In or Out: Network Adequacy
Regulation and Out-of-Network Litigation

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Health plan enrollment has surged since the federal Affordable Care Act (ACA) became law in 2010. The most explosive growth has been in government-funded health plans: Medicare Advantage (MA) plans, Qualified Health Plans (QHPs) offered on health insurance Exchanges, and managed Medicaid plans. In 2015, MA enrollment increased by more than 1 million, and nearly one in three Medicare beneficiaries (16.8 million) belonged to an MA plan.[1] The Exchanges, which opened in 2014, had a total enrollment in 2015 of 9.9 million members.[2] In 2013, managed Medicaid plans had 44.5 million members in 39 jurisdictions, representing 71.7% of all Medicaid enrollment.[3] That number is projected to grow by 13.5 million by the end of 2016.[4]

It is no secret that government-funded health plans are heavily regulated and face significant cost pressures. So they have increasingly turned to narrow provider networks as a tool for containing costs and offering competitive premiums and cost sharing.[5] The basic goal of a "narrow network" is to deliver increased patient volume (and thus revenue) to the provider in return for lower costs achieved through reduced rates, increased quality, or some combination of the two.

Critics of narrow networks abound. As Modern Healthcare has reported:

> [T]here is significant consumer and provider dissatisfaction with how many of these plans are organized, including concern about inadequate access and information. Critics say insurers have made many missteps in

> building adequate networks and maintaining accurate, up-to-date provider directories. In some rural areas, there are too few in-network providers, forcing plan members to travel long distances to see one.[6]

In response to such dissatisfaction, the Centers for Medicare & Medicaid Services (CMS) have enhanced their network adequacy standards for Medicare Advantage Organizations (MAOs) for 2016. CMS has also proposed enhanced standards for QHPs and Medicaid managed care organizations (MCOs) for 2017.

These trends have significant consequences for providers. For some providers, the payor mix has shifted from traditional Medicare, traditional Medicaid, and employer group plans to government-funded plans. The competition to participate in the provider networks of the government-funded plans has stiffened as the networks have narrowed. At the same time, the legal remedies that out-of-network providers have against some government-funded plans are relatively limited. Out-of-network providers face new constraints on their ability to balance bill members of government-funded and commercial plans, while commercial payors are continuing to sue out-of-network providers to stop improper referrals and cost-sharing waivers.

Not surprisingly, the changing landscape is affecting contract negotiations between payors and providers. The side that understands the network adequacy requirements for government-funded plans, the legal remedies available to payors and out-of-network providers, and the legal constraints on balance billing will have an advantage at the bargaining table. To that end, this paper surveys the network adequacy requirements for MAOs, QHPs, and MCOs. It also analyzes new balance billing developments and recent out-of-network litigation.

I. CMS is expanding its network adequacy standards for MAOs and increasing its enforcement of those standards.

MA is a managed care alternative to traditional Medicare. MAOs offer MA plans pursuant to contracts with HHS.[7] They must comply with the statutes and CMS regulations governing traditional Medicare and the MA program.[8]

A. CMS has established minimum network adequacy standards for MAOs.

CMS regulations require MAOs to ensure that all covered services "are available and accessible under the plan." That is, an MAO must "[m]aintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served."[9] To do so, the MAO must adopt its own written network adequacy standards that meet or exceed the minimum network adequacy standards established by CMS.[10] The CMS standards have three quantitative criteria: (1) a minimum number of providers, (2) a maximum travel time to providers, and (3) a maximum travel distance to providers.[11] MAOs must continuously monitor their networks for compliance with those criteria, and take corrective action as necessary.[12]

The regulations also require disclosures. MAOs must disclose at the time of enrollment (and annually thereafter) "[t]he number, mix, and distribution (addresses) of providers from whom enrollees may reasonably be expected to obtain services … ."[13] In other words, they must disclose their provider directory to MA plan members. MAOs must also make "a good faith effort to provide written notice of a termination of a contracted provider at least 30 calendar days before the termination effective date to all enrollees who are patients seen on a regular basis by a provider … ."[14]

In August 2015, the U.S. Government Accounting Office (GAO) issued a report criticizing CMS' network adequacy standards. The GAO found that CMS' quantitative criteria failed to measure the actual availability of network providers. Additionally, the GAO concluded that CMS applied its quantitative criteria only during the annual application process, did little to test the quantitative data supplied by MAOs during that process, failed to conduct compliance audits, and had not established any requirements for MAO disclosures regarding provider terminations.[15] Perhaps anticipating the GAO's report, CMS announced in its Final Call Letter for 2016 that it would be enhancing its network adequacy standards for MAOs.

