "providers" are to be paid by MCOs "on a timely basis."

HFS badly misreads the statutory language. According to HFS, Section u-2(f)'s reference to Section (a)(37)(A) substitutes "practitioners" for "providers" as the group to be paid on the required schedule. But u-2(f) plainly states *who* must be paid "on a timely basis" – "health care providers." That the regulations for Section (a)(37)(A) provide timelines for both "practitioners" and "other" providers, *see* HFS-Br. 31, is irrelevant because u-2(f) does not refer to the regulations. It expressly applies the

[5] The Manual is a*vailable at* https://www.illinois.gov/hfs/SiteCollectionDocuments/MCOManual.pdf.

30/90-day rule of (a)(37)(A) to "health care providers" paid by MCOs. Under HFS's interpretation, u-2(f) would provide no rule at all for most "providers," improperly negating the statute's use of the word. *Maine Cmty. Health Options,* 140 S. Ct. at 1323 ("Court . . . hesitates to adopt an interpretation . . . which renders superfluous another portion of that same law.") (cleaned up).

HFS also claims that u-2(f) permits any payment schedule by MCOs to "providers" that is "not inconsistent" with Section (a)(37)(A). HFS-Br. 31-32. But Section (a)(37)(A) applies *only* to payments by HFS. It has no application to payments by MCOs and sets no limits on when MCOs must pay. Section u-2(f) does that. If u-2(f) merely requires payments by MCOs that are "not inconsistent" with the requirements of Section (a)(37)(A), it would impose no timing obligations at all, an absurd reading.

HFS argues that Saint Anthony relies on use of the word "ensure," but that Saint Anthony "fails to mention" that "ensure" is found in Section (a)(37)(A). It suggests that "ensure" does not apply to Section u-2(f). HFS-Br. 35; *see also id*. 23-24. But (a)(37)(A) requires "claims payment procedures" that "ensure" timely payment. When u-2(f) adopts (a)(37)(A)'s payment "procedures," they include "ensur[ing]" timely payment. If provider claims are not being timely paid in the real world, whatever contract provisions exist are not "ensuring" timely payment and violate federal law. SAH-Br. 28-29.

2. HFS's Unstated "Practical" Concerns Do Not Exist.

HFS argues that reading u-2(f) to require HFS to have contract provisions with the MCOs that "ensure" MCOs actually pay on time—as opposed to empty, ignored, or unenforced provisions—"would raise obvious practical difficulties." HFS-Br. 26. HFS does not identify any because there are none, unless it means compliance with the 30/90-day requirement. And that is not a "difficulty." It is a binding statutory duty.

Perhaps HFS's "practical difficulties" is a euphemism for "it costs too much." But HFS "'may not ignore the Medicaid Act's requirements in order to suit budgetary needs.'" *Bontrager v. Ind. Family & Soc. Servs. Admin.*, 697 F.3d 604, 611 (7th Cir. 2012) (quoting *Ark. Med. Soc'y, Inc. v. Reynolds*, 6 F.3d 519, 531 (8th Cir. 1993)). HFS receives billions of federal Medicaid dollars based on its agreement to comply with Medicaid's requirements. *Talevski v. Health & Hosp. Corp.*, 6 F.4th 713, 715-716 (7th Cir. 2021) ("In return for federal funding, participating states must comply with the program's statutory and regulatory requirements ….") (citing *Bontrager*, 697 F.3d at 606).

HFS has the authority, tools, and ability to do what u-2(f) requires. It has broad authority—and obligations—to obtain detailed information about Medicaid claim processing from MCOs. Federal law requires that HFS-MCO contracts permit HFS "to audit and inspect any books and records" of an MCO related to "services performed and determinations of amounts payable under the contract." 42 U.S.C. §1396b(m)(2)(A)(iv). HFS is required to have an "*independent review*" *of the*

"timeliness" of MCO services performed annually. 42 U.S.C. §1396u-2(c)(2)(A)(i). HFS is required by state law to collect and report data on the timeliness of MCO claims payments. 305 ILCS 5/5-30.1(g-6) & (g-7).[6] HFS's unsupported assertion that it "would have to create a duplicate accounting system for every MCO" is wrong. HFS-Br. 29-30. As noted above, HFS already collects the exact type of data necessary to determine if MCOs are complying with Section u-2(f).

HFS also has the power to enforce compliance. HFS admits that it has leverage via authority to terminate MCO contracts. 42 U.S.C. §1396u-2(e)(4). If an MCO repeatedly fails to comply with any part of Section u-2, HFS "shall" impose the intermediate sanctions, appointing temporary management of the MCO and permitting the MCOs' enrollees to withdraw without cause. 42 U.S.C. §1396u-2(e)(3). HFS can put MCOs on performance plans, as done to CountyCare after CountyCare paid only 40% of claims within 30 days and only 62% within 90 days, in part because, as discovery revealed, it was improperly diverting Medicaid funds to pay other County bills. *See* R26-1.[7] HFS need only provide MCOs notice of sanctions. 42 U.S.C. §1396u-2(e)(5). HFS has the tools, but refuses to use them.

