No. 22-534

In the Supreme Court of the United States

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

Petitioner,

v.

ST. ANTHONY HOSPITAL, *et al.*,

Respondents.

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

Amicus Curiae Brief of the Medicaid Health Plans of America in Support of Petitioner

STEPHEN D. LIBOWSKY*
Counsel of Record
MANATT, PHELPS & PHILLIPS, LLP
151 North Franklin Street, Suite 2600
Chicago, IL 60606
slibowsky@manatt.com
(312) 477-4798

MICHAEL KOLBER
MANATT, PHELPS & PHILLIPS, LLP
7 Times Square
New York, NY 10036

MARINA SHVARTS
MANATT, PHELPS & PHILLIPS, LLP
2049 Century Park East, Suite 1700
Los Angeles, CA 90067

Counsel for Amicus Curiae

TABLE OF CONTENTS

INTEREST OF *AMICUS CURIAE* 1

SUMMARY OF THE ARGUMENT........................ 2

ARGUMENT 7

I. Inventing a Novel and Unjustified Private Right of Action Carries High Stakes. 7

A. The Seventh Circuit's Decision Will Adversely Impact Managed Care Programs Affecting Millions of Enrollees and Hundreds of Billions of Dollars in Expenditures. 7

B. MCOs Provide Important Benefits for the Health Care System.. 9

II. In the Managed Care Model, Provider-MCO Disputes Are Governed by Contract Law and State Administrative Remedies.......................... 11

III. Creating a New Federal Private Right of Action to Allow Providers to Evade Contractual Dispute Resolution Mechanisms or State Contract Law Will Inject Costs and Uncertainty into the Medicaid Managed Care System......... 16

TABLE OF CONTENTS
(continued)

A. Creating a New Private Right of Action Disrupts Existing Contract Dispute Resolution Procedures and Ignores the Parties' Bargained-for Terms.......... 16

B. A Federal Private Right of Action for Prompt Payment Violations Would Unnecessarily Burden States and Federal Courts Without Evidence that Presently Available Remedies Cannot Resolve These Disputes...... 18

C. The Unspecified Boundaries and Remedies of the New Right Inject Needless Uncertainty Into the Managed Care System. 20

IV. There Is No Crisis of MCO Late Payments to Necessitate the Seventh Circuit's Drastic Remedy. 22

CONCLUSION... 25

TABLE OF AUTHORITIES

CASES

AT&T Mobility LLC v. Concepcion,
563 U.S. 333 (2011) 16

Harris v. McRae,
448 U.S. 297 (1980) 7

Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc.,
473 U.S. 614 (1985) 17

Moses H. Cone Mem'l Hosp. v. Mercury Constr. Corp.,
460 U.S. 1 (1983) 17

STATUTES & REGULATIONS

42 U.S.C. § 1396-1 7

42 U.S.C. § 1396a(a)(5) 8

42 U.S.C. § 1396a(a)(10) 8

42 U.S.C. § 1396a(a)(23) 8

42 U.S.C. § 1396a(a)(37)(A) 3, 13

42 U.S.C. § 1396b(m)(2)(A) 11

42 U.S.C. § 1396u-2 8

42 U.S.C. § 1396u-2(b)(1) 8

42 U.S.C. § 1396u-2(b)(2) 3, 8

42 U.S.C. § 1396u-2(f) 3, 12, 13

40 Pa. Stat. Ann. § 991.2161 15

305 Ill. Comp. Stat. Ann. 5/5-30.1(g-6) 23

305 Ill. Comp. Stat. Ann. 5/5-30.1(g-7) 23

TABLE OF AUTHORITIES
(continued)

305 Ill. Comp. Stat. Ann. 5/5-30.1(g-8)................. 15

Ariz. Rev. Stat. Ann. § 36-2903.01.B.4................. 15

Ark. Code Ann. § 20-77-1701 *et seq.*...................... 15

Cal. Health & Saf. Code § 1371.39(a)................... 15

Tenn. Code Ann. § 56-32-126................................ 15

42 C.F.R. § 438.3 11

42 C.F.R. § 438.4(b)(9) 23

42 C.F.R. § 438.6 10

42 C.F.R. § 438.8(j).. 23

42 C.F.R. § 438.8(k)(1) 23

42 C.F.R. § 438.68 23

42 C.F.R. § 438.114(c)(1)(i) 2, 3

N.M. Code R. § 8.308.15.10.................................... 15

OTHER AUTHORITIES

CMS, *August 2022 Medicaid & CHIP Enrollment Data Highlights*, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html (last visited Jan. 3, 2023).. 7

TABLE OF AUTHORITIES (continued)

Commonwealth Fund, *How States Are Using Comprehensive Medicaid Managed Care to Strengthen and Improve Primary Health Care* (July 30, 2020), https://www.commonwealthfund.org/publications/issue-briefs/2020/jul/how-states-are-using-comprehensive-medicaid-managed-care 11

Cong. Rsch. Serv., *Medicaid: An Overview* (updated Feb. 22, 2021), https://crsreports.congress.gov/product/pdf/R/R43357 7

Elizabeth Hinton & Lina Stolyar, *10 Things to Know About Medicaid Managed Care*, KFF (Feb. 23, 2022), https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care 9, 10, 11