B. CMS has enhanced its network adequacy standards for MAOs for 2016 by adding qualitative criteria and expanding enforcement activities.

CMS has announced that in 2016, "[p]roviders whose practices are closed or who are otherwise unavailable cannot be used to successfully meet our network adequacy standards." Going forward, the agency expects that MAOs will "establish and maintain a proactive, structured process that enables them to assess, on a timely basis, the true availability of providers which includes, as needed, an analysis to verify that the provider network is sufficient to provide adequate access … ." An effective process would include "at least monthly" contacts with providers "to ascertain their availability and, specifically, whether they are accepting new patients … ."[16]

MAOs are likewise "expected to update their online provider directories ***in real-time***, which means that MAOs are to make updates when they are notified of changes in a provider's status, or when the MAO itself makes contracting changes to its network of providers."[17] Inaccuracies may be viewed "as an indication that the MAO may be failing

established CMS access standards." CMS intends to enforce its standards through direct monitoring, post-application audits, and compliance and enforcement actions.[18]

CMS' new approach creates ongoing compliance risks for MAOs regarding provider access and availability. Those risks might prompt MAOs to proactively identify and cure any network gaps by contracting with additional providers. Non-contract providers might be able to leverage the same risks to their benefit during contract negotiations. Any added leverage for providers would be significant given that non-contract providers have only limited legal remedies against MAOs.

C. The federal courts are split on whether non-contract providers must pursue claims against MAOs through the administrative process.

The threshold issue in any payment dispute between a non-contract provider and an MAO is whether the non-contract provider's legal claims are ones "arising under" the Medicare Act. Such claims are cognizable only under 42 U.S.C. §§ 1395ii, 405(g), and 405(h), which authorize civil actions for judicial review of final administrative decisions by the Secretary of HHS.[19] "A federal district court does not have subject matter jurisdiction over any claim arising under the Medicare Act until a claimant has first gone through [the HHS] administrative appeals process."[20] "[T]he exhaustion requirement applies to all claims arising under the Medicare Act."[21]

Consistent with this framework, CMS regulations require non-contract providers to challenge MAO "organization determinations" through the administrative appeals process. The non-contract provider's ultimate recourse under the regulations is an action for judicial review against the Secretary of HHS in federal court (assuming that the appeals process is exhausted and the amount-in-controversy requirements is met). The

steps in the administrative appeals process are detailed below.

An MAO has the right to pay—and a non-contract provider is obligated to accept as payment in full—the amount that traditional Medicare would have paid.[22] When the MAO pays below traditional Medicare, CMS encourages the non-contract provider to exhaust the MAO's internal dispute process and take whatever "other actions it deems appropriate."[23] This begs the question of whether "other actions" may include bringing legal claims against the MAO without invoking the administrative process (as CMS requires when challenging an organization determination).

Federal courts disagree on whether federal or state courts have jurisdiction to answer this question. They likewise disagree on whether state common law claims against MAOs arise under the Medicare Act, and must go through the administrative process. The most recent cases addressing these issues are also discussed below.

1. *Challenges to organization determinations conclude with an action for judicial review against the Secretary of HHS in federal court.*

An organization determination is "any determination made by an [MAO] with respect to" payment for any "health services furnished by a provider other than the [MAO] that the enrollee believes … [a]re covered under Medicare" or "[i]f not covered under Medicare, should have been furnished, arranged for, or reimbursed by the [MAO]."[24] Organization determinations include an "[MAO]'s refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the MA organization."[25] For example, coverage denials are organization determinations.