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[6] The "model" MCO contract cited by HFS, does not support its position. HFS-Br. 9-10 & n.1; R24-1. An unsigned "model" contract is neither an "official record," nor did Saint Anthony incorporate the "model" contract into the Complaint by pleading generally that actual HFS-MCO contracts exist. *See* A10-11. Even if it were proper to consider the "model," it confirms HFS's unlimited access to MCO data. *See* R24-1:12 §5.28.1.3 (requiring MCOs to respond to "any" *ad hoc* data request from HFS).

[7] *See* R26-1, which is admissible because it illustrates the allegations in the Complaint. *Geinosky v. City of Chicago*, 675 F.3d 743, 745 n.1 (7th Cir. 2012). *Compare* R26-1 *with* R1:¶¶51, 72, 75.

HFS suggests that it is difficult determining whether a claim is "clean" so as to enforce the 30/90-day rule. HFS-Br. 30. But Saint Anthony is not asking HFS to review every claim submitted to MCOs. HFS's duty is to collect data on the clean claims after the MCOs pay them to determine compliance with the 30/90-day rule. The MCOs know when the claim was received, whether it was clean initially (because they paid it without asking for information) or later (after the MCO got additional information), and when it was paid. MCOs can easily report the data HFS needs to measure compliance with the 30/90-day rule.[8]

3. HFS Confuses Rights, Duties with Remedies.

HFS misapplies a statement in the Complaint that states that the *relief* Saint Anthony seeks includes the possibility, if nothing else moves the MCOs to compliance, that HFS terminate MCO contracts. According to HFS, this prayer for relief means that Saint Anthony's complaint must be dismissed for infringing upon HFS's enforcement discretion. HFS-Br. 27-28. This confuses a prayer for relief contingent upon MCO non-compliance with requirements HFS has yet to promulgate with Saint Anthony's right to sue.

Section u-2(f) requires HFS to ensure that MCOs pay "providers" "on a timely basis." Saint Anthony has the right to ask the Court to require HFS to require MCO compliance. That right (and HFS's duty) do not define the terms of a possible injunction enforcing timely payment. Agency discretion may or may not impact the

[8] HFS makes no effort to defend the district court's "aggregate" or substantial claim-payment interpretation for meeting the 30/90-day rule, which is incorrect for the unrebutted reasons discussed at SAH-Br. 29-30.

scope of the injunction. But HFS's argument cannot impact whether a duty (and claim) exists in the first place, only what relief may be ordered if HFS directs the MCOs to comply and one or more refuses.

HFS's discretion-infringement arguments are wrong. Section u-2(f)'s requirement is outcome-based. It requires HFS to ensure specific percentages of claims are paid on a specific timeline. It does not dictate the means. HFS can choose the tools to generate compliance, which might include, if necessary, terminating an MCO's contract, as one option. The statute specifies outcomes—not process.

This lawsuit is not about usurping HFS's discretion. It is about requiring HFS to exercise its discretion to comply with federal law. HFS argues that it does not need to enforce the timely payment requirements because its contracts with the MCOs shift all responsibility to them. That is a refusal, not an exercise, of discretion. To remedy that refusal, Saint Anthony seeks an injunction requiring HFS to "use all available means" to achieve compliance up to and including, if necessary, terminating MCO contracts.

HFS's argument was rejected in *O.B. v. Norwood*, 838 F.3d 837, 842 (7th Cir. 2016). The Court affirmed an injunction, over HFS's objection that the injunction did not spell out specific "affirmative steps" to achieve compliance. This Court rejected HFS's position that "the plaintiffs substitute themselves for HFS." *Id.* Instead, the Court recognized that the injunction "should be understood simply as a first cut: as insisting that the state do *something* rather than nothing to" meets its federal obligations. *Id.* *See also id.* at 844 (Easterbrook, J., concurring) ("All a district court

can do in a situation such as this is require the defendant to start trying. Rule 65(d) requires 'reasonable' detail, not more detail than is possible under the circumstances.").

HFS also argues that Saint Anthony is both taking away its discretion (HFS-Br. 27-28) and not telling HFS how to exercise that discretion (HFS-Br. 43). Saint Anthony is not trying to do either at this point. As Judge Easterbrook put it in *O.B.*, it is asking the district court to tell HFS "to start trying."

4. Saint Anthony's Private Right of Action

HFS does not dispute that u-2(f) satisfies two of three *Blessing* factors, as the district court also found: it uses mandatory language and is not vague. SAH-Br. 34; *see also* HFS-Br. 40-43; *Blessing v. Freestone*, 520 U.S. 329, 340-41 (1997). The disputed *Blessing* factor is whether providers like Saint Anthony are intended beneficiaries of Section u-2(f). As stated at SAH-Br. 19-33, they are.

HFS argues otherwise, claiming that timely payment is only an "incidental" benefit. HFS-Br. 40. It asserts that Medicaid recipients are the "intended" beneficiaries, citing *dicta* in a Supreme Court plurality opinion expressing "doubts" about an argument not raised in that case. HFS-Br. 40 (citing *Armstrong*, 575 U.S. 320, 331-332 (2015)). "Doubts" in dicta do not replace holdings in *Blessing*, which require examining the statutory language at issue to determine if it is "phrased in terms of the persons benefitted." *Gonzaga University v. Doe*, 536 U.S. 273, 283-84 (2002). HFS does not discuss the language of u-2(f) in its private-right analysis,

probably because the language is clearly phrased in terms of benefiting "health care providers." *See* HFS-Br. 40-43; SAH-Br. 19-33.

