

AHCA/NCAL MANAGED CARE PLAYBOOK

This guide is designed to assist American Health Care Association members operating Skilled Nursing Facilities (“SNFs”) and Assisted Living Facilities (“ALFs”) to better negotiate the terms of their agreements with Medicare Advantage (“MA”) and Medicaid Managed Care (“MMC”) plans. It is also intended to provide guidance on the following issues:

- I. The legal authority of the Centers for Medicare and Medicaid Services (“CMS”) and individual state governments to oversee, and intervene in, contractual relationships between SNFs/ALFs and MA / MMC plans
- II. Strategies to address common disputes between SNFs/ALFs and MA / MMC plans; and
- III. Legal actions available to SNFs/ALFs to enforce their rights through litigation against MA / MMC plans.

As a preliminary matter, it is worth noting that health care providers’ managed care agreements increasingly require the provider and the plan to resolve any disputes through arbitration. As a result, there is limited case law to serve as precedent in future disputes or to guide providers seeking to understand the legal landscape. This Playbook thus draws from statutes, regulations, agency guidance and our members’ common experience to provide insight into providers’ rights vis-à-vis MA and MMC plans.

I. CMS and State Government Oversight of Contractual Relationships

It is important for members to understand some of the important legal principles that govern these types of plans. More specifically, it is important how the law impacts the negotiation of agreements with these types of plans and, ultimately, the enforcement of their terms.

A. MA Plans

As is the case under original Medicare, MA plans are required to provide “extended care services”¹ to their members requiring post-acute care and treatment in skilled nursing facilities

¹ The term “extended care services” means the following items and services furnished to an inpatient of a skilled nursing facility (SNF) either directly or under arrangements as noted in the list below:

- Nursing care provided by or under the supervision of a registered professional nurse;
- Bed and board in connection with furnishing of such nursing care; • Physical or occupational therapy and/or speech-language pathology services furnished by the skilled nursing facility or by others under arrangements with them made by the facility;

(SNFs). MA plans are not required to apply the requirement of a three-day qualifying stay for their members to receive SNF services and the clear majority of MA plans do not apply this requirement. In an effort to contain costs, MA plans often exercise tight oversight of SNF length stays through authorization and utilization processes which do not apply under original Medicare. As a result, SNF lengths of stays covered by MA plans are typically less than those in the Medicare Part A fee-for-service (FFS) system.

The law governing MA plans is almost entirely federal in nature. While states establish, implement, and enforce general health maintenance organization (HMO) insurance licensure requirements for MA plans, the administration of the MA program is otherwise governed by federal law. Under this law, CMS is prohibited from intervening in the terms of the agreements (and particularly the rates of payment). Therefore, these terms are left up to the MA plan and the provider to negotiate directly.

In addition, CMS and states take a “hands-off” approach to relationships between providers and MA plans, so there is little oversight of MA plan practices relating to provider agreements. Unfortunately, this often works to the disadvantage of SNFs and other providers in that MA plans typically have far more leverage in the contracting process, particularly in service areas where there are a higher number of SNFs and/or there are lower SNF occupancy rates. Similarly, and considering disparities in bargaining positions, providers may feel hesitant to vigorously enforce the terms of their agreements. For example, providers may fear that they will be terminated from the network, lose preferred provider status, or receive lower reimbursement rates if they seek to enforce the terms of their agreements. These are the unfortunate realities of doing business with MA plans in the current environment.

In contrast, CMS exercises far more enforcement and oversight over the treatment of patients enrolled with MA plans. For example, grievances, appeals, and other disputes between enrollees and MA plans are counted as part of the CMS Five-Star Quality Rating System, which has a direct impact on the revenues of MA plans. Also, enrollees may appeal coverage decisions under a multi-step process, including internal plan appeals and independent review appeals. The timing of these reviews will vary according to the urgency of the proposed or pre-existing services. For example, this process would allow enrollees to remain at their respective settings of treatment (hospital, SNF, or other location) until the appeal is decided. This higher degree of oversight regarding treatment of enrollees is, in large part, mandated by Congress through legislation passed in 1997 and 2003.

B. MMC Plans

MMC plans covering Managed Long Term Services and Supports (“MLTSS”) are required to provide Medicaid benefits for long term services and supports (LTSS). Unlike the Medicare program, each state’s Medicaid program is regulated under both state and federal law, including

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- Medical social services;
 - Such drugs, biologicals, supplies, appliances, and equipment, furnished for use in the skilled nursing facility, as are ordinarily furnished by such facility for the care and treatment of inpatients;
 - Medical services provided by an intern or resident-in-training of a hospital with which the facility has in effect a transfer agreement under an approved teaching program of the hospital, and other diagnostic or therapeutic services provided by a hospital with which the facility has such an agreement in effect, and
 - Other services necessary to the health of the patients as are generally provided by skilled nursing facilities, or by others under arrangements

the terms of the individual state's Medicaid State Plan and any related Medicaid waivers, both of which are subject to CMS approval and oversight.

