No. 21-2325

IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

SAINT ANTHONY HOSPITAL,

Plaintiff-Appellant,

v.

ELIZABETH M. WHITEHORN, in her official capacity as Director of the Illinois Department of Healthcare and Family Services,

Defendant-Appellee,

And

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

Intervening Defendants-Appellees.

On Appeal from the United States District Court for the Northern District of Illinois, Eastern Division.
On Remand from the Supreme Court of the United States.
No. 1:20-cv-02561.The Honorable Steven C. Seeger

BRIEF OF MEDICAID HEALTH PLANS OF AMERICA AS *AMICUS CURIAE* IN SUPPORT OF DEFENDANTS-APPELLEES' PETITIONS FOR REHEARING OR FOR REHEARING *EN BANC*

Stephen D. Libowsky
MANATT, PHELPS & PHILLIPS, LLP
151 N. Franklin Street, Suite 2600
Chicago, IL 60606
(312) 529-6300/Fax (312) 529-6300
slibowsky@manatt.com

Michael Kolber
MANATT, PHELPS & PHILLIPS, LLP
7 Times Square
New York, NY 10036
(212) 790-4500/Fax (212) 790-4545
mkolber@manatt.com

Attorneys for Amicus Curiae
Medicaid Health Plans of America

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Attorney's Printed Name: Stephen D. Libowsky

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Address: 151 N. Franklin Street, Suite 2600

Chicago, IL 60606

Phone Number: 312-529-6300 Fax Number: 312-529-6315

E-Mail Address: slibowsky@manatt.com

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STATEMENT OF INTEREST[1]

Amicus curiae Medicaid Health Plans of America (MHPA) is a nonprofit trade association of Medicaid managed care organizations (MCOs), representing more than 150 MCOs who currently serve nearly 48 million Medicaid beneficiaries in 40 states, the District of Columbia, and Puerto Rico. MHPA's members include for-profit and nonprofit entities, and national and regional MCOs. Since 1995, MHPA has promoted the interests of the MCO industry through federal advocacy, research, and educational materials.

MHPA has an interest in maintaining and expanding managed care's benefits and to prevent policy changes that undermine Medicaid managed care. MHPA has an overall perspective of how the Medicaid managed care system operates. That perspective is crucial to understanding how the panel's unprecedented decision impacts the efficient and cost effective administration of benefits for millions of people who rely on Medicaid for their health care.

[1] MHPA's counsel authored this entire brief. No party, party's counsel or any other person, other than MHPA, contributed money that was intended to fund the brief. MHPA is filing a motion with this brief under Rule 29(b)(2).

SUMMARY OF ARGUMENT

This case should have been a routine reimbursement dispute between a hospital and the health plans with which it contracted. An Illinois hospital alleged that Medicaid MCOs failed to pay claims timely in accordance with their contracts. The panel decision encourages litigants to abandon the effective and well-established path to resolve these disputes—suits or arbitrations for contract damages, state administrative remedies, or both—in favor of an unprecedented opportunity to litigate contract disputes as purported infringements of federal rights by the State.

The panel decision threatens to upturn Congress' careful and longstanding design of the managed care system—the mechanism by which millions of people receive healthcare throughout the Seventh Circuit—by creating a novel and previously unknown right. In managed care, providers' health care claims for reimbursement are adjudicated by MCOs, and any disputes are resolved through contract suits or arbitration or regulatory oversight.[2] The panel decision rewrites this effective and enduring reality.

Contractual relationships and their enforcement are at the heart of the managed care system, which covers approximately 85% of the nation's 77 million Medicaid enrollees: States contract with MCOs to provide or arrange for health care services to Medicaid beneficiaries. MCOs in turn contract with

[2] A limited caveat, irrelevant to this case, exists for non-contracted emergency service providers entitled to receive payment under federal law, 42 U.S.C. § 1396u-2(b)(2).

providers to deliver those services. The federal Medicaid statute governs each contract.

Section 1932(f) of the Social Security Act, 42 U.S.C. § 1396u-2(f), from which the panel holds that its new-found 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 within 30 days of receipt, and 99% within 90 days of receipt.

States enforce these payment schedules through regulatory oversight of MCOs and, when necessary, by exercising their contractual rights. Providers can and do litigate the timeliness of payment as contract claims against MCOs. But the panel found an additional mechanism to enforce payment schedules: § 1396u-2(f) is made enforceable via a federal lawsuit to compel

States to take some undefined action to "try to ensure that the MCOs actually pay providers" promptly. A.7.[3]

The panel decision upturns Congress' design by requiring States and federal courts to adjudicate individual healthcare claims, the role the statute specifically assigns to MCOs. Under the panel decision, States and federal courts would need to do so because only claims that meet the contractual standards for payment (clean claims) must be paid promptly. To determine violations of the statute, States and courts will have to decide if the claims in dispute are "clean"—inclusive of all information needed for adjudication. This makes a dispute over prompt payment inherently suited for existing contract dispute resolution mechanisms and, as the panel recognized, "inappropriate" to be resolved under this novel cause of action. A.25.