Non-contract providers may request an organization determination as the

representative of an enrollee, or directly.[26] The parties to an organization determination may thus include: the enrollee (including his or her representative); an assignee of the enrollee (that is, a physician or other provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service); or any other provider determined to have an appealable interest in the proceeding.[27] The organization determination is binding on all parties—including any non-contract provider—unless it is reconsidered by the MAO.[28]

As a first step in any Medicare appeal, a non-contract provider may seek reconsideration of an organization determination as a representative of the enrollee.[29] Alternatively, a non-contract provider may seek reconsideration directly if they complete a waiver of liability statement, which provides that they will not bill the enrollee regardless of the outcome of the appeal.[30] After the non-contract provider completes the waiver of liability, the enrollee ceases to have an appealable interest.[31]

If the reconsideration decision is unfavorable, then the matter must be reviewed by an independent outside entity that contracts with HHS.[32] If that outside entity issues an unfavorable decision and the amount-in-controversy threshold is met, then the non-contract provider may appeal a third time by requesting a hearing before an administrative law judge (ALJ).[33] If the decision of the ALJ is unfavorable, then the non-contract provider may file a fourth-level appeal with the Medicare Appeals Council (MAC). The MAC's decision ends the administrative appeals process.[34]

So long as the four levels of the appeals process are exhausted and the amount-in-controversy threshold is met, "any party" may obtain judicial review by suing the

Secretary of HHS in federal district court.[35] The district court conducts judicial review based on the administrative record.

2. *Federal courts split on whether common law claims by non-contract providers arise under the Medicare Act and require administrative exhaustion.*

The U.S. Court of Appeals for the Third Circuit recently held in *MHA LLC v. HealthFirst, Inc.*, No. 15-1715, 2015 WL 7253669 (3d Cir. Nov. 17, 2015), that a non-contract provider's claims against an MAO for unjust enrichment and breach of implied contract belonged in state court. The provider alleged that the MAO "improperly asserted that certain services were not authorized or did not qualify as emergency care, wrongly denied claims as untimely, and/or ignored or refused to process them." Such conduct was supposedly meant to pressure the provider into going in network.

The Third Circuit analyzed the jurisdictional issue by applying the test for embedded federal issues announced by the U.S. Supreme Court in *Grable & Sons Metal Products, Inc. v. Darue Engineering & Manufacturing*, 545 U.S. 308 (2005). Under that test, there is federal jurisdiction if the state law claim necessarily raises a federal issue that is disputed and substantial, and any congressionally approved balance of federal and state jurisdiction will not be disturbed. The Third Circuit found state jurisdiction because the parties' claims and defenses did not require statutory interpretation. Any interpretive questions were not "actually disputed and substantial," and state courts were competent to apply the Medicare laws to the facts. The Third Circuit did not address the issue of administrative exhaustion expressly, beyond remanding to state court.

The Third Circuit declined to follow *New York City Health and Hospitals Corporation v. WellCare of New York, Inc.*, 769 F.Supp.2d 250, 258-59 (S.D.N.Y. 2011),

where a non-contract provider brought common law claims against an MAO to recover alleged underpayments, and the district court found federal jurisdiction under *Grable*. While the district court in *WellCare* found federal jurisdiction, it declined to order administrative exhaustion. It reasoned that "the mandatory administrative review process does not apply to payment disputes between an [MAO] and a Non-Contracted Provider that does not involve government liability or enrollee liability."

The district court in *Ohio State Chiropractic Association v. Humana Health Plan, Inc.*, No. 5:14cv2313, 2015 WL 350391 (N.D.Ohio Jan. 23, 2015) reached the opposite conclusion on the exhaustion issue after exercising removal jurisdiction over the providers' claims against the MAO under the federal officer doctrine. The MAO had recouped alleged overpayments from the providers by reducing subsequent payments to them. The providers responded by suing the MAO in state court for breach of implied contract, and declaratory and injunctive relief. The MAO removed under the theory that it was acting as a federal officer when recouping the overpayments.