HFS's position that the Medicaid statute was not intended to benefit providers conflicts with this Court's post-*Armstrong* holding that another Medicaid provision *can* be privately enforced by providers. *BT Bourbonnais Care, LLC v. Norwood*, 866 F.3d 815, 821 (7th Cir. 2017) ("[W]e are confident that" "section 1396a(a)(13)(A) benefits nursing home operators….") (finding private right of action). HFS's lack of *Blessing* analysis is effectively a concession that providers meet *Blessing's* third requirement.

HFS's arguments under u-2(f) reprise its incorrect arguments, addressed above at 10-14, that Saint Anthony is seeking to litigate individual claim disputes and deprive HFS of its discretion. HFS-Br. 41-42. Neither is correct, as shown above.

C. Section (a)(8)

HFS incorrectly argues that Section (a)(8) does not supply a private right of action because: (1) the term "individuals" should be read as limited to Medicaid recipients, HFS-Br. 35-36, 44; (2) Section (a)(8) contains no payment schedule, HFS-Br. 36-37; and (3) 42 U.S.C. §1396a(a)(30)(A), which HFS labels "analogous," does not support a private right, HFS-Br. 44-45.

1. "Payment" for "Care and Services"

As described in Saint Anthony's opening brief (SAH-Br. 37-41), Section (a)(8) requires that "medical assistance" be provided with "reasonable promptness to all eligible individuals." 42 U.S.C. §1396a(a)(8). "Medical assistance" is defined to

include "***payment***" for "care and services." 42 U.S.C. §1396d(a). "Individuals" is not defined. There is no dispute that "payment" for "care and services" is made only "to" providers of "care and services," not to Medicaid recipients who receive the "care and services." HFS-Br. 36 ("…the providers of that care, *who receive those payments*…").

Saint Anthony submits that the undefined term "individuals" includes individual providers to whom a "payment" is provided. To foreclose that reading, HFS asserts that "individuals" excludes providers, and would read the language to mean that Medicaid recipients themselves be provided "payment" for their "care and services." HFS contends that "individuals" must mean Medicaid recipients, but ignores the textual problem its interpretation creates.

Saint Anthony's reading gives a sensible meaning to the statutory language, consistent with the overall statutory scheme. The dictionary definition of "individuals" includes a "single … thing, as opposed to a group," which includes a single provider. This reading is consistent with "medical assistance" – defined in the statute to include "payment." Payment can only be made to providers. HFS's interpretation directly conflicts with that definition because Medicaid recipients do not receive "payment."

Saint Anthony's reading is also consistent with other provisions discussed above for prompt payment of providers: Sections (a)(37)(A), u-2(f), and u-2(h)(2)(B). Congress's requirement that providers receive "payment" "with reasonable promptness" for the "care and services" they provide is thus consistent with the overall Medicaid scheme. By contrast, it is inconsistent with the Medicaid scheme

for Congress to have intended in Section (a)(8) that Medicaid recipients themselves receive "payment" for what they are not entitled to receive.

2. "Reasonable Promptness"

Contrary to HFS-Br. 36-37, a defined payment timeline is not required for Section (a)(8) to be privately enforceable. *See* SAH-Br. 39-40. To be enforceable, the statutory language ("reasonable promptness") must not be "so 'vague and amorphous' that its enforcement would strain judicial competence." *Blessing*, 520 U.S. at 340-41. This Court has answered that question already. *O.B.* affirmed a district court ruling granting a preliminary injunction to enforce Section (a)(8). The injunction required HFS to "*take prompt measures* to obtain home nursing for class members," which this Court found to be a "reasonably clear directive." 838 F.3d at 840. Moreover, the 30/90-day rule from neighboring provisions supplies a precise schedule. *See* SAH-Br. 40.

3. "Analogous" Statutory Provision

HFS argues that because a Supreme Court plurality found 42 U.S.C. §1396a(a)(30)(A) not privately enforceable, Section (a)(8) is not. HFS-Br. 44-45. This ignores the separate language at issue. *Blessing*, 520 U.S. at 340 (A "*particular* statutory provision" gives rise to a private right of action if "Congress ... intended that *the provision in question* benefit the plaintiff.").

Section (a)(30)(A) is far less definite than (a)(8). Section (a)(8) requires payments to be made with "reasonable promptness." The only real *Blessing* issue is whether that is sufficiently definite to be within judicial competence. It clearly is.

SAH-Br. 39-40. Section (a)(30)(A), on the other hand, encompasses the more complicated issue of the *amount* of payments for services. It uses only the measuring language "consistent with efficiency, economy, and quality of care and … sufficient to enlist enough providers so that care and services are available under the plan." Determining reasonable promptness, particularly with the clear guidance provided by the 30/90-day rule, is not difficult. Far more challenging would be determining an amount "consistent with efficiency, economy, and quality." HFS does not provide the *Blessing* analysis, nor dispute that Section (a)(8) has been held privately enforceable by Medicaid recipients many times. *See* SAH-Br. 37-38.

II. Saint Anthony Was Entitled to File a Supplement.

The district court unreasonably denied Saint Anthony's Motion to Supplement ("Motion").