Health Management Assocs., *Medicaid Managed Care Spending Tops $420 Billion in 2021* (Sept. 1, 2022), https://www.healthmanagement.com/blog/medicaid-managed-care-spending-tops-420-billion-in-2021 7

TABLE OF AUTHORITIES
(continued)

Ill. Dept. of Healthcare & Family Servs., *Analysis of HFS-Contracted MCO Claims Processing and Payment Performance for Services in Q1 and Q2 of CY 2021*, www2.illinois.gov/hfs/SiteCollectionDocuments/MCOHospitalClaimsProcessingReportQ1AndQ22021.pdf 24

Illinicare Health Provider Manual, N.D. Ill., Dkt. No. 83-2 14

Iowa Dept. of Human Servs., *Managed Care Organization (MCO) Annual Performance Report - SFY21* (Dec. 2021), https://www.legis.iowa.gov/docs/publications/DF/1231688.pdf 24

Jungwon Park, *Length of Stay and Inpatient Costs Under Medicaid Managed Care in Florida*, INQUIRY: J. Health Care Org., Provision, and Fin., Oct. 14, 2015, www.ncbi.nlm.nih.gov/pmc/articles/PMC5813651/pdf/10.1177_0046958015610762.pdf 10

Kaiser Family Found., *Total Medicaid MCO Enrollment* (updated July 1, 2020), https://www.kff.org/other/state-indicator/total-medicaid-mco-enrollment 8, 9

Kaiser Family Found., *Total Medicaid MCO Spending* (updated Aug. 2022), https://www.kff.org/other/state-indicator/total-medicaid-mco-spending...........8, 9

TABLE OF AUTHORITIES (continued)

Kathleen Healy-Collier et al., *Medicaid Managed Care Reduced Readmissions for Youth With Type 1 Diabetes*, 22 Am. J. Managed Care 250 (Apr. 2016), https://cdn.sanity.io/files/0vv8moc6/ajmc/2b231983beedca72dfdac5178de1ba62347e53f1 10

Lisa P. Oakley et al., *Oregon's Coordinated Care Organizations and Their Effect on Prenatal Care Utilization Among Medicaid Enrollees*, 21 Maternal & Child Health J. 1784 (Sept. 2017) 10

Medicaid & CHIP Payment & Access Comm'n, *Managed Care*, https://www.macpac.gov/topics/managed-care (last visited Jan. 3, 2023) 9

Medicaid & CHIP Payment & Access Comm'n, *Provider Payment and Delivery Systems*, https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems (last visited Jan. 3, 2023) 8, 9, 10

Meridian Health Plan Illinois Hospital Agreement with Saint Anthony Hospital, N.D. Ill. Dkt. No. 78-1 .... 12, 13, 14

TABLE OF AUTHORITIES (continued)

State of Illinois Contract Between Department of Healthcare and Family Services and [Model Contract] for Furnishing Health Services by a Managed Care Organization, https://www2.illinois.gov/hfs/SiteCollectionDocuments/2018MODELCONTRACTadministrationcopy.pdf (last visited Jan. 3, 2023)..12, 13, 15, 23

Tianyan Hu & Karoline Mortensen, *Mandatory Statewide Medicaid Managed Care in Florida and Hospitalizations for Ambulatory Care Sensitive Conditions*, 53:1 Health Servs. Rsch. 293 (Feb. 2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5785303/pdf/HESR-53-293.pdf 10

INTEREST OF *AMICUS CURIAE*[1]

Amicus curiae Medicaid Health Plans of America (MHPA) is a nonprofit trade association of managed care organizations (MCOs), with a sole focus on Medicaid managed care. It represents more than 130 MCOs serving more than 49 million Medicaid beneficiaries in 40 states, the District of Columbia, and Puerto Rico. MHPA's members include both for-profit and nonprofit entities, national and regional MCOs, as well as single-state health plans that compete in the Medicaid market. Since 1995, MHPA has promoted the interests of the MCO industry through federal advocacy, research, annual conferences, and educational materials, among other activities. MHPA is dedicated to supporting innovative policy solutions to enhance the delivery and coordination of comprehensive, cost-effective, and quality health care for Medicaid enrollees.

Over the course of two generations, managed care has evolved to become a model for Medicaid care in the United States. Medicaid MCO health plans have pioneered systems, protocols, and treatments to arrange for the provision of quality care, to produce robust outcomes, and to deliver budget predictability on a large scale—consistent with MHPA's members' values and mission-driven approach to care. MHPA has an interest in maintaining and expanding managed care's benefits

[1] Counsel for MHPA authored this brief in whole, and no person or entity other than MHPA, or its members or counsel made a monetary contribution to the preparation or submission of this brief. Counsel for MHPA notified counsel of record for all parties in this case of its intention to file this brief.

to all eligible individuals and populations and to mitigate policy changes that undermine the Medicaid managed care system.

SUMMARY OF THE ARGUMENT

This case should have been a routine reimbursement dispute between contracted providers and payors of health care services. An Illinois hospital alleged that Medicaid MCOs failed to timely pay claims in accordance with prompt payment obligations. A clear, effective, and well-established path exists for providers and MCOs to resolve reimbursement conflicts—parties can enforce their contractual rights, turn to available state administrative remedies in a health care system subject to extensive regulatory oversight, or both.