The district court found that the providers' action was inexorably intertwined with a claim for Medicare benefits—and arose under the Medicare Act—because any resolution of the MAO's recoupment rights would alter the MA plan's future estimated medical expenses. That alteration would directly impact not only the Government's finances but also future premiums for MA members. The district court accordingly dismissed based on the providers' failures to exhaust administrative remedies[36]

The providers in *Ohio State Chiropractic Association* have appealed the district court's ruling to the U.S. Court of Appeals for the Sixth Circuit. On November 23, 2015,

the Sixth Circuit asked the U.S. Department of Justice (DOJ) to fil an amicus brief on behalf of HHS that addresses the federal officer jurisdiction and administrative exhaustion issues. The DOJ's amicus brief and the Sixth Circuit's forthcoming ruling should inform how payors and providers approach those issues going forward.

II. CMS and the NAIC have proposed new standards for QHPs on network adequacy, provider transitions, and "surprise bills."

Issuers offer QHPs to consumers on the Exchanges created by the ACA. CMS must certify QHPs before they can be offered. QHPs must be recertified annually. During certification and recertification, CMS assesses whether each QHP meets the ACA's network adequacy requirement. Specifically, the ACA requires that each QHP "ensure a sufficient choice of providers … and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers."[37] Each QHP must have a network that is "sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay."[38] Each issuer must "make its provider directory for [its] QHP available to the Exchange for publication online … and to potential enrollees in hard copy upon request. In the provider directory, [the] QHP issuer must identify providers that are not accepting new patients."[39]

On December 2, 2015, CMS proposed a rule for QHPs offered on Federally-facilitated Exchanges (FFEs) that would establish new standards in three areas: (1) network adequacy, (2) provider transitions, and (3) surprise bills. If finalized, the proposed rule would apply to QHP certifications and re-certifications during the 2017 plan year. CMS' proposed rule follows the National Association of Insurance

Commissioner's (NAIC) adoption of its Health Benefit Plan Network Access and Adequacy Model Act on October 12, 2015. The NAIC Model Act addresses the same three issues in a more comprehensive manner. The implications of the proposed rule and the NAIC Model Act are significant for both issuers and providers.

A. CMS' proposed default network adequacy standards for QHPs are similar to the quantitative standards for MA plans, and are therefore favorable to issuers.

CMS' proposed rule enables the States to participate in regulating the network adequacy of QHPs. Under the proposed rule, FFEs would rely on State reviews for network adequacy in States in which an FFE operates, provided that CMS determines that the State uses "an acceptable quantifiable metric commonly used in the health industry to measure network adequacy, approved by HHS."[40] "An acceptable quantifiable metric" would include, at a minimum: (i) CMS' default standard for FFEs, consisting of a county-specific time and distance standard similar to what CMS uses for MA plans; or (ii) prospective minimum provider-covered person ratios for the specialties with the highest utilization rate for the State. In States that do not review for network adequacy, the FFE would conduct an independent review under CMS' default standard for FFEs.[41] Much like MAOs, issuers would be permitted to submit a proposed justification for why any variances are reasonable and should be approved.[42]

The quantitative default standards are not meant to "prohibit narrow networks or otherwise impede innovation in plan design." Rather, they are intended "to establish a minimum floor consistent with the levels generally maintained in the market today."[43] CMS projects that less than 10 percent of QHPs would fall below the standards.[44] So the impact for most issuers should be limited.

Nevertheless, the quantitative default standards are "designed to dovetail" with the NAIC Model Act, and "allow States flexibility to apply a standard that takes into consideration their specific needs."[45] The NAIC Model Act contains a network adequacy standard that requires access "without unreasonable ***travel or*** delay," and is therefore more robust than what appears in CMS's existing regulations.[46] The NAIC Model Act would make the state's Insurance Commissioner responsible for determining network adequacy by reference to "reasonable criteria," which may include both quantitative criteria (e.g., "[w]aiting times for an appointment with participating providers") and qualitative criteria (e.g., "[t]he ability of the network to meet the needs of covered persons, which may include low income persons, children and adults with serious, chronic or complex health conditions or physical or mental disabilities … .").[47]

CMS has solicited comments on "other network adequacy standards that may be appropriate to apply to QHPs in an FFE in future years, including standards included in the [NAIC Model Act]."[48] For example, CMS has solicited comment on whether to add a "wait time standard," and require issuers to survey contracted providers to determine whether they are accepting new patients.[49] This is significant because CMS anticipates that its proposed rule will affect only a small percentage of QHP networks. A transition to the more robust NAIC framework might create pressure on issuers to contract with enough providers to ensure that care is not only accessible but also available.