State Medicaid programs that utilize MMC plans come in many different shapes and sizes. While there are federal regulations governing the use of MMC (including the delivery of MLTSS) that place various requirements on the states and participating health plans, states have significant leeway in designing MMC programs and overseeing and enforcing plan compliance with program requirements as well as their compliance with state licensing provisions.

For example, subject to federal approval, states may establish minimum or maximum reimbursement rates that MMC plans are required to pay to providers offering MLTSS. These state requirements are commonly referred to as "rate floors" and are enforceable against MMC plans under state law.

States also can require that MMC plans: (1) follow all the requirements established by the Medicaid fee-for-service program in authorizing and paying for covered services, (2) pay clean claims submitted by providers within certain established timeframes, (3) apply a state-approved definition of a "clean claim," (4) pay interest on late claims made to providers, and (5) meet certain standards of network adequacy for MLTSS. State Medicaid agencies may impose corrective and enforcement actions, including levying fines, against MMC plans that employ unfair practices relating to their administration of claims and other business practices.

Finally, states can authorize MMC plans to redirect beneficiaries to receive different levels of care or to receive care in different settings before the beneficiary is admitted to a SNF. For example, the MMC plan may direct the patient to receive in-home services or to an assisted living facility. Whenever an MMC plan directs patient care in this fashion, providers should ensure that there is legal authority under state law, the State Medicaid Plan, or the State Waiver request for the plan to do so.

Providers need to understand, and advocate for, any state policy that requires MMC plans to be accountable for implementing certain care and payment policies. The ability of the state Medicaid agency to apply corrective and enforcement actions against MMC plans that do not adhere to the rules is crucial.

In addition to any state statutes applicable to the MMC program, in most instances, the terms of the MMC program will be contained in the State Medicaid Plan or Waiver Request submitted to CMS by the applicable "single state agency." That agency is commonly known as the "Department of Health" or a similar reference and will be primarily responsible for the MMC program.

However, there is also likely a state agency with licensing authority over MMC plans. This may be a state's "Department of Insurance," "Department of Managed Care," or a similar reference that has enforcement authority over claims practices, including payment delays and unfair claims practices. It is essential for providers to understand, and advocate for, greater MMC plan accountability through both types of agencies. There are some types of MMC plans that are exempt from licensure but these are largely limited to County Operated Health Systems ("COHS"), which are non-profit organizations established by county authorities. All the other types of plans (particularly the large commercial plans) will be licensed by the insurance licensure authority and subject to enforcement authority.

MMC programs are required by federal and state law to focus on the well-being of enrollees. These programs must implement systems to ensure beneficiary access to various sources of information and support. Federal law requires additional state support for beneficiaries receiving MLTSS services. These types of issues are likely to be overseen by the “single state agency” rather than the insurance licensure authority. However, unfair coverage practices should fall within the enforcement jurisdiction of both types of agencies.

II. Non-Litigation Strategies to Address Common Disputes between SNFs and Plans

A. Insufficiency of Payment Rates

Renegotiation Strategies. When a plan’s reimbursement rates are unsustainably low, or the plan’s behaviors make the relationship unworkable, it might be time to revisit the managed care agreement. A plan may be enticed to negotiate if it believes that it may lose a valuable in-network provider. This may be an empty threat, however, if leaving a particular MA or MMC plan’s network simply is not a viable option for the SNF or ALF. This will depend on the plan’s penetration in the market, SNF / ALF occupancy rates in the plan’s service area, the facility’s typical census and payor mix, and whether loss of the facility as an in-network provider would cause network adequacy problems for the plan.

Historically, MA plan network adequacy has not been closely overseen by CMS. This lack of oversight combined with narrowing provider networks has led to a backlash, resulting in more significant oversight that will officially start in 2019, when CMS will start reviewing MA plan networks on three-year cycles rather than only when an MA plan applies or renews its status in the program. CMS will also conduct intermediate full network reviews under certain circumstances, such as when Medicare beneficiaries report access issues. Further, new federal guidelines allow CMS to conduct network adequacy review when a managed care agreement between an MA plan and a provider is terminated if CMS determines the agreement to be “significant,” in which case CMS may request to review the network to ensure the MA plan’s ongoing compliance with network adequacy requirements.² This additional oversight should translate to more provider leverage in geographic areas where network adequacy is already precarious. Such leverage is decreased by certain limitations of CMS’s network adequacy reviews, which are largely based upon MA plan self-reporting, possibly inaccurate provider network directories, and CMS’ primary emphasis on geography-based provider-to-enrollee ratios. SNF network adequacy metrics look at the number of staffed, Medicare beds under contract, but actual SNF bed availability and variances in specialization (e.g., emphasis on stroke rehabilitation versus orthopedic or cardiac rehabilitation) are not an area of emphasis. Nevertheless, if factually grounded, potential network inadequacies maybe an important tool in negotiations with MA plans.