The Seventh Circuit, however, trailblazed a new route by recognizing a private right of action under Section 1983 to permit providers dissatisfied with the timeliness or amounts of MCO payments to sue the State in federal court. The Seventh Circuit engrafted this novel right of action onto a statute that does not impose any duty on States to serve as direct guarantors of MCO payments, but which, to the contrary, affirms that in the managed care system, the payment of claims lies in the realm of contract.[2] This novel right of action drastically

---

[2] A limited caveat to the purely contractual relationship exists for non-contracted emergency services for which providers are entitled to receive payment under federal law. *See* 42 C.F.R. § 438.114(c)(1)(i). This circumstance is not at issue in this case, and an extensive statutory and regulatory regime addresses those payments, which are the legal responsibility of the MCO,

redefines the rights, obligations, and relationships of stakeholders in the Medicaid managed care system and threatens to destabilize that health care system, affecting millions of lives in Illinois and beyond.

The managed care system—which provides Medicaid benefits to approximately 70% of the nation's 80 million Medicaid enrollees—operates via a series of contractual relationships: States contract with MCOs to provide or arrange for the provision of health care services to Medicaid beneficiaries. And MCOs contract with providers to deliver those services. Contracts, with comprehensive regulatory oversight, govern every aspect of the provider-payor relationship, including claims processing, payment, and resolution of claim disputes.

Section 1932(f) of the Social Security Act, 42 U.S.C. § 1396u-2(f), from which the new right emanates, fits squarely within this contractual framework: States must include provisions addressing prompt payment in contracts with MCOs. "A contract . . . with a medicaid managed care organization shall provide that the organization shall make payment" to health care providers "on a timely basis consistent with the claims payment procedures described in section 1396a(a)(37)(A) of this title, unless the health care provider and the organization agree to an alternate payment schedule[.]" Section 1396a(a)(37)(A) requires 90% of claims for covered services "for which no further written information or substantiation is required in order to make payment," i.e., clean claims, to be paid

---

not the State. 42 U.S.C. § 1396u-2(b)(2); 42 C.F.R. § 438.114(c)(1)(i).

within 30 days of receipt, and 99% within 90 days of receipt (the "Timely Payment Clause").[3]

The Timely Payment Clause is enforceable by States against MCOs via contractual claims and by providers via their own respective contracts with MCOs, or via available state administrative remedies. The Seventh Circuit held that the Timely Payment Clause is also enforceable via a federal lawsuit to compel States to take some undefined action to "ensure that providers receive prompt payment from MCOs." Pet. App. 38a–39a.

The Seventh Circuit understood that creating this heretofore unknown right could have consequences that "cause a massive disruption to the State's Medicaid program." Pet. App. 40a (internal quotation marks omitted). And it will—in more ways than the Seventh Circuit appreciated—by adding tremendous costs, uncertainty, and risk for the managed care system and its millions of beneficiaries.

First, the new right permits contracted providers to evade and ignore the bargained-for dispute resolution mechanisms established in their agreements with MCOs, which typically require binding arbitration. This violates settled federal policy in favor of arbitration and undermines the expectations on which plan and provider business relationships were built: that disputes will be

[3] There is no dispute that Illinois incorporated the required provisions into its MCO agreements. Pet. App. 59a (Brennan, J., dissenting) ("the Hospital admits that the State's contracts do include the necessary payment provisions").

resolved in an efficient and cost-effective manner, including in arbitration, state-court contract litigation, or available state administrative proceedings. Contrary to those expectations, the decision below risks embroiling States and MCOs in expensive, uncertain, and prolonged federal court litigation that the contracts, and indeed the entire statutorily designed structure of managed care, were designed to avoid.

Second, the new right will impose tremendous burdens on States and federal courts, and inevitably burden the Medicaid system with additional costs because payment issues are a fact-intensive inquiry that will require a deep dive into the adjudication of countless claims. This is so because only claims that meet the contractual standards for payment (clean claims) must be paid promptly. To determine if violations of the Timely Payment Clause occurred, craft an injunction to avoid future violations, and monitor compliance, States and courts will have to first determine if claims are clean, including being for covered services, timely submitted, and inclusive of all information needed for adjudication. A dispute over prompt payment is inherently a contractual reimbursement dispute to decide if claims are covered and otherwise payable. It is well-suited for existing dispute resolution forums and, as the Seventh Circuit recognized, "inappropriate" for federal courts. Pet. App. 40a–41a ("requiring the district court to adjudicate issues at the claim-by-claim level . . . would be inappropriate").

Third, the Seventh Circuit created tremendous uncertainty and risk in failing to specify the boundaries of the new right or possible remedies. It

understood that some parameters are required and held that only alleged systemic failures open federal court doors. "[R]etail-level relief," or "claim-by-claim level" adjudication, "would be inappropriate" for the federal forum. Pet. App. 40a–41a. But it refused to clarify what rises to the level of systemic violation—a standard not tethered to statutory text—inviting countless lawsuits as providers experiment in the art of pleading this new claim. Indeed, it is an untenable distinction since the statutory standard is already a systemic one because it establishes an aggregate performance standard. But if a provider challenges payments, the only way to evaluate compliance is through claim-by-claim analysis. While courts work through the task of defining the threshold, the managed care system will be ensnared in costly lawsuits with uncertain outcomes for years.