A. The District Court Applied Improper Grounds.

HFS ignores Rule 15 case law. *See* SAH-Br. 42-45. The cases it cites distinguish themselves. None involved a plaintiff's first request, early on, after minimal discovery. *See Otis Clapp & Son, Inc. v. Filmore Vitamin Co.*, 754 F.2d 738, 741 (7th Cir. 1985) (*four year-old* case, month from trial); *MAO-MSO Recovery II, LLC v. State Farm Mut. Auto. Ins. Co.*, 994 F.3d 869, 871 (7th Cir. 2021) (denial of *third* amended complaint after expiration of deadline to amend while summary judgment briefing underway); *Glatt v. Chicago Park Dist.*, 87 F.3d 190, 194 (7th Cir. 1996) (16 months after filing where "legal basis for the new claim [was] not articulated clearly" and "[a]ll the factors mentioned in the cases interpreting [Rules 15(a) and 15(d)]

weighed against the grant of" the motion). Saint Anthony filed the Motion nine months after filing and the case had been at a stand-still for six months. It described the legal basis for the Supplement, stating a valid due process claim supported by a Seventh Circuit case. None of the Rule 15 factors weighed against granting the motion. SAH-Br. 42-45.

HFS relies on the district court's statements that the Supplement would "expand the scope of the case" and "prolong the case because the case is otherwise over." HFS-Br. 47-48. HFS ignores authority rejecting these reasons. *See* SAH-Br. 43-44. To warrant denial, the potential expansion or prolongation of a case must cause *undue* prejudice to the defendant or *undue* delay, neither of which the district court found (or could reasonably find). *Id.* (citing *Dubicz v. Commonwealth Edison Co.*, 377 F.3d 787 (7th Cir. 2004)). Contrary to HFS-Br. 48, the district court did not "emphasize[] St. Anthony's delay[.]" The district court did not find any "delay" by Saint Anthony, let alone *undue* delay.

Neither did Count III "expand" the case, let alone do so with undue prejudice. Count III of the Supplement was narrower than Counts I-II, focusing on the forms of remittance that provided inadequate notice. Whether due process required more notice in the remittance forms addressed transparency allegations that had already been pleaded in Counts I-II and was factually simpler than those Counts.

There was no prejudice or surprise to HFS shown. As HFS admits, HFS-Br. 47, Saint Anthony's Complaint had alleged many of the facts related to the transparency problem. Nor was discovery far along. Discovery only on Saint

Anthony's preliminary injunction motion consisted of initial document production and a handful of depositions. At HFS's request even that halted less than three months after Saint Anthony filed its complaint, while the court considered motions from HFS and the MCOs. *See* SAH-Br. 42, n.16; R81. HFS points to the inclusion of the traditional fee-for-service program in the Supplement's allegations, but fails to explain how that minimal addition impacts the case in any way, let alone unduly prejudices it.[9]

No prejudice to HFS resulted from the fact that the Motion to Supplement was filed "six months after HFS's motion to dismiss was fully briefed," HFS-Br. 48. Motions to dismiss often prompt motions to amend. Neither Rule 15 nor the cases treat that period as relevant. Indeed, case law states that courts "should" grant motions to amend or supplement even after *granting* motions to dismiss "[u]nless it is *certain* from the face of the complaint that any amendment would be futile or otherwise unwarranted[.]" Decisions denying such a motion after dismissing a complaint are "reviewed rigorously on appeal." *Runnion v. Girl Scouts of Greater Chi. & Nw. Ind.*, 786 F.3d 510, 519 (7th Cir. 2015).[10]

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[9] The fee-for-service part of HFS's Medicaid program decreased in size in proportion to the growth of the managed care system. *See* SAH-Br. 4-6. The traditional fee-for-service program is "primarily for persons recently enrolled in Medicaid before they enroll with an MCO[.]" HFS-Br. 9.

[10] HFS identifies no difference between the denial of a motion for leave to amend, as opposed to a motion to supplement, after the granting of a motion to dismiss. The same "freely granted" standard applies to both. *See Glatt v. Chicago Park Dist.*, 87 F.3d 190, 194 (7th Cir. 1996).

HFS is wrong that Saint Anthony "never sought leave to file a reply disputing [the] evidence" presented in HFS's Response to the Motion to Supplement. HFS-Br. 52. Saint Anthony *specifically* asked to file a reply *with HFS's consent*. A37. The district court denied the request, noting that case law provides that the "court should freely give leave [to supplement] when justice so requires." SA1. This underscores the arbitrariness of the court's subsequent denial on grounds the court refused to allow Saint Anthony to dispute in the reply it had sought to file.

HFS cites the district court's statement that Saint Anthony was free to allege the due process claim in a new action, HFS-Br. 49. But it does not dispute that HFS would likely argue that such a new lawsuit is barred by the district court's dismissal with prejudice, for which there is support in this Court's holding in *Arrigo v. Link*, 836 F.3d 787, 799 (7th Cir. 2016). *See* SAH-Br. 44, n.17.