² Medicare Managed Care Manual, Chapter 4.

MMC plan network adequacy varies from state to state. States that more tightly monitor network adequacy often publish particular network adequacy standards that, in the case of SNFs, may include (1) a specific number of average SNF bed availability per capita per county, (2) requirements to contract for certain types of MLTSS (e.g., long-term care behavioral services), and (3) limits on driving time between facilities and certain residential areas. MMC plans usually must file network adequacy reports with state oversight agencies on an annual basis.

Network adequacy reports filed by MA and MMC plans are publicly available, and thus should be studied by SNFs and ALFs before embarking on negotiations or re-negotiations with such plans. But such reports may not always be accurate. For example, in January 2017, CMS determined that 45.1% of MA plan provider directories reviewed by CMS were inaccurate.³ Nevertheless, it is wise to review such reports, verify their accuracy as to the SNF's particular geographic area, and understand how the SNF assists the MA or MMC plan with its network adequacy. Sometimes, the plan representatives are not even aware that loss of a particular managed care agreement with a SNF would create network inadequacy until this is shown to the plan representatives during a renegotiation discussion.

Additionally, proving to the plan that the current managed care rates are insufficient is often important to a successful renegotiation. SNFs that know, by diagnosis and associated acuity, their actual costs of care can show the inadequacy of reimbursement rates. Calculation of actual costs is far more compelling than simply arguing that the current rates are lower than other plans. Inclusion of “soft” costs in the calculations, such as staffing costs associated with tedious plan requirements such as onerous prior authorization requirements, responses to requests for additional records, and other plan-created tasks, is fair and appropriate in any cost discussion.

Negotiate for Single Case Rates. Under MMC, in circumstances where the rates are not acceptable for one or more specific enrollees, CMS has acknowledged that an MMC plan and a SNF or ALF can negotiate a one-time “single case agreement” to negotiate an appropriate reimbursement rate without forcing the MMC plan and the provider to renegotiate their entire managed care agreement.⁴ The facility's incentive to negotiate a single case agreement might depend on whether the state has set a rate floor that would protect it from low reimbursement in the event the agreement is terminated during a resident's stay.

Similarly, in both the Medicare and Medicaid context, there may be opportunities to negotiate single case agreements in excess of any legally required minimum rates even if the facility *has* left a particular plan's network. For example, even though Medicare requires MA plans to reimburse out-of-network providers on par with Medicare Part A rates, there may be an opportunity to negotiate a single case rate that exceeds that FFS amount. These negotiations could take place on a case-by-case basis if the plan is seeking to place a particular enrollee in that facility based on the facility's location, reputation, or clinical areas of expertise. In those circumstances, the facility might be well-positioned to negotiate for an appropriate reimbursement rate for that enrollee.

Threaten Termination. When dealing with an MMC plan, a SNF or ALF might find itself in a better position to bargain when multiple enrollees of the plan currently reside in the facility. Federal regulations provide that enrollees have the opportunity to disenroll from that MMC plan

³ Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance, <https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/2018-Network-Adequacy-Guidance.pdf>.

⁴ 81 Fed. Reg. 27498, 27622.

and enroll in another if the facility transitions to out-of-network status during the enrollee’s stay.⁵ This allows the facility to recommend to enrollees and their families that they consider changing to a different MMC plan with which the facility will remain in-network. Accordingly, MMC plans typically fear termination of a managed care agreement because it usually triggers loss of enrollees.

Addressing the Insufficiency of Tiered Rates. Typically, the methodologies employed by MA plans regarding SNF payment are based upon either (1) specified per diem “levels” or “tiers” representing the frequency and intensity of nursing, therapy, and other services provided by the SNF given the acuity of the enrollee, or (2) a percentage (usually within the range of 80-100%) of the per diem rate established by the Medicare Part A program. MA plans exercise tight oversight of the individual per diem rates covering the stays of their enrollees. In addition, average SNF lengths of stay for MA plan enrollees is substantially less than Medicare Part A enrollees.