B. <u>CMS' proposed standards for continuity of care during provider transitions are less flexible than those of the NAIC Model Act</u>.

CMS proposes requiring issuers to make a "good faith effort to provide written notice of discontinuation of a provider 30 days prior to the effective date of the change or

otherwise as soon as practicable, to enrollees who are patients seen on a regular basis by the provider or who receive primary care from the provider."[50] A good faith effort would have to be made regardless of the reason for the discontinuation. For terminations without cause, the issuer would have to permit any enrollee in "active treatment" to continue their treatment until it is complete, or for 90 days, whichever is shorter. The continued treatment would be at in-network cost-sharing rates.[51]

In contrast, the NAIC would require health carriers and participating providers to give at least sixty (60) days written notice to each other before the provider is removed, or leaves the network without cause. The health carrier would have to make a good faith effort to provide written notice within thirty (30) days to all covered persons who are patients seen by the provider on a regular basis, regardless of whether the provider is removed or leaves without cause.[52] If the provider is a primary care professional, then the good faith obligation to provide written notice would extend to all covered persons who are patients.[53] The thirty (30) days would run from the health carrier's issuing or receiving of the notice exchanged with the provider.[54] In addition to providing notice, the health carrier would have to make available to the patient a list of participating providers plus information on how to request continuity of care.[55]

The potential continuity of care period for covered persons undergoing an "active course of treatment" would extend to the earlier of: (a) termination of the course of treatment; (b) ninety (90) days, unless the Medical Director determines that a longer period is necessary; (c) the date that care is successfully transitioned to a participating provider; (d) the date that benefit limitations under the plan are met or exceeded; or (e)

the care becoming medically unnecessary.[56] Continuity of care would be granted by the health carrier only when the provider agrees in writing to continue the terms of its provider contract with the health carrier as to the individual patient, *and* forego seeking payment from the patient beyond what the patient would have owed if the provider was still participating in the health carrier's network.[57]

The NAIC definition of "active course of treatment" and the CMS definition of "active treatment" are the same. Both terms mean: (I) an ongoing course of treatment for a life-threatening condition; (II) an ongoing course of treatment for a serious acute condition; (III) the second or third trimester of pregnancy; or (IV) an ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes.[58] The NAIC also defines the terms "life-threatening health condition" and "serious acute condition."[59] CMS has solicited comment on whether those terms should be defined in its final rule.[60]

The NAIC Model Act is more flexible than the CMS standard when it comes to determining the end date of the continuity of care period. It also conditions the health carrier's continuity of care obligation on the provider's agreement to temporarily continue the prior contractual arrangement. It is thus a mixed bag for health carriers and providers that is less friendly to enrollees than the CMS standard.

C. CMS' proposed standards for out-of-network cost sharing for "surprise bills" are simpler and more provider-friendly than those in the NAIC Model Act.

A so-called "surprise bill" for out-of-network services results when an enrollee chooses an in-network facility, and unknowingly receives services from an out-of-

network provider (*e.g.*, an anesthesiologist) who provides services at the facility. The billed charges for the out-of-network services exceed the in-network allowable. The enrollee must absorb those charges notwithstanding their efforts to obtain only in-network services from the facility and its associated providers.

CMS' proposed rule would protect QHP enrollees from surprise bills by requiring the issuer to choose between two options. The first option would be to count any cost-sharing paid for an essential health benefit furnished by an out-of-network provider in an in-network setting towards the enrollee's annual limit on in-network cost-sharing. The second option would be to provide the enrollee with at least ten business days' written notice that using the out-of-network provider may lead to additional charges (including balance bills) that will ***not*** count towards the annual limit on in-network cost-sharing.[61] CMS' proposed rule ***would not impose any obligations on providers***, nor would it preempt state laws that go further in protecting enrollees from surprise bills.[62]

If adopted, the NAIC Model Act would go beyond than CMS' proposed rule in protecting enrollees. It would do so by imposing requirements on not only health carriers but also non-participating facility-based providers (NFPs) and facilities:

- *Facilities would have to disclose non-emergency out-of-network services*. The facility's written disclosure would have to inform the patient that they might receive out-of-network services from a NFP, describe the range of charges for such services, and inform the patient that they may either accept their charges or invoke their legal remedies. The facility would have to obtain signatures from the inpatients that acknowledge receipt of the disclosures.[63]

- *Health carriers would have to disclose out-of-network non-emergency services.* The health carrier's disclosure would have to occur at pre-certification, and inform the covered person of the potentially higher cost-sharing and balance

billing that would result if a NFP were to perform the services. The notice would also have to state what the plan will pay for the services performed by a NFP, and identify any covered services that are available from participating providers.[64]

- *NFPs would have to give billing notices for out-of-network emergency services.* The NFP's billing notice would have to inform the covered person that they must pay their in-network cost-sharing amount, have no obligation to pay the remaining balance, and should forward the bill to their health carrier for consideration.[65]

- *NFPs would have to limit balance billing.* NFPs would have to provide "patient responsibility notices" informing covered persons that they may: (1) pay the balance bill; or (2) send the bill to their health care plan for processing under the health carrier's NFP billing resolution or mediation process if the delta between the charge and the plan's allowable exceeds a statutory threshold; or (3) rely on other rights or remedies under state law. NFPs who fail to give notice could not balance bill. If the NFP gives notice and the patient invokes dispute resolution, then the NFP could not collect more than the "appropriate cost sharing."[66]

- *Health carriers would have to establish programs for paying NFPs*. Payments by health carriers would be presumptively reasonable if they are based on the higher of the health carrier's contracted rate, or a statutory percentage of the Medicare rate. NFPs that do not accept the payment by the health could elect to mediate with the carrier (and split the costs of the mediation). Only after a failed mediation could the NFP seek a higher amount.[67]

The state Insurance Commissioner would enforce these requirements, together with the state agencies that regulate providers and facilities.[68]

The NAIC Model Act approach bears some similarity to New York's "Emergency Medical Services and Surprise Bills Law," which became effective on March 31, 2015. For example, the New York law requires facilities and physicians to disclose the health care plans in which they participate, as well as the estimated cost of non-emergency services.[69] The disclosure must include the network status of other providers who would

participate in treating the patient yet would bill separately.[70] Additionally, the New York Law limits balance billing by non-participating physicians:

- *Non-emergency Services*. If an insured patient receives services from a non-participating physician, and the physician accepts an assignment of benefits, then the physician cannot balance bill. The payor must pay the physician the billed amount or try to negotiate another amount. If the physician has not accepted an assignment or the patient is uninsured, then the physician may balance bill.[71]

- *Emergency Services*. If the patient is insured and the physician has not accepted an assignment of benefits, then the payor must pay the physician a reasonable fee and ensure that the patient pays no more than if they were in-network. If the patient is uninsured, then the physician may bill the full amount.[72]

If the parties dispute the amount or obligation to pay, then they may pursue the issue in a new dispute resolution program managed by the Department of Financial Services.[73]

On October 16, 2015, New York Attorney General Eric Schneiderman announced settlements of enforcement actions against four urgent care centers for alleged violations of the New York law. Under the settlements, each urgent care center must enhance its disclosures to patients, take steps to ensure that patients do not incur out-of-network costs if the required information is not communicated to the patient, *and require all health care providers at the center to be an in-network participating provider with all health care plans with which the center contracts as an in-network participating provider*.[74] The settlements create a strong incentive for facilities to mitigate compliance risks by insisting that all of their health care providers maintain parallel network contracts.

If additional states enact protections against surprise bills similar to those found in the New York law or the NAIC Model Act, then NFPs may face increased pressure to go in network. The pressure may come from facilities seeking to reduce compliance risks

and administrative burdens. It may also come from issuers that gain the statutory right to make benchmark payments to NFPs that are presumptively reasonable. If the NFP's prospect of recovering more than the benchmark payment is low given the presumption of reasonableness (and any procedural hurdles imposed by statute, such as mediation), then it makes economic and practical sense to go in network. In short, an unintended consequence of surprise bills laws may be increased network contracting.