B. The Supplement Stated a Valid Claim.

HFS supports the denial by attacking a claim Saint Anthony did not ask to bring: The Supplement did not allege a "property right" in remittances. HFS's Brief 49-52. It alleged a property right in the payments, the HAP Claims Payment Increases and Other Add-On Payments and adjusters (defined as "HAP Claims Payment Increases") (A44, 47). Remittances are the vehicle for providing *notice* of what is being paid. The Supplement challenged the inadequate notice because remittances did not disclose any information concerning payment of the HAP Claims Payment Increases or the basis for computation of the Medicaid payments with which

the HAP Claim Payment Increases are to be included. It alleged that the remittances are the only form of notice it receives, and they are inadequate.[11]

Contrary to HFS's Brief at 49-51, the Supplement did not assert claims against MCOs under the Saint Anthony-MCO contracts or otherwise. Illinois law—not the contracts—requires that HFS ensure Saint Anthony be paid the HAP Claims Payment Increases as part of Medicaid claim payments. *See* SAH-Br. 49 (citing 305 ILCS 5/5A-12.7(a) ("the Department shall … make payments to hospitals or require capitated managed care organizations to make payments as set forth in this Section"). HFS has no answer to this clear statement of its responsibility for the payment of HAP Claims Payment Increases. Due process—not the contracts—imposes the responsibility on HFS to provide notice, or ensure the MCOs do so, to permit Saint Anthony to determine if it is paid what it is entitled.

HFS's argument that the Supplement seeks to hold it responsible for non-state action is wrong. The cases cited at HFS-Br. 49-51 reject attempts to hold (i) private actors to constitutional standards for private conduct;[12] or (ii) the government liable

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[11] HFS refers, for the first time in this case, to a "Form 835" that purportedly is to accompany Medicaid payments to providers. HFS-Br. 9, 12. The Form is not in the record and HFS made no arguments regarding it, or contended that it provides notice regarding the HAP Claims Payment Increases. HFS does not state what information it provides or whether MCOs use it. Therefore, there is no argument to which Saint Anthony can respond related to the Form.

[12] *González-Maldonado v. MMM Healthcare, Inc.*, 693 F.3d 244 (1st Cir. 2012) (private HMOs); *N.J. Primary Care Ass'n v. State Dep't of Human Servs.*, 722 F.3d 527, 537 (3d Cir. 2013) (private MCO); *Am. Mfrs. Mut. Ins. Co. v. Sullivan*, 526 U.S. 40, 51 (1999) (private insurer); *Manhattan Cmty. Access Corp. v. Halleck*, 139 S. Ct. 1921, 1926 (2019) (private operator of public access cable channel); *Forziano v. Indep. Grp. Home Living Prog.*, 613 Fed. Appx. 15, 19-20 (2d Cir. 2015) (private group

(*continued on next page*)

for private conduct for which it was not responsible.[13] Here Saint Anthony seeks to hold *HFS* to its non-delegable duty to provide notice required by due process related to the payment of its claims. Whether made by HFS or through the MCOs, HFS is responsible for ensuring Saint Anthony receives adequate notice.[14]

Gonzalez-Maldonado, HFS-Br. 50, supports Saint Anthony, not HFS. It was a lawsuit against private HMOs, not the government, concerning capitation payments to doctors. There was no state action because the HMOs' decision to use capitation payments was voluntary, not government-mandated. 693 F.3d at 248. The court stated that if the government had required the companies to pay doctors via capitation, "the proper suit would be normally against the government itself and rarely against those who merely obeyed the government's order." *Id.* In *Blum*, also cited by HFS, the court found no state action in private nursing homes' discharge and transfer decisions, but said it "would have a different question before us" if the "State 'affirmatively command[ed]'" the discharge or transfer of the Medicaid patients. 457 U.S. at 1005. Thus, both cases support the claims asserted in the Supplement.

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homes); *Bourbon Cmty. Hosp., LLC v. Coventry Health & Life Ins. Co.*, No. 3:15-cv-00455-JHM, 2016 WL 51269, 2015 U.S. Dist. Lexis 173656 (W.D. Ky. Dec. 28, 2015) (private MCOs); *Wittner v. Banner Health*, 720 F.3d 770 (10th Cir. 2013) (private medical center and doctors).

[13] *Banks v. Sec'y of Ind. Family & Soc. Servs. Admin.*, 997 F.2d 231, 244 (7th Cir. 1993) (government not responsible for private hospitals' lawsuits); *Blum v. Yaretsky*, 457 U.S. 991 (1982) (state not responsible for private nursing homes' independent decisions).

[14] This principle was applied in *K.B. ex rel. T.B. v. Michigan Dep't of Health & Human Servs.*, 367 F. Supp. 3d 647, 662 (E.D. Mich. 2019), which HFS ignored.

HFS's argument that there is no state action related to claims paid by the MCOs because the provision of "healthcare for the needy" is not "a traditional, exclusive government function," HFS-Br. 51, mischaracterizes Saint Anthony's claim and is unsupported by the law. Saint Anthony's claim does not depend on whether healthcare for the needy is an exclusive government function. It rests on HFS's delegation of the payment of HAP Claims Payment Increases to MCOs and its failure to provide adequate notice of those payments under due process principles. *See* SAH-Br. 9-10. The distribution of public funds under a formula set by state law is a traditional, exclusive public function that was entirely carried out by HFS for decades, until the recent changes leading to the delegation of some of the payments to MCOs. *See* SAH-Br. 10. HFS's relationship with the MCOs in relation to the HAP Claims Payment Increases satisfies Supreme Court precedent under its flexible approach for determining when the actions of private parties are attributable to HFS—case law that HFS ignores entirely. *See* SAH-Br. 50-51.