Finally, in failing to specify what remedies are available, the Seventh Circuit risks serious harm and disruption of health care for millions of enrollees. As an example, courts are ill-suited to weigh the discretionary issues in determining what quantum of harm or potential harm merits terminating an MCO's state contract and creating disruptions to patients and providers (nonparties who are not before the court) that will ensue. Yet, these are the types of decisions that are foisted on the federal courts by the decision below.

The Seventh Circuit acknowledged that this is a "high stakes" case for stakeholders in the Medicaid system, and that lower courts may impose "judicial relief that would be hard to justify," and handle this case (and others like it) in "poor ways[.]" Pet. App.

12a, 48a. The stakes of experimentation gone awry are too high to open the door by inventing this new right. Given the significant consequences for Medicaid managed care programs nationwide involving dozens of States, millions of people, and hundreds of billions of dollars in spending each year, the Court should grant the petition and reverse the ruling of the Seventh Circuit.

ARGUMENT

I. Inventing a Novel and Unjustified Private Right of Action Carries High Stakes.

A. The Seventh Circuit's Decision Will Adversely Impact Managed Care Programs Affecting Millions of Enrollees and Hundreds of Billions of Dollars in Expenditures.

Medicaid is the joint state-federal program to provide health coverage to low-income individuals, established under title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1 *et seq., Harris v. McRae*, 448 U.S. 297, 308 (1980). Medicaid covers around 80 million enrollees.[4] With expenditures in 2021 of over $740 billion, Medicaid is one of the largest payors in the U.S. health care system.[5]

---

[4] CMS, *August 2022 Medicaid & CHIP Enrollment Data Highlights*, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html (last visited Jan. 3, 2023).

[5] Health Management Assocs., *Medicaid Managed Care Spending Tops $420 Billion in 2021* (Sept. 1, 2022), https://www.healthmanagement.com/blog/medicaid-managed-care-spending-tops-420-billion-in-2021; Cong. Rsch. Serv.,

Congress gave States great flexibility in administering their Medicaid programs. *See* 42 U.S.C. §§ 1396a(a)(5), (23), 1396u-2. In exercising that discretion, States have overwhelmingly chosen managed care delivery systems. Under the traditional fee-for-service model, a single state Medicaid agency pays providers the rates specified in the state plan for covered health care services. Under the managed care model, States pay MCOs a capitation rate—a fixed dollar payment per member per month (PMPM) and shift the risk of cost variability and burdens of claims processing and other administration to MCOs.[6] In exchange for these PMPM payments, States require MCOs to provide or arrange for the provision of a defined set of services to each person enrolled in the plan. *See* 42 U.S.C. §§ 1396a(a)(10), 1396u-2(b)(1), (2).

Over 70% of Medicaid beneficiaries and over 50% of Medicaid expenditures are in managed care.[7] Forty states plus the District of Columbia enroll at least some of their beneficiaries in comprehensive

Medicaid: An Overview, at 1 (updated Feb. 22, 2021), https://crsreports.congress.gov/product/pdf/R/R43357.

[6] Medicaid & CHIP Payment & Access Comm'n (MACPAC), *Provider Payment and Delivery Systems*, https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems (last visited Jan. 3, 2023).

[7] Kaiser Family Found. (KFF), *Total Medicaid MCO Enrollment* (updated July 1, 2020), https://www.kff.org/other/state-indicator/total-medicaid-mco-enrollment; KFF, *Total Medicaid MCO Spending* (updated Aug. 2022), https://www.kff.org/other/state-indicator/total-medicaid-mco-spending.

risk-based managed care plans.[8] Illinois has embraced the managed care model and has followed this national trend since 2006. MCOs now cover over 70% of Illinois Medicaid beneficiaries (over 2.1 million people and over $10 billion per year). Pet. App. 15a.[9]

B. MCOs Provide Important Benefits for the Health Care System.

The managed care payment model has gained broad acceptance because of the benefits it provides States and beneficiaries, including the ability of States to gain greater control and predictability over Medicaid budgets by paying MCOs a fixed monthly fee, not based on utilization, to provide health care services.[10] The risk of health care costs exceeding the States' payment and the burden of day-to-day plan administration and claims processing is now on the MCOs.[11]

States also have the ability to set and require MCOs to meet health care quality and outcome targets for Medicaid populations—such as

---

[8] Elizabeth Hinton & Lina Stolyar, *10 Things to Know About Medicaid Managed Care*, KFF (Feb. 23, 2022), https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care.

[9] *See also* KFF, *Total Medicaid MCO Enrollment*, *supra* note 7; KFF, *Total Medicaid MCO Spending*, *supra* note 7.

[10] Hinton & Stolyar, *supra* note 8; MACPAC, *Managed Care*, https://www.macpac.gov/topics/managed-care (last visited Jan. 3, 2023).