Often, the difficulty with MA plans is not the tiered rates themselves, but the failure of the plan to pre-authorize services at the higher level / acuity categories. As part of the prior authorization process, which does not exist for Medicare Part A enrollees, MA plans often attempt to disagree with SNFs about whether particular patients are justifiably attributed to a higher tier. These debates, in large part, are clinically-focused and involve the SNF debating with a utilization reviewer from the MA plan, who may or may not be a nurse or physician. The problem is compounded by the SNF’s need to move quickly and admit the patient from the hospital or other care setting before the prior authorization debate with the MA plan has been resolved. Of course, once the enrollee is admitted, the SNF may lose some leverage with the MA plan in a negotiation of the proper tier during the prior. Good strategies for dealing with these types of disputes are: (1) involve the SNF Director of Nursing, the enrollee’s attending physician, the SNF Medical Director, and/or SNF therapy provider in any acuity discussions – MA plans are more reluctant to deny higher level tier status if supported by such clinicians; (2) for MA plans that consistently and improperly deny higher-level tier status, the SNF should document the frequency and key details of such instances in a single spreadsheet – this can be used by the SNF during subsequent managed care agreement renewal discussions, in a direct complaint to the CMS Regional Office, and in communications with the MA plan representatives and any state-level insurance oversight agencies; and (3) promptly notify the enrollee of the MA plan’s decision and the enrollee’s appeal rights, and assist the enrollee with appealing the decision (see the discussion of “organizational decision” appeals below in [Section III](#)).

B. Prompt Payment Problems

Federal law requires that MA plans include a “prompt payment” provision in their provider agreements but does not dictate the timeframe. Claims submitted by non-contracted providers must be paid within 60 days, so MA plan contracts often use this 60-day timeframe as the contractual prompt payment deadline.

In contrast, state law typically specifies prompt payment requirements for MMC plans, which may be found in state statutes, state insurance agency regulations, or state Medicaid program regulations. In some cases, state law applicable to MMC plans is similar to federal law for MA

⁵ See 42 C.F.R. § 438.56.

plans, in that state law may simply require the existence of a prompt payment requirement in a MMC agreement without dictating a maximum number of days for payment.

Despite the existence of such prompt payment provisions in statute, regulation, or in contract, providers often report delays in payment from MA and MMC plans. In some instances, a plan may not have any interest or late fee penalties to which it is subject, so the failure to meet the prompt payment requirement is inconsequential to the plan. In addition, for MMC plans, state law provides a margin of error for the plan that applies to its claims from all providers (e.g., a plan must pay only 90% or some other percentage of its claims on time), thus allowing the MMC plan to pay certain types of providers late while still meeting the percentage threshold. Lastly, a common tactic used by plans is to allege that they are not beyond the prompt payment deadline because the providers' claims at issue were not "clean claims" as required by law or the managed care agreement.

The more effective strategies for dealing with such disputes are to ensure that the managed care agreement contains: (1) interest penalties and attorney fee reimbursement provisions that make it less likely a plan will pay a claim late, (2) a percentage threshold for paying claims on time that is specific to the facility (*i.e.*, the plan must pay 95% of the facility's claims on-time – not just 95% of claims from all providers); and (3) a good, and objective rather than subjective, definition of a "clean claim" (e.g., "For purposes of this Agreement, a 'clean claim' means a claim which contains all of the data elements required by form [UB-92][UB-04][CMS 1500][CMS 1450]."). If, despite the existence of such language in the managed care agreement or applicable law, the plan nonetheless ignores prompt payment requirements, then, in addition to threatening or filing breach of contract litigation, a formal complaint to the state insurance licensing agency is usually recommended.

It is also important for the SNF or ALF to understand its own clean claim rate ("CCR"), calculated by dividing the number of claims that pass all plan edits (thus requiring no manual intervention), by the total number of claims filed. The CCR should be calculated for each separate plan with which the facility contracts. If the definition of "clean claim" is similar for two different health plans, but the CCR for one plan is 95% and the CCR for the second plan is 65%, then the facility may be able to demonstrate that the second plan's software or payment policies are flawed. Such documented discrepancies can be helpful in discussions with the plans, complaints to the state insurance licensing agency, complaints to CMS or the state Medicaid program, and in litigation. Consistently monitoring CCR has the ancillary benefit of allowing a facility to quickly determine whether changes in billing software, billing staff, or other systems are causing a downward spike in CCR that may be unrelated to plan payment policies.