Contrary to HFS-Br. 51, Saint Anthony cited ample authority establishing that due process requires that HFS ensure that Saint Anthony receives adequate notice to determine whether it is being paid the funds due it, including *Vargas v. Trainor*, 508 F.2d 485, 490 (7th Cir. 1974), and *M.A. v. Norwood*, 133 F. Supp. 3d 1093, 1099-1100 (N.D. Ill. 2015). SAH-Br. 45-46, n.18. HFS ignores *M.A. v. Norwood* (as did the district court). Its distinction of *Vargas* (this Court's decision that that the district court also ignored) is bogus: HFS states that in *Vargas* the government admitted it was reducing public benefits, whereas here HFS claims it is paying "everything

owed[.]" HFS-Br. 52. But due process requires notice of how the government (or the entity disbursing its funds) reaches a decision, regardless of whether it admits that it is depriving the recipient of a property interest.[15] If HFS and the MCOs are paying "everything owed[,]" then they should have no difficulty listing the components in the remittances so that Saint Anthony can verify.

It is not surprising that the MCOs seek to cloak their calculations. But it is mystifying that the governmental stewards of these massive public expenditures so ardently defend the absence of transparency and accountability when it comes to massive amounts of funds that are supposed to be paid to providers of healthcare to the poor.

HFS misreads *Glatt* as requiring Saint Anthony "'substantiate' its *claim* … which it failed to do." HFS-Br. 51 (citing *Glatt*, 87 F.3d at 194). Not so. Rather, *Glatt* found a *motion* to supplement unsubstantiated. 87 F.3d at 194 ("the good ground for denying [the plaintiff's] *motion* was that [the plaintiff] failed to substantiate *it* ….). It did not hold, as HFS suggests, that a validly stated claim alleged in a pleading must be "substantiated."[16]

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[15] As summarized in the Supplement, underpayments happen regularly and can go undetected for months due to the lack of transparency. SAH-Br. 12 (citing A50).

[16] Subsequent cases have cited *Glatt* to mean, *inter alia*, that a party must "substantiate his reasons for amendment," *Crim v. Bd. of Educ.*, 147 F.3d 535, 548 (7th Cir. 1998), that "[d]istrict courts do not have to engage in guessing games about proposed amendments," *Doe v. Howe Military Sch.*, 227 F.3d 981, 989-90 (7th Cir. 2000), and that the "theoretical availability of" a claim would not justify changing a lawsuit when other reasons justifying denial of a motion to amend or supplement exist, such as undue delay or undue prejudice, *see Brown v. Yan Yu*, No. 13-cv-08306, 2015 U.S. Dist. LEXIS 50343, at *5-6 (N.D. Ill. Apr. 16, 2015), *Patrick v. City of*

(*continued on next page*)

III. Saint Anthony's Claims Are Properly in Federal Court.

The MCOs' brief, Doc. 42 ("MCO-Br."), focuses on an issue not decided by the district court: whether to grant the MCOs' motions to stay the federal court proceedings and compel separate arbitrations with each. MCO-Br. 8-17. The district court denied these motions as moot when it granted HFS's motion to dismiss. SA2. If this Court reverses the dismissal, then the district court can decide whether to stay this lawsuit and proceed to arbitration. *Cf. Singleton v. Wulff*, 428 U.S. 106, 120 (1976) (". . . a federal appellate court does not consider an issue not passed upon below.").

Regardless, the MCOs are wrong that Saint Anthony's claims belong in arbitration. Their basic argument is that Saint Anthony seeks relief from the MCOs directly, and that such relief can be obtained only through arbitration. That mischaracterizes Saint Anthony's claims, misreads the MCOs' contracts, and ignores the distinct relationships between HFS, MCOs, and providers.

The MCOs also misrepresent a factual matter: They state that Meridian demanded arbitration with Saint Anthony in June 2020 and that "[t]he arbitration is currently stayed at Saint Anthony's request." MCO-Br. 7. In fact, the arbitration was stayed because *Meridian* did not comply with the contractual preconditions to initiating arbitrations. Therefore, the arbitrator ruled that Meridian was not entitled to proceed. R96-1, R97. Since that ruling last year, Meridian has made no effort to

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Chicago, No. 06 c 3780, 2008 U.S. Dist. LEXIS 44116, at *11-12, 2008 WL 2339649 (N.D. Ill. June 4, 2008).

cure its noncompliance with the arbitration requirements. This demonstrates that the MCOs' real goal is not to arbitrate, but to use the arbitration agreement with Saint Anthony to impede Saint Anthony's effort to cause HFS to meet its obligations under federal law.

A. Saint Anthony's Claims Against HFS Are Not Arbitrable.

The MCOs' argument runs headlong into a well-establish rule: "Federal courts have a 'virtually unflagging obligation' to exercise the jurisdiction conferred on them by Congress," *AAR Int'l, Inc. v. Nimelias Enters. S.A.*, 250 F.3d 510, 517-18 (7th Cir. 2001) (quoting *Colorado River Water Cons. Dist. v. United States*, 424 U.S. 800, 817 (1976)); *see also Susan B. Anthony List v. Driehaus*, 573 U.S. 149, 167 (2014) ("'[A] federal court's obligation to hear and decide cases within its jurisdiction is virtually unflagging.'").