[11] MACPAC, *Provider Payment and Delivery Systems*, *supra* note 6.

improving disease management, increasing preventative care utilization, and reducing hospitalizations—by tailoring financial incentives, like performance bonuses and penalties, to achieve desired goals. *See* 42 C.F.R. § 438.6.[12]

The managed care model allows for robust care coordination, reduction of wasteful utilization, and incentives for preventative care. MCOs have delivered cost savings and improved outcomes for patients' health and State budgets. For example, MCOs have demonstrated that care can be effectively delivered in lower cost settings, driving nationwide shifts from inpatient to outpatient care; reducing unnecessary hospital admissions, readmissions, and lengths of stay; and increasing access to primary care services.[13]

---

[12] MACPAC, *Provider Payment and Delivery Systems*, *supra* note 6; Hinton & Stolyar, *supra* note 8.

[13] Kathleen Healy-Collier et al., *Medicaid Managed Care Reduced Readmissions for Youth With Type 1 Diabetes*, 22 Am. J. Managed Care 250, 250–51 (Apr. 2016), https://cdn.sanity.io/files/0vv8moc6/ajmc/2b231983beedca72df dac5178de1ba62347e53f1.pdf; Tianyan Hu & Karoline Mortensen, *Mandatory Statewide Medicaid Managed Care in Florida and Hospitalizations for Ambulatory Care Sensitive Conditions*, 53:1 Health Servs. Rsch. 293, 293, 304–06 (Feb. 2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5785303/pdf/ HESR-53-293.pdf; Jungwon Park, *Length of Stay and Inpatient Costs Under Medicaid Managed Care in Florida*, INQUIRY: J. Health Care Org., Provision, and Fin., Oct. 14, 2015, at 1, www.ncbi.nlm.nih.gov/pmc/articles/PMC5813651/pdf/10.1177 _0046958015610762.pdf; Lisa P. Oakley et al., *Oregon's Coordinated Care Organizations and Their Effect on Prenatal*

MCOs also allow States to innovate and address members' total health needs by addressing various social determinants of health in their service offerings. Among other things, MCOs provide referrals to social services, screen enrollees for behavioral health and social needs, and partner with community-based organizations, with the goal of improving health outcomes for State Medicaid populations.[14] The nationwide shift from fee-for-service systems to managed care has occurred in part because MCOs have made these positive contributions to the health care system.

II. In the Managed Care Model, Provider-MCO Disputes Are Governed by Contract Law and State Administrative Remedies.

The Medicaid managed care system is based on contracts, and is subject to strict regulatory oversight. *See, e.g.*, 42 C.F.R. § 438.3 (requiring States to submit MCO contracts to CMS for review and mandating inclusion of specific provisions).

States enter into contracts with MCOs requiring MCOs to provide or arrange for the provision of covered services to state Medicaid enrollees in exchange for a PMPM capitation payment. *See* 42

Care Utilization Among Medicaid Enrollees, 21 Maternal & Child Health J. 1784 (Sept. 2017).

[14] Hinton & Stolyar, *supra* note 8; The Commonwealth Fund, *How States Are Using Comprehensive Medicaid Managed Care to Strengthen and Improve Primary Health Care* (July 30, 2020), https://www.commonwealthfund.org/publications/issue-briefs/2020/jul/how-states-are-using-comprehensive-medicaid-managed-care.

U.S.C. §§ 1396b(m)(2)(A), 1396u-2(f).[15] MCOs contract with providers, who ultimately deliver the services. *Id.*; Pet. App. 14a. Providers that contract with MCOs willingly choose to participate in the Medicaid program and enter into agreements with plans.

MCO agreements with providers cover all aspects of their relationship.[16] In relevant part, as illustrated by the contracts at issue here, they detail requirements for claim submission, processing, and reimbursement procedures, and establish a dispute resolution process:

- Providers must submit claims for reimbursement within time frames set forth in the agreement, typically within 180 days of rendering a service. N.D. Ill. Dkt. No. 78-1 at p. 14 ¶ 4.2.2 (Meridian Health Plan Illinois Hospital Agreement with Saint Anthony Hospital (Meridian HSA)).

---

[15] *See, e.g.*, State of Illinois Contract Between Department of Healthcare and Family Services and [Model Contract] for Furnishing Health Services by a Managed Care Organization (Illinois Model MCO Contract), https://www2.illinois.gov/hfs/SiteCollectionDocuments/2018MODELCONTRACTadministrationcopy.pdf (last visited Jan. 3, 2023).

[16] A limited exception from this framework is out-of-network emergency services, which are not at issue in this case. Those are governed by extensive rules specifically applicable to those services.

- Plans will pay a "clean claim" within a certain number of days of receipt, typically 30 days. Meridian HSA at p. 14 ¶ 4.3.
- Among other things, a clean claim:
    - is submitted within the time frame required under the agreement;
    - contains all information necessary for processing and payment, such as accurate provider and patient name, date of service, insurance plan, and proper codes indicating services rendered;
    - is for a service covered under the agreement.
    - is for a medically necessary service;
    - is for a member enrolled in the plan; and
    - is not a duplicate claim. Meridian HSA at pp. 5–6 ¶ 1.3; Illinois Model MCO Contract, *supra* note 15, ¶ 5.29.