The panel decision creates tremendous uncertainty and risk by failing to specify the boundaries of the new right or possible remedies. The panel appeared to provide some guardrails by opining that "retail-level relief" or "claim-by-claim level" adjudication "would be inappropriate" in a § 1983 suit, and only "systemic" violations are actionable. A.25. But the panel did not clarify what rises to the level of systemic violation—a standard not tethered to statutory text—inviting countless lawsuits. Nor does it appear the panel understood that any "systemic" relief necessarily involves claim-by-claim

[3] "A." refers to the appendix to the State's Petition for Rehearing or Rehearing En Banc.

assessment, as adjudication of the obligation to pay a certain percentage of clean claims within a specified time period inevitably requires determining which claims are clean and which are not.

The panel acknowledged that this is a "high stakes" case for stakeholders in the Medicaid system, and that lower courts may handle this case (and others like it) in "poor ways[.]" A.2, 31. The immense disruption of injecting States and federal courts into managed care claim adjudication requires this Court to reconsider the panel decision.

ARGUMENT

I. Transforming a Contract Dispute into an Action To Enforce Federal Rights Against a State Official Ignores How Congress Designed Medicaid Managed Care.

Under Medicaid, the joint state-federal program to provide health coverage to low-income individuals, states typically contract with Medicaid MCOs to arrange and pay for covered items and services, in exchange for a fixed monthly payment from the State for each enrollee. *See* 42 U.S.C. §§ 1396b(m), 1396u-2. States have overwhelmingly chosen to implement Medicaid via managed care because it provides financial predictability, administrative simplicity, and improved outcomes, as compared to the traditional model where a State Medicaid agency is directly responsible for processing and paying healthcare providers' claims. MCOs cover 77% of

Illinois Medicaid beneficiaries (over 2.6 million people representing $19 billion in Medicaid spending each year).[4]

Managed care allows for robust care coordination, reduction of wasteful utilization, and incentives for preventative care. 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.[5] The nationwide shift from fee-for-service systems to managed care has occurred because MCOs have made these positive contributions to the health care system.

Section 1396u-2(f) is one important aspect of the Medicaid statute's regulation of the contracts between States and MCOs, and, indirectly, between MCOs and providers—far from unambiguously conferring an "individual federal right" required to make a statute enforceable under

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[4] Centers for Medicare & Medicaid Services, Managed Care Enrollment Summary, https://data.medicaid.gov/dataset/52ed908b-0cb8-5dd2-846d-99d4af12b369/data?conditions[0][property]=year&conditions[0][value]=2021&conditions[0][operator]=%3D (July 21, 2023); KFF, Total Medicaid MCO Spending, https://www.kff.org/other/state-indicator/total-medicaid-mco-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[5] *See, e.g.*, Anna Chorniy et al., Exploding Asthma and ADHD Caseloads: The Role of Medicaid Managed Care, 60 J. Health Econ. 1 (July 2018); 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); *see generally* Sellers Dorsey et al., 2022 State of Medicaid Managed Care Report 49-54.

§ 1983. *Health & Hosp. Corp. of Marion Cnty. v. Talevski*, 143 S. Ct. 1444, 1455 (2023).

The panel's decision rewrites the statute to bestow an *individual* federal right to providers and rests on an unfounded assumption—that contract law cannot remedy alleged breaches because "[a]rbitration provisions in . . . contracts might well require arbitration for each individual claim in dispute," necessitating "thousands of individual" arbitrations. A.6. The opposite is actually true. Payors and providers regularly engage in arbitrations or contract litigation to address reimbursement issues, including payment schedules. The extensive authority given to arbitrators and state court judges to provide relief is more than adequate to leave reimbursement disputes in their hands. Illinois Constitution, Article VI; 6 C.F.R. § 502.407. And here, there is no indication that plaintiff's allegations of underpayment by Illinois MCOs require a novel federal right and remedy because they could not be resolved via contractual remedies. The plaintiff never even tried to assert its contractual rights against the MCOs.

The panel tried to limit the sweep of this new right by claiming it would be limited only to "systemic" violations—to be defined in future cases. But such cases would necessarily be comprised of individual claim adjudications; timely payment disputes involve aggregate assessments of MCO claim payments, which inevitably require review of each individual claim adjudication to assess whether each claim was clean, when it became clean,

and when was it paid. *Cf.* A.48 (Brennan, J., dissenting) (claims of systemic delay or underpayment "necessarily involves adjudicating the underlying claims on the merits"). These contractual questions should be, as they always have been, resolved as contract disputes, or in state administrative proceedings, not in a federal court enforcing a nonexistent federal right.