The Supreme Court has made clear that "although arbitration is well suited to resolving contractual disputes … it cannot provide an adequate substitute for a judicial proceeding in protecting the federal statutory and constitutional rights that §1983 is designed to safeguard." *McDonald v. City of West Branch*, 466 U.S. 284, 290 (1984). That applies here.

Saint Anthony's claims arise under the Medicaid statute and 42 U.S.C. §1983. They are *solely* against HFS. The Medicaid statute obligates HFS to ensure that the MCOs pay "clean claims" in accordance with the 30/90-day rule. To be sure, Saint Anthony alleges that the MCOs have failed to comply with this rule, as a factual predicate for its claim that HFS has systematically failed to monitor and enforce

compliance with that rule in violation of Saint Anthony's rights under federal law – a failure that HFS admits. *See* 31-32 *infra*.

In mischaracterizing the "crux of Saint Anthony's complaint" to be "the MCOs' payment and administration of claims" (MCO-Br. 8), the MCOs ignore the distinctions between Saint Anthony's *claim*, its *injury*, and the *remedies* it seeks. Saint Anthony's *claim* is that *HFS* is violating federal law by not ensuring compliance with the statutory and constitutional requirements. Its *injury* is that claims are paid late, without a breakdown of the component parts, so that Saint Anthony does not know whether it has been paid all it is owed. Its requested *remedy* is that HFS do something to ensure that clean claims get paid on time and that the payments disclose what is being paid. The "crux" of Saint Anthony's complaint is focused on HFS's statutory duty to ensure that the MCOs comply with federal law. Saint Anthony does not seek relief from the MCOs. Instead it has proceeded solely against HFS: the *only* party who can require uniformity and transparency from the MCOs, and thereby ensure a systemic solution.

The MCOs are wrong that the Saint Anthony-MCO contracts established an "alternative payment schedule" for the payment of clean claims, thus overriding the 30/90-day schedule provided by federal law. MCO-Br. 4. To the contrary, the MCOs' own agreements with HFS bind them to the federal prompt-payment requirement. *See* R24-1:122, §5.29; HFS-Br. 10 n.1. None of the Saint Anthony-MCO contracts opted out of the 30/90-day schedule. In fact, only one of the four MCOs (Meridian) even tweaked the schedule at all, and then only to make it slightly *stricter* in that

Meridian has agreed to pay *all* clean claims in 30 days. R78-1:14, §4.3. In any event, the federal timeliness mandate remains, and nothing in the Medicaid statute (or elsewhere) suggests that Congress intended to allow the MCOs or private arbitration to override or substitute for HFS's oversight duties in ensuring that federal law is followed.

B. The Arbitration Clauses Do Not Apply Here.

Contrary to the MCOs' assertions (MCO-Br. 9-11), the arbitration clauses in the MCOs' respective contracts with Saint Anthony are inapplicable. They set forth an unremarkable requirement that if Saint Anthony wants to bring a claim against the MCOs, it must or may do so via arbitration. But Saint Anthony's federal statutory claims are against *HFS*, not the MCOs. The arbitration clauses neither apply to nor preclude Saint Anthony from pursuing federal relief against HFS.

The MCOs contend that a party cannot "'frame[] its claims'" to bypass arbitration where the arbitration agreement covers the "subject matter" of the claims. MCO-Br. 12. But the arbitration clauses in the Saint Anthony-MCO contracts do *not* cover the subject matter at issue here, which is the duty of a State agency to oversee MCOs as required by federal law.

The Meridian contract is illustrative. It requires arbitration of a "dispute" if "written notice to the other party describing the nature of the dispute and a proposed resolution" fails. R78-1:16, ¶¶6.1-6.2. But the "dispute" is one between Saint Anthony and Meridian, not one between Saint Anthony and HFS. It would be impermissible, indeed absurd, for Saint Anthony to give notice to Meridian and

demand arbitration of its claim that HFS is providing inadequate oversight of all Illinois MCOs, and that the Medicaid statute requires HFS to do more. Saint Anthony could not ask an arbitrator to decide such a claim, nor could an arbitrator do so. The same is true even if background for the "dispute" with HFS is that Meridian has not complied with the statutory prompt-payment requirement. That is because the remedy Saint Anthony seeks is for HFS to ensure that all MCOs do so on a consistent basis, something neither Meridian nor an arbitrator in a one-MCO arbitration could provide. The Blue Cross and IlliniCare contracts are similarly limited to disputes regarding those agreements. Two more arbitrators also could not provide the relief Saint Anthony seeks against HFS. *See* R79:20, §XIII.2 (Blue Cross); R83:3-4 (IlliniCare).

Notably, the arbitration clause in the contract with CountyCare, which is the largest insurer that Saint Anthony deals with and the worst offender when it comes to ignoring the 30/90-day payment requirement, *see* R:26-1, is *optional*, not mandatory. Following good-faith discussions, "[a]ny remaining claim or controversy ***may*** be resolved, ***as agreed upon by the Parties at the time,*** through binding arbitration[.]" R80:3-4. There has been no such "agreement," and, regardless, Saint Anthony's claims against HFS arise under federal law. The CountyCare arbitration clause is inapplicable, as the MCOs do not dispute.