Provider-MCO contracts may include a prompt payment schedule. If not, State contracts with MCOs require MCOs to reimburse, in the aggregate, 90% of clean claims for covered services within 30 days of receipt, and 99% of all clean claims within 90 days. 42 U.S.C. §§ 1396a(a)(37)(A), 1396u-2(f); Illinois Model MCO Contract, *supra* note 15, ¶ 5.29.

If disputes arise between MCOs and providers, contracts spell out the dispute resolution

mechanisms and available remedies that govern the dispute. By way of example:

- Providers can submit requests for appeal or reconsideration of adverse claims decisions within specified time frames. N.D. Ill. Dkt. No. 83-2 at pp. 57–59 (Illinicare Health Provider Manual describing provider complaint process).
- Plans and providers must provide notice of all billing disputes and make a good faith effort to negotiate and resolve them. Meridian HSA at pp. 15–16 ¶¶ 4.9, 6.1.
- If negotiation fails, either party may request mediation. Meridian HSA at p. 16 ¶ 6.2.1.
- If the parties do not mediate, or mediation does not resolve the dispute, either party may seek binding arbitration. Meridian HSA at p. 16 ¶ 6.2.2.
- If there are no alternative dispute resolution provisions in the contract, the provider has whatever state law contract rights and remedies that are available in state court litigation.

Ultimately, the relationship between MCOs and providers is governed by those parties' contracts, and contract law controls the handling of disputes.

States have provided additional administrative remedies, such as mechanisms for providers to submit grievances or complaints about payment, and tools to remedy violations, not limited to imposing monetary sanctions, placing MCOs on

corrective action plans, and terminating the contractual relationship with the MCOs. For example, in Illinois the Department of Healthcare and Family Services maintains a provider complaint portal through which providers can submit unresolved disputes with MCOs. The regulator can, among other things, make MCOs pay claims, and its decisions are final. 305 Ill. Comp. Stat. Ann. 5/5-30.1(g-8); Illinois Model MCO Contract, *supra* note 15 ¶¶ 7.16, 7.16.9, 8.5. Similarly, in California, providers may submit complaints about unfair payment patterns, and other grievances, to the Department of Managed Health Care. *See, e.g.*, Cal. Health & Saf. Code § 1371.39(a).

States across the country have adopted mechanisms allowing for the expeditious submission and resolution of provider disputes. *See, e.g.*, Ariz. Rev. Stat. Ann. § 36-2903.01.B.4 (Arizona grievances and appeal system); Ark. Code Ann. §§ 20-77-1701 *et seq*. (Arkansas Medicaid Fairness Act); N.M. Code R. § 8.308.15.10 (New Mexico provider appeal rights against MCOs); 40 Pa. Stat. Ann. § 991.2161 (Pennsylvania grievances and appeals system); Tenn. Code Ann. § 56-32-126 (Tennessee prompt payment requirements and dispute resolution).

The foregoing contractual and administrative remedies can address (and have addressed) any dispute that may arise between the parties over payment.

III. Creating a New Federal Private Right of Action to Allow Providers to Evade Contractual Dispute Resolution Mechanisms or State Contract Law Will Inject Costs and Uncertainty into the Medicaid Managed Care System.

A. Creating a New Private Right of Action Disrupts Existing Contract Dispute Resolution Procedures and Ignores the Parties' Bargained-for Terms.

Claims reimbursement disputes between providers and MCOs are an inevitable part of doing business and are expressly accounted for in parties' agreements. MCOs process extremely large numbers of claims, and mistakes sometimes occur. Providers sometimes input incorrect procedure or diagnosis codes, omit necessary information, or submit claims to the wrong payor. Payors may misread or miss information provided or apply an incorrect rate. Parties may also have substantive disagreements: Was a service covered? Was it medically necessary? Was it performed in an appropriate clinical setting?

Agreed-upon dispute resolution procedures in contracts add value to the health care delivery system by encouraging less costly and less time-consuming informal resolution processes and minimizing disruption to the parties' ongoing business operations. *See AT&T Mobility LLC v. Concepcion*, 563 U.S. 333, 344 (2011) ("The point of affording parties' discretion in designing arbitration processes is to allow for efficient, streamlined procedures").

The private right of action created by the Seventh Circuit eviscerates these benefits by enabling providers to ignore their contracts and march into federal court over claims disputes. It also conflicts with the parties' bargained-for rights to channel disputes into arbitration. Enforcing arbitration rights is a well-established federal policy. *See, e.g.*, *Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc.*, 473 U.S. 614, 626–28 (1985); *Moses H. Cone Mem'l Hosp. v. Mercury Constr. Corp.*, 460 U.S. 1, 24 (1983).

The Seventh Circuit's decision to rewrite the law rests fundamentally on an unfounded assumption—that contract law cannot remedy alleged breaches because "[a]rbitration provisions in . . . contracts would likely require arbitration for each individual claim in dispute," necessitating "thousands of individual" arbitrations. Pet. App. 17a. The opposite is true. Payors and providers often engage in arbitrations or state court contract litigation to address broad reimbursement issues across extended time periods and numerous claims. The extensive authority given to arbitrators and state court judges to provide relief is more than adequate to leave reimbursement disputes in their hands. And there is no indication on the record here that Saint Anthony's allegations of underpayment by Illinois MCOs require a novel federal remedy because they could not be resolved via contractual remedies. Saint Anthony never tried to assert its contractual rights.