The panel even acknowledged that claims disputes are not appropriate to resolve under § 1983: "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 . . . ." A.25. "A process that required a district judge to micromanage claims would be inappropriate here." *Id.*

The panel's lack of clarity as to what providers must plead to avail themselves of the newly created right invites countless lawsuits by providers looking to circumvent their previously agreed-to contractual dispute resolution mechanisms. In the system Congress established, regulators, not courts, determine when MCOs are engaging in noncompliance that requires sanctions, including up to termination of a MCO's contract. Nothing in this case, where the plaintiff did not even try to resolve the dispute using its contract remedies, suggests there is any need for courts to meddle in how regulators exercise their administrative discretion.

II. Enforcement Under § 1983 Is Inconsistent with the Comprehensive Contractual Enforcement Congress Designed.

Enforcement of the § 1396u-2(f) via § 1983 is inconsistent with the comprehensive enforcement scheme Congress designed: Medicaid managed care is based on contracts and is subject to strict regulatory oversight. *See, e.g.*, 42 U.S.C. § 1396b(m)(2)(A) (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 per-member per-month capitation payment. *See id.*[6] MCOs contract with providers, who deliver healthcare services. *Id.* 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. 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 within time frames set forth in the agreement, typically within 180 days of rendering a service. N.D. Ill.

[6] *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://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/healthchoiceillinoiscontractmodeltemplate.pdf.

Dkt. No. 78-1 at p. 14 ¶ 4.2.2 (Meridian Health Plan Illinois Hospital Agreement with Saint Anthony Hospital (Meridian HSA)).

- 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:
    - contains all information necessary for processing: date of service, insurance plan, and codes indicating services rendered;
    - is for a service covered under the agreement; and
    - is for a member enrolled in the plan. Meridian HSA at pp. 5–6 ¶ 1.3; Illinois Model MCO Contract, *supra* note 6, ¶ 5.29.

Provider-MCO contracts 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 6, ¶ 5.29.

If disputes arise between MCOs and providers, contracts specifically spell out the dispute resolution mechanisms and available remedies that govern the dispute. For 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 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, the provider has contract rights and remedies.

The Medicaid statute requires that states establish intermediate sanctions, such as monetary penalties and appointment of temporary management, to enforce MCOs' obligations. 42 U.S.C. § 1396u-2(e). For example, Illinois maintains a provider complaint portal for providers to submit unresolved disputes. 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 6 ¶¶ 7.16, 7.16.9, 8.5. Contract and administrative remedies can and do address disputes that may arise between the parties over payment.

III. There Is No Crisis of MCO Late Payments.

Underlying the panel's creation of a new, undefined federal right and risk the ensuing "massive disruption" is an incorrect and unjustified hostility to managed care. The panel 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." A.18. Not only is that conjecture wrong and wholly unsupported, but it is also completely irrelevant because providers, including the plaintiff here, already have adequate recourse and remedies—the ability to arbitrate or sue and correct alleged wrongs, or seek administrative relief. No § 1983 right of action is necessary.

Indeed, Illinois MCOs comply with their payment obligations. The State's recent report covering the second half of fiscal year 2022 shows that all but one MCO met timely payment requirements. Excluding that one MCO, the remaining MCOs were paying at least 95% of claims within 30 days, and, across all MCOs, 98.97% of hospital claims were being paid within 90 days of receipt. HFS monitors MCO performance,[7] and, as the panel acknowledged, has imposed a corrective action plan on the one noncompliant MCO. A.29. MCOs are not systemically failing to pay providers timely, and Illinois has not abdicated its obligations to supervise the MCOs. 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.

[7] Ill. Dep't of Healthcare & Family Services, Analysis of HFS-Contracted MCO Claims Processing and Payment Performance For Services in Q3 and Q4 of CY 2022, https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/mcohospitalclaimsprocessingreportq3andq42022.pdf, at 9-10.

CONCLUSION

For the foregoing reasons, the Court should grant the petition for rehearing, or in the alternative, grant the petition for rehearing banc.

June 6, 2024

MANATT, PHELPS & PHILLIPS, LLP

By: *s/Stephen D. Libowsky*

Stephen D. Libowsky
Michael Kolber
MANATT, PHELPS & PHILLIPS, LLP

Attorneys for Amicus Curiae
Medicaid Health Plans of America

CERTIFICATE OF COMPLIANCE

This amicus brief complies with this Court's length limitation because it contains **2,583** words, excluding exempted parts of the brief. This brief also complies with this Court's typeface and typestyle requirements because it has been prepared in a proportionally spaced typeface using Microsoft Word in 13-point Century Schoolbook font.

Dated: June 6, 2024

MANATT, PHELPS & PHILLIPS, LLP

By: *s/Stephen D. Libowsky*

Attorney for Amicus Curiae
Medicaid Health Plans of America

CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing document with the Clerk of the Court for the United States Court of Appeals for the Seventh Circuit by using the appellate CM/ECF system. I certify that all participants in the case are registered CM/ECF users, and that service will be accomplished by the appellate CM/ECF system.

Dated: June 6, 2024

MANATT, PHELPS & PHILLIPS, LLP

By: *s/ Stephen D. Libowsky*

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