C. Retroactive Utilization Review

There are three types of plan utilization review: prior authorization review (conducted before or at the time care commences), concurrent review (conducted during the SNF or ALF stay), and retroactive review (conducted after the facility stay concludes). Although certain problems arise out of prior authorization and concurrent review (such as the failure to approve certain tiered levels of care as discussed above), the most troublesome form of utilization review is often retroactive review because the facility has already provided the services to the enrollee (a) in reliance upon certain reimbursement rates, and (b) based on a community standards of care, which may dictate a certain level of care regardless of such rates. Of course, it is not a defense to a medical malpractice lawsuit that the MA or MMC plan involved provides inadequate reimbursement.

Often, even after making prior authorizations for services based on medical necessity documentation, a plan will retroactively request medical records information and seek to recoup payments made for particular enrollees. Of course, an absolute prohibition on reversals of prior authorizations once made is the provider-friendly approach and does exist in many managed care agreements.⁶ Alternatively, facilities should attempt to ensure that managed care agreements prevent reversals of prior authorizations unless the plan can prove that (1) the facility knowingly provided inaccurate or false information at the time of the prior authorization, or (2) the facility failed to provide material information that (a) was available to the facility at the time of the prior authorization and (b) if such material information had been known to the plan at the time of its prior authorization, it would not have approved the prior authorization.

Additionally, because of the inherent subjectivity involved in retroactive utilization review, if possible, a facilities should track the identity of the plan’s reviewers. Facilities that have done this historically have been able to show that certain reviewers reverse prior authorizations significantly more often than other reviewers. Identifying the clinical credentials of such reviewers as part of the tracking may also show that certain reviewers without strong clinical backgrounds are much more likely to reverse prior authorizations – such tracking information can be useful in meetings with plans, appeals of specific denials, communications with CMS and state oversight agencies, and in litigation.

D. Unilateral Amendments to Provider Agreements and Manuals by Plans

Most managed care agreements allow the plan to unilaterally amend key terms and provisions at any time, and sometimes without even providing advance written notice. Plans maintain that they need such flexibility to administer hundreds or thousands of agreements and to respond quickly to policy and coverage decisions by CMS and state MLTSS programs. But the ability to unilaterally amend an agreement, administrative manual (sometimes referred to as the “provider manual”), reimbursement rates, and payment policies should not be unfettered. The agreement can state that unilateral amendments are allowed only if the amendment is required by law or a coverage decision by CMS or the state MLTSS program. The agreement may also stipulate that the plan: (1) must provide affirmative written notice in the form of a letter or email to the SNF in the event of any unilateral change, identifying the specific document and provision in the document that has been changed; (2) must give the SNF at least 30, 60, or 90 days’ notice before implementing any such change; (3) may not change its fee schedule more than once per 12-month period; and (4) must allow a provider to terminate the agreement within 30 days of receiving the written notice of change. Such requirements would avoid historic problems faced by providers who are unaware of unilateral changes because they receive no advanced written notice.

Under MMC, SNFs should also check applicable state laws and regulations. Many states have statutes that mandate the measures listed in the paragraph above even if the managed care agreement does not. But many states do not have such statutes or, if they do, such statutes may not apply to the MMC plans contracting with SNF providers.

⁶ For example, such a clause may state: “The Plan acknowledges and agrees that it may not reverse, to the Facility’s detriment, a prior authorization determination made pursuant to this Agreement; provided, however, that the foregoing prohibition shall not be construed as preventing the Plan from implementing the required outcomes of any appeals process for appeals made by, or validly made on behalf of, the affected patient.”

Plans sometimes abuse the unilateral amendment rights they may have. For example, MA plans have attempted to circumvent termination without cause notice requirements that require 90 days' advance written notice through an "amendment" process, whereby the MA plans impermissibly terminated the network status of certain providers through a 30-day written notice of "amendment." Accordingly, even when unilateral amendment is permitted, the scope of what may be unilaterally amended likely is limited to specific changes, and unilateral amendments may not effectively modify certain material terms of the agreement, such as the notice required for termination of the agreement.

III. Enforcement of Provider Rights

In a dispute with a managed care plan, an individual provider – or even a sizable chain – may feel outmatched, and filing a lawsuit may seem like the only way to get the plan to come to the table. Though litigation (or the threat of litigation) is an extremely important tool in resolving disputes with plans, it is also costly and time-consuming, and litigation in the highly-regulated Medicare and Medicaid spaces poses its own challenges. Before delving into the special considerations relevant to litigation against an MA / MMC plan, we have therefore identified possible alternatives sources of pressure that may be just as effective in changing a plan's behavior.