The Seventh Circuit contends that the new right is justified because it concerns not individual claims disputes, but alleged systemic violations. But the case that would be heard in federal court is

fundamentally comprised of individual claim adjudications, and calling this a "systemic" question does not create a distinct species of conflict. Timely payment disputes always involve aggregate assessments of MCO payments, which inevitably require review of individual claim adjudications to assess whether each claim was clean and when it became clean: Was the claim accurate, and did it contain all the necessary and required information? Did it pertain to covered services? Was it timely submitted? These inquiries involve contractual questions that should be, as they always have been, resolved in arbitration, state courts, or state administrative proceedings, and not in federal court under a newly created federal right found in no federal statute or regulation. *See* Pet. App. 69a (Brennan, J., dissenting) ("Congress's chosen tools for ensuring prompt payment" are "private suits and arbitration by healthcare providers against MCOs, along with discretionary enforcement by states").

B. A Federal Private Right of Action for Prompt Payment Violations Would Unnecessarily Burden States and Federal Courts Without Evidence that Presently Available Remedies Cannot Resolve These Disputes.

Because examination of underlying claims is unavoidable if a provider contests timely payment, the new right of action would require States, and ultimately federal courts, to micromanage MCO claims adjudication. Indeed, States would have to engage in parallel claims processing and real-time dispute resolution to avoid being hauled into federal court for failing to ensure that MCOs promptly pay.

Pet. App. 71a (Brennan, J., dissenting) ("'day-to-day' functions and enforcement are returned to the states"). Federal courts would likewise have to examine the minutiae of individual claim determinations to see whether they satisfy the aggregate standard. Pet. App. 70a (Brennan, J., dissenting) ("[A] district court can hardly decide if an MCO has systemically underperformed if it does not examine claims for untimely payment on the merits, and then determine whether the 'systemic' threshold has been reached.").

The Seventh Circuit acknowledged that managed care claims processing is a task Congress intended to be handled by MCOs, with the goal of limiting administrative burdens on States: "We recognize that part of the rationale for adopting the managed-care model was to ease the State's administrative burden. Measures that would force [the State] to take a more aggressive oversight role could reduce some of the administrative benefits the State hoped to gain by the switch to managed care." Pet. App. 44a; *see also* Pet. App. 62a (Brennan, J., dissenting) ("[T]he managed care structure was designed to alleviate the burden on states of managing the 'day-to-day' functions previously performed by states under a fee-for-service system.").

The Seventh Circuit also acknowledged that claims disputes are not an appropriate area for federal courts: "any form of retail-level relief, i.e., requiring the district court to adjudicate issues at the claim-by-claim level[] would strain judicial resources . . . ." Pet. App. 40a. "A process that required a district judge to micromanage claims would be inappropriate here." Pet. App. 41a.

But "micromanag[ing] claims" is precisely what this new right of action would require. MCOs and States would be forced to abandon efficient processes and procedures in place, state contract law would be ignored, and federal courts would be forced into the role of super claims administrator.

Caution and prudence would dictate that prior to enacting a new federal right of action—not found in any statute or regulation—to force States to "ensure" that timely payments are made by MCOs, one would at least first determine whether existing remedies, including enforcement of the MCO-provider contract under State contract law, are insufficient. There is no such evidence—arbitrations, state contractual claims, and state administrative remedies can and do remedy any MCO noncompliance with the Timely Payment Clause if necessary.

Congress put in place a system that has worked for decades, and there is no reason to change it because one provider refuses to follow the well-established path under contract law to bring its claims.

C. The Unspecified Boundaries and Remedies of the New Right Inject Needless Uncertainty Into the Managed Care System.

The burdens on all stakeholders in the managed care system are exacerbated by the fact that the Seventh Circuit created an expansive legal right for individual providers without providing clarity on the circumstances under which the right applies or

detailing the remedies available to providers in exercising their rights.

The only guidance offered is that the alleged violation must entail something more than a few late payments, but when the failure to comply with the Timely Payment Clause becomes a "systemic problem" is anyone's guess. Pet. App. 46a ("[w]e need not and should not adopt a mathematical definition of 'systemic' failures"). Would a systemic failure occur if MCOs miss the benchmarks over three months? Six? A year? And by how much would they have to miss the benchmark in order to make a new federal remedy available? Would paying 89% of claims within 30 days be a minor problem or a systemic one? Since the Timely Payment Clause is by definition analyzed in the aggregate of all claims, would anything short of perfection in meeting the 30/90 standard be deemed a failure across the system? These quandaries illustrate just how illusory the Seventh Circuit's purported distinction between claim-by-claim adjudication and policing of "systemic failure" in fact is.

The lack of clarity as to what providers must plead in order to avail themselves of the newly created right and the absence of guidance on available remedies invites countless lawsuits by providers looking to circumvent their previously agreed-to contractual dispute resolution mechanisms or other state law remedies. While lower federal courts across the country grapple with these questions, courts, States, MCOs, and providers will be ensnared in years of costly litigation over the nature and scope of claims that could and should have been submitted to cost-

effective contractual and state administrative enforcement mechanisms, including arbitration, in the first instance.