C. Adjudicating Individual Claims with MCOs is Unnecessary.

Contrary to MCO-Br. 12-14, the MCOs' contracts do not require Saint Anthony to arbitrate individual claim-payment disputes with the MCOs as a precondition to

suing HFS. Nothing in the MCOs' contracts precludes Saint Anthony from suing HFS without exhausting any arbitral remedy, even if one exists. Nor do the contracts purport to waive any right Saint Anthony has with regard to claims against HFS or to limit the fora in which such a right may be asserted. *See McDonald*, 466 U.S. at 290. The MCOs' contracts do not encompass the Saint Anthony-HFS dispute at all. Indeed, HFS is not and, under state law cannot be, a party to any Saint Anthony-MCO arbitrations. *See* 705 ILCS 505/8(b). Its duty to oversee the MCOs does not arise under the Saint Anthony-MCO agreements, nor can an arbitrator decide it.

Saint Anthony's relief here does not require arbitration of any individual Medicaid claim. Saint Anthony requests no money from, nor an injunction against, the MCOs. Instead, it seeks an order requiring HFS to monitor the MCOs, as required by law, to ensure that they comply with the federal prompt-payment mandate and to provide transparency to ensure that the amount paid is correct. That does not require MCOs to pay claims they properly and timely dispute, or to give up their right to arbitrate genuine disputes with Saint Anthony.

Nor does the resolution of Saint Anthony's claims require the district court to engage in a claim-by-claim review about whether a claim is "clean," has been properly billed, and so on, as the MCOs contend. MCO-Br. 12-14. As discussed above, the MCOs know when they received and paid claims, and whether they did so without requesting further information, *i.e.*, whether the claims were "clean." Saint Anthony's request for a preliminary injunction is about HFS's failure to collect this data and monitor and enforce compliance with the 30/90-day rule. Without reviewing

individual claims, a court can require HFS to direct the MCOs to report that information, and HFS can enforce non-compliance with the federal-payment mandate. *See, e.g.*, *Youakim v. Miller*, 562 F.2d 483, 491 (7th Cir. 1977), *aff'd sub nom. Miller v. Youakim*, 440 U.S. 125 (1979) (concluding that district court has equitable power under 42 U.S.C. § 1983 to order a state agency to promulgate new rules and regulations consistent with the demands of federal statutory law and rejecting agency's argument that doing so amounts to "an unwarranted intrusion into the internal affairs of the state"). The same is true regarding the systemic lack of transparency in the remittances, which indisputably do not disclose all components of the payments so that Saint Anthony can easily determine whether the MCO is paying it correctly. *See* A60-89. There is nothing for an arbitrator to decide (and very little as a factual matter for a federal court).

Indeed, HFS's *own* documents establish that the payment deadline for "clean" claims is not being met. *See, e.g.*, R86-2, Ray Decl. ¶42 & Ex. 2 thereto; R86-3, Dawson Decl. & Ex. 1. HFS also has admitted that it has not been monitoring or enforcing the prompt-payment mandate because *it does not know* if the MCOs are paying clean claims on time.[17] And it does not have the necessary information

[17] The admissions are found here: HFS tracks average time to *adjudicate* claims, but not the average time for MCOs actually to *pay* providers' clean claims. *See* R86-2, Ray Decl. ¶43 (the data collected by HFS "indicates that, on the aggregate, the MCOs are generally adjudicating claims within 30 days of receipt from healthcare providers, although there are some exceptions."). HFS does not track *any* provider-specific data. R56:7 (HFS noting that "the Department does not have this type of provider-specific data because it collects *aggregate* data for each MCO"). Thus, HFS is failing to collect relevant data—the MCOs' time to pay clean claims—on either an aggregate basis or provider-by-provider basis.

because, before this suit, HFS never asked the MCOs for this most basic information. *Thus, the central factual issue in Saint Anthony's claim against HFS is admitted. It cannot be decided in or changed by arbitrations.* It is powerful evidence of HFS's lack of oversight and of the need for judicial relief. Separate arbitrations between Saint Anthony and the MCOs would not resolve the dispute between Saint Anthony and HFS about its failures to address the systemic problems with its oversight and enforcement of prompt-payment requirement and lack of remittance transparency.

CONCLUSION

This Court should reverse and remand for further proceedings before a different district court judge. *See* Cir. R. 36.

Dated: January 14, 2022

Respectfully submitted,

SAINT ANTHONY HOSPITAL

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CERTIFICATE OF COMPLIANCE

This brief complies with the word limitations set forth in this Court's order dated December 30, 2021, because it contains 8,353 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

This brief also complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and Circuit Rule 32 and the typestyle requirements of Fed. R. App. P. 32(A)(6) because it has been prepared in a proportionally spaced typeface (12-point Century Schoolbook) using Microsoft Word.

January 14, 2022

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CERTIFICATE OF FILING AND SERVICE

I hereby certify that on January 14, 2022, I electronically filed this brief with the Clerk of the Court for the United States Court of Appeals for the Seventh Circuit using the CM/ECF system. All participants in the case are registered CM/ECF users and service will be accomplished by the CM/ECF system.

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