A. Non-Litigation Options to Resolve SNF-Plan Disputes

Approaching the Regulators. MA plans are directly regulated by CMS, while MMC plans are regulated by one or more state agencies. In both cases, an agency responsible for monitoring the plan's behavior typically can take enforcement actions against the plan for noncompliance with legal requirements, or even to terminate the plan's agreement to provide services to Medicare or Medicaid patients in future years. Some states, such as New York have mechanisms in place for providers to submit complaints against an MMC plan without engaging in a formal appeal or legal challenge. Some of these states, like California and Illinois, may require you to present your complaint to the plan itself before complaining to the state oversight agency.⁷

In either case, lodging an informal or formal complaint with the regulating agency may prompt the agency to investigate or take further action against a plan, which may be enough to get the plan to correct its behavior. Typically, under MMC, state agencies with oversight authority will promptly investigate complaints promptly by making direct inquiry to the plan, asking for its written response to the provider's complaint and requesting supporting information. If a provider's complaint to the state agency is sufficiently detailed and accompanied by supporting evidence, the state agency's investigation is normally detailed. This approach has successfully altered plan behavior for many providers. Although it is possible to file anonymous complaints as well under circumstances where the provider fears retaliation by the plan, anonymous complaints often are not taken as seriously, or investigated as thoroughly by the state agency. Indeed, one of the benefits to filing a conspicuous, rather than anonymous, claim with the regulating agency is to make sure the plan knows the provider organization has actually lodged the complaint – most plans are less likely to

⁷ The mechanism to raise a complaint against an MMC plan varies across states. In New York, for example, provider complaints are directed to different agencies depending on the nature of the complaint: while complaints regarding payment denials are directed to the Department of Health, complaints regarding late payments are directed to the Department of Financial Services. In California, complaints against a MMC plan should be directed to the Department of Managed Health Care. In neither case does the complaint trigger a legal proceeding; rather, the state agency seeks to resolve the issue informally.

anger a provider in the future that has demonstrated it will, under appropriate circumstances, file a complaint with the regulating agency.

Political Avenues. In some cases, the regulating agency may not be receptive to complaints, or take the position that policing the plan's conduct falls outside its purview. This may be the case where the problematic behavior is not the subject of any law or regulation, and simply represents a managed care plan exercising its market power or behaving in ways that are governed by the managed care agreement with the provider. Also, in states where multiple health plans have left the marketplace altogether, a state agency may be less aggressive in asserting its oversight. Nevertheless, a political body that is interested in ensuring its constituents' access to care may be interested in assisting a provider. Where the plan's behavior threatens a provider's ability to keep its doors open and continue to serve a certain patient population, policy makers at the local, state, or federal level may be interested in mediating a solution that prevents those outcomes. In many states, patient-focused consumer nonprofit organizations exist, and they frequently partner with provider groups in jointly addressing concerns about plan conduct.

B. Legal Action Against Managed Care Plans

MA and MMC plans are highly regulated by the state and federal governments in the benefits they provide and their interactions with Medicare and Medicaid enrollees. As a result, certain issues can be resolved only in an administrative forum, where the government plays a special role in determining the outcome of any dispute, or there may be no legal basis for a claim at all if the federal Medicare law has preempted any state law provider protections. In contrast, other claims may be treated like any other managed care contract dispute and subject to the dispute resolution provisions of the agreement. Though the procedural requirements to bring a claim will thus vary based on the program involved (Medicare or Medicaid), the state, and the terms of the managed care agreement itself, we have attempted to describe general considerations a SNF should consider before pursuing legal action against an MA or MMC plan below.

The managed care agreement may require providers to bring any claim against the plan through arbitration and/or on an individual basis. The first step in determining how to proceed against a plan is always reviewing the managed care agreement. In many cases, these agreements may require the parties to resolve their disputes in arbitration, rather than through civil litigation. The arbitration agreement may contain a number of other parameters that impact the evaluation of whether it is worth pursuing the claim. For example, although it may be cost-effective to bring a claim in concert with other providers facing the same issues with that plan, managed care agreements often include language that bars providers from bringing the equivalent of a class action through arbitration. Similarly, they may bar litigants from seeking equitable relief or appealing an unfavorable decision.

The contract language may also impose procedural limitations that will determine how the arbitration is conducted. For example, the agreement will most likely specify the organization that will conduct the arbitration, the most common being the American Arbitration Association (AAA), JAMS, or the American Health Lawyers Association (AHLA). The agreement may also set forth requirements for the arbitrator, such as experience resolving health care disputes, or whether a panel of arbitrators will be used instead of a single arbitrator. Finally, the agreement may specify where the arbitration will take place and the discovery rules that will apply. All of these variables will determine how the arbitration proceeds and whether it is worthwhile to pursue the claim at all.