And while the parties experiment in federal courts, the risk of devastating consequences of experimentation gone awry due to the lack of guidance from the statute or the Seventh Circuit hangs over the managed care system. District courts, left to their own devices to experiment with appropriate remedies, have no expertise to weigh the harms of payment disputes to litigants before the courts against harms to the health care delivery system as a whole caused by potential remedial acts, including drastic ones like termination of MCO-State contracts. This is precisely the sort of calculus that calls for the expertise of administrative agencies. If district courts handle disputes between MCOs and providers in "poor ways," they risk disrupting the administration of health care for millions of Medicaid enrollees. Pet. App. 12a. The stakes of the wait-and-see approach adopted by the Seventh Circuit are unjustifiably high.

IV. There Is No Crisis of MCO Late Payments to Necessitate the Seventh Circuit's Drastic Remedy.

Underlying the Seventh Circuit's willingness to create a new, undefined federal right and risk the ensuing "massive disruption" is unjustified hostility to managed care. The Court believes that "[i]t has long been obvious to all that under the managed-care system of Medicaid, MCOs have a powerful incentive to delay payment to providers for as long as possible and ultimately to underpay to maximize

their own profits." Pet. App. 35a. Not only is that conjecture wrong and wholly unsupported, it is completely irrelevant because providers, including the plaintiff here, already have adequate recourse and remedies—the ability to arbitrate or sue in state court and correct the alleged wrongs, or seek administrative relief.

What's more, the Seventh Circuit misunderstands MCO incentives. MCOs are in the business of arranging for the provision of health care services to enrollees primarily through provider networks. Without providers willing to contract with them, MCOs could not operate. *See, e.g.*, 42 C.F.R. § 438.68 (requiring MCOs to have sufficient numbers of providers in network to meet the needs of enrollees). MCOs also have strict limits on profits. Medical Loss Ratio regulations require MCOs to spend 85% of capitation revenue on claims or health care quality improvement activities. States can demand refunds if that standard is not met. Administrative expenses and profits are strictly limited and cannot come at the expense of paying claims. 42 C.F.R. §§ 438.4(b)(9), 438.8(j), (k)(1); Illinois Model MCO Contract ¶ 7.10.8, *supra* note 15. MCOs have no incentive to create a deluge of impoverished providers and would fail if they did.

Indeed, data from Illinois itself shows that at the systemwide level, Illinois MCOs are generally in compliance with their prompt payment obligations. Illinois is required to publish MCO performance data every six months that "identifies the percentage of claims adjudicated within 30, 60, 90, and over 90 days, and the dollar amounts associated with those claims." 305 Ill. Comp. Stat. Ann. 5/5-

30.1(g-6), (g-7). The most recent report covering the first two quarters of fiscal year 2021 shows that all but one MCO met timely payment requirements on the measured metric—institutional hospital claims. They paid 97.7% of claims within 30 days of submission in the first quarter, and 98% in the second.[17] The one MCO that fell short was placed on a corrective action plan and has demonstrated notable improvement.[18] MCOs are not systemically failing to pay providers, and Illinois is not abdicating its obligations to supervise the MCOs.

As another example, Iowa transitioned to risk-based managed care in 2016 and now serves 95% of its members through MCOs. According to its 2021 performance report, Iowa's two accredited MCOs paid non-pharmacy claims, on average, in under 10 days.[19] With the exception of one month in which one of the entities fell slightly short of target (hardly a systemic violation), the MCOs processed between 95% and 99% of claims within 30 days, and between 97% and 100% within 45.[20] The report concluded that "[w]ith exception of July 2020 . . . both MCOs

---

[17] Ill. Dept. of Healthcare & Family Servs., *Analysis of HFS-Contracted MCO Claims Processing and Payment Performance for Services in Q1 and Q2 of CY 2021*, at 21, www2.illinois.gov/hfs/SiteCollectionDocuments/MCOHospitalClaimsProcessingReportQ1AndQ22021.pdf.

[18] *Id.*

[19] Iowa Dept. of Human Servs., *Managed Care Organization (MCO) Annual Performance Report - SFY21* (Dec. 2021), at 11, 13, https://www.legis.iowa.gov/docs/publications/DF/1231688.pdf.

[20] *Id.*

exceeded contractual requirements for percentages of claims paid within 30/45 days."[21]

In other words, the system works, and if failures occur, existing remedies adequately vindicate provider rights without the invention of new uncharted grounds for liability not contemplated by Congress.

CONCLUSION

For the foregoing reasons, the Court should grant the petition and reverse the decision below.

January 6, 2023

Respectfully submitted,

STEPHEN D. LIBOWSKY*
Counsel of Record
MANATT, PHELPS &
PHILLIPS, LLP
151 North Franklin
Street, Suite 2600
Chicago, IL 60606
slibowsky@manatt.com
(312) 477-4798

MICHAEL KOLBER
MANATT, PHELPS &
PHILLIPS, LLP
7 Times Square
New York, NY 10036

MARINA SHVARTS
MANATT, PHELPS &
PHILLIPS, LLP
2049 Century Park
East, Suite 1700
Los Angeles, CA 90067

Counsel for Amicus Curiae
Medicaid Health Plans of America

---

[21] *Id.* at 4.