The nature of the dispute will determine whether a provider must proceed through administrative channels before going to court, and whether the claim is barred altogether.

Depending on the substance of its complaint against a plan, a provider may be required to wade through an administrative appeals process *before* bringing the claim in court, or a provider may be barred from bringing the claim at all. When a provider seeks to enforce its contractual rights under the managed care agreement, however, a provider can typically pursue the claim directly in court without seeking administrative review, much like legal challenges against any other managed care plan.

- ***Disputes Related to Enrollee Benefits and Coverage.*** Under MA, if a claim “arises under” the federal Medicare law, or is “inextricably intertwined with a claim for Medicare benefits,” then it may be subject to the administrative review procedures that CMS has established to challenge certain decisions made by MA plans.⁸ The decisions subject to this appeals process, which are called “organization determinations,” typically center on enrollee benefits or coverage issues. These issues include decisions respecting payment for care, the MA plan’s “refusal to provide or pay for services,” or the MA plan’s failure to or delay in approving care. Examples of claims subject to the administrative process include provider challenges to an MA plan’s medical necessity determination or a claim by an out-of-network provider against an MA plan for payment.⁹
- ***Administrative Appeals.*** Appealing through administrative channels can be time-consuming and costly, because the process involves reconsideration by the MA plan, a CMS contractor, and/or CMS itself, all before the claim can be taken to court. Moreover, the appeal requires quick action – most initial requests must be made within 60 days of the organization determination, unless the MA plan has terminated provider services that had previously been authorized, in which case a “fast-track appeal” must be initiated within a day. The challenge must be brought on behalf of a particular patient, and the provider must waive its right to payment from the patient for the service at issue.

Guidance from Medicare suggests that only an out-of-network provider can use these administrative channels to challenge an MA plan’s organization determinations on behalf of a patient.¹⁰ While courts disagree on whether the law actually allows a contracted provider to bring such a claim, even if the administrative channel *is* available to a contracted provider, the reality is that most challenges brought by a contracted provider must be resolved through arbitration pursuant to the managed care agreement.¹¹

Together, these factors may explain why these appeals are quite rare. A recent study found that just 1% of MA plans’ denials of coverage or payment were appealed by the enrollee or provider

⁸ *Do Sung Uhm v. Humana, Inc.*, 620 F.3d 1134, 1141 (9th Cir. 2010); *Rencare, Ltd. v. Humana Health Plan of Tex., Inc.*, 395 F.3d 555, 557-558 (5th Cir. 2004).

⁹ *United Behavioral Health v. Maricopa Integrated Health Sys.*, 240 Ariz. 118, 125 (2016); *Tenet Healthsystem GB, Inc. v. Care Improvement Plus*, 875 F.3d 584 (11th Cir. 2017); *Prime Healthcare Huntington Beach, LLC v. SCAN Health Plan*, 210 F.Supp.3d 1225 (C.D.Cal. 2016).

¹⁰ Medicare Managed Care Manual, Chapter 13, Section 70.1.

¹¹ *Prime Healthcare Servs., et al. v. Humana Ins. Co.*, Case No. 16-1097 (E.D. Cal. 2018); *United Behavioral Health v. Maricopa Integrated Health Sys.*, 240 Ariz. 118, 125 (2016).

to the first level of appeal.¹² However, the same study found that these appeals are overwhelmingly successful, and 75% of denials of coverage were overturned in whole or in part through the administrative process.

The federal grievance and appeal processes for MMC plans resemble the processes for MA, though it only provides for one level of appeal.¹³ Like in the Medicare context, the regulations specify that a provider may appeal on a patient's behalf with the patient's permission, though only if state law allows it.¹⁴ Though the determination of whether a provider's claim is subject to administrative review may be based on similar considerations to the Medicare context, state law may impact this analysis.¹⁵

Disputes Based on State Law. Some courts have concluded that state law generally applicable to health plans *cannot* be applied in the MA context, because federal law preempts most state efforts to regulate MA plans. For example, a group of hospitals were unsuccessful in their effort to enforce a Texas prompt pay statute against an MA plan, because federal Medicare regulations already require an MA plan to incorporate prompt pay provisions in its agreements with providers. The court concluded that the state statute did not apply to the health plan's MA line of business, even though it was more specific and more protective of providers than the MA regulation regarding prompt pay.¹⁶ As discussed earlier, the only topics that the Medicare statute leaves to the states to regulate on their own are "State licensing laws or State laws relating to plan solvency," which can be the basis for legal challenges against an MA plan.¹⁷

In contrast, the MMC statutes give states wide latitude to regulate MMC plans directly, so a court is less likely to determine that an action against an MMC plan based in state law is entirely preempted. For example, providers may consider bringing an action against a plan based on its violation of the state's prohibition on unfair business practices. In some states, the statute supplies a cause of action in the event of a violation of any law that constitutes an unfair business practice.¹⁸

Disputes Related to the Plan's Breach of Contract. If the dispute involves the plan's performance under the managed care agreement – for example, payment of agreed-upon reimbursement rates or compliance with the agreement's prompt pay provisions – there is typically no need to pursue the claim through administrative channels, and the claim can be pursued in court from the outset. This is because the dispute is "solely between" the plan and provider, and is "based on the parties' privately-agreed-to payment plan," rather than the

¹² HHS Office of Inspector General: Medicare Advantage Appeal Outcome and Audit Findings Raise Concerns About Service and Payment Denials, OEI-09-16-00410 (September 2018).

¹³ 42 C.F.R. § 438.400.

¹⁴ 42 C.F.R. § 438.402.

¹⁵ See, e.g., *Pentskiff Interpreting Servs. v. Dep't of Health*, 2013 UT App. 156 at *7.

¹⁶ *Houston Methodist Hosp. v. Humana Ins. Co.*, 266 F.Supp.3d 939 (S.D. Tex. 2017).

¹⁷ 42 U.S.C. § 1395w-26(b).

¹⁸ *Samura v. Kaiser Foundation Health Plan, Inc.*, 17 Cal. App. 4th 1284, 1299-1300 (1993) (explaining that some violations of the Knox-Keene Act, which governs managed care plans in California, can serve as the basis for an unfair competition claim brought under California Business & Professions Code).

regulatory scheme that governs MA or MLTSS benefits.¹⁹ However, these breach of contract actions may be subject to arbitration provisions.

MA and MMC Response to Provider Litigation. MA and MMC plans may use several stalling tactics when faced with legal challenges. For example, a plan may claim that a claim should have been brought through administrative channels rather than litigation, raising the same issues described above; if the plan successfully argues that the provider must exhaust administrative review, this may have the effect of defeating the claim altogether if the time for seeking administrative review has passed. For example, in the MA context, a request for reconsideration of an organization determination must be made within 60 days from the date of notice of the MA plan's decision.²⁰

Another common stalling tactic is to attempt to insist that a case brought in state court belongs in federal court. MA and MMC plans might attempt to “remove” a case to federal court if the dispute involves questions of federal law. Though all cases involving Medicare and Medicaid managed care involve federal law to some extent, if the parties are not from different states, removal is only appropriate if the case “arise[s] under” federal law. In both the MA and the MMC context, courts have concluded that claims brought under state law or under the managed care agreement itself do not necessarily belong in federal court.²¹ Although the removal of a case to federal court may cause an approximately 30-day delay, SNFs should not be concerned about litigating a dispute in federal court rather than state court.

To dissuade a provider from proceeding against it, an MA or MMC plan may claim that it at some point overpaid the provider and seek to recoup those payments in the same litigation or arbitration in which the provider is pursuing its own claims against the plan. The purported overpayment may be unsubstantiated and unrelated to the subject matter of the provider's claim, but the plan's claim can be a significant deterrent to continuing an action against the plan. A provider might conclude that the risk that the plan prevails (and the provider, accordingly, owes money to the plan) is so great that it cannot follow through with its action against the plan.

Finally, when faced with valid provider litigation claims, whether in court or in an arbitration setting, MA and MMC plans frequently initially defend the case, which may require the provider to provide time-consuming answers to written discovery requests and participate in depositions. A common tactic is for the plan, after the conclusion of the discovery period and on the eve of the trial or hearing, make a settlement offer to the provider to resolve the pending litigation. Essentially, the plan had no intention of proceeding to trial or hearing, but it nonetheless desired to delay its payment obligation to the provider. In such situations, the plan often refuses to pay for the provider's attorney fees, expert witness fees, interest on the principal amount owed, and other costs of filing the court action or arbitration. Nevertheless, it can be difficult for providers in that situation to turn down a settlement offer that equals all or substantially all the value of the denied claims, especially if there are questions as to the validity of some of the claims.

¹⁹ *Rencare*, 395 F.3d at 558; *Prime Healthcare Servs., et al. v. Humana Ins. Co.*, Case No. 16-1097 (E.D. Cal. 2018).

²⁰ 42 C.F.R. § 422.582.

²¹ *PremierTox, Inc. v. Ky. Spirit Health Plan, Inc.*, 2012 U.S. Dist. LEXIS 74672 (W.D. Ky.); *Rencare*, 395 F.3d at 558.