III. CMS has proposed that the States adopt minimum quantitative network adequacy standards for MCOs due to variations in state requirements.

Most of the States administer their state Medicaid programs by contracting with managed care organizations (MCOs). CMS requires such States to ensure that each MCO "[m]aintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract."[75] Additionally, each MCO must: require its providers to meet State standards for timely access to care and services; ensure that network providers offer hours that are no less than the hours for commercial enrollees; and make services available 24 hours a day, 7 days a week, when medically necessary.[76]

At the time of contracting, the MCO must provide supporting documentation demonstrating that the MCO "[o]ffers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of enrollees for the service area."[77] The documentation must also show that the MCO "[m]aintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area."[78] Such documentation may also be required when there are significant changes in the MCO's operations.[79]

On June 1, 2015, CMS issued a proposed rule that would amend these standards in primarily three respects. First, the network adequacy standard would be strengthened to require that services be available and accessible *in a timely manner*.[80] Second, the proposed rule would require the States to adopt minimum time and distance standards for seven provider types.[81] The States would develop their standards based on seven factors.[82] The standards would apply only to those provider types that are among the seven listed by CMS, and are covered by the State's MCO contract.[83] Third, the MCOs would have to provide supporting documentation of their compliance annually.[84]

These modest reforms may benefit out-of-network providers seeking in-network contracts with MCOs because many current State standards are neither rigorous nor vigorously enforced. Indeed, the HHS Office of Inspector General (OIG) recently surveyed State Medicaid agencies and found that:

> State standards for access to care vary widely. For example, standards range from requiring 1 primary care provider for every 100 enrollees to 1 primary care provider for every 2,500 enrollees. Additionally, standards are often not specific to certain types of providers or to areas of the State. States have different strategies to assess compliance with access standards, but they do not commonly use what are called "direct tests," such as making calls to providers. Further, most States did not identify any violations of their access standards over a 5-year period. …. Finally … CMS provides limited oversight of State access standards.[85]

The OIG also assessed provider availability in Medicaid managed care. Its findings on availability paralleled those which it made regarding access:

> We found that slightly more than half of providers could not offer appointments to enrollees. Notably, 35 percent could not be found at the location listed by the plan, and another 8 percent were at the location but said that they were not participating in the plan. An additional 8 percent were not accepting new patients. Among the providers who offered appointments, the median wait time was 2 weeks. However, over a

> quarter had wait times of more than 1 month, and 10 percent had wait times longer than 2 months. Finally, primary care providers were less likely to offer an appointment than specialists; however, specialists tended to have longer wait times.[86]

In States with lax standards or enforcement, even modest pressure on MCOs to expand their networks may increase the leverage of providers in network contracting.

Any increased leverage could have a significant impact on contract negotiations because of the limited remedies available to out-of-network providers. Federal law authorizes MCOs to pay—and requires out-of-network emergency services providers to accept—the original Medicaid rate as payment in full for emergency services.[87] MCOs are obligated to "adequately and timely" cover out-of-network non-emergency services only if the services are necessary, covered by the State's contract with the MCO, and unavailable through the MCO's network.[88]

Such situations are infrequent due to the pre-authorization regimes of the MCOs. When they do arise, the out-of-network provider must coordinate with the MCO to ensure that the "cost to the enrollee is no greater than it would be if the services were furnished within the network."[89] Some States have adopted regulations mandating the rate payable to the out-of-network provider.[90] Other States have attempted to address the issue in their MCO contracts.[91] If the out-of-network provider is not obligated to accept a specific rate, and cannot agree with the MCO on the amount due, then the state courts are likely to have jurisdiction.[92] A few courts have recognized that out-of-network providers may recover the reasonable value of their services from MCOs under a *quantum meruit* theory.[93] But the law varies by state. And it is underdeveloped. So both sides have a strong incentive to negotiate a reasonable resolution to any payment dispute.

IV. Commercial payors are still on offense against out-of-network providers.

One of the primary goals of any provider network is cost containment. To meet that goal, the payor must limit referrals to out-of-network providers, and maintain financial incentives that steer members to in-network providers. A provider network may erode if in-network providers refer enrollees to out-of-network providers, or if out-of-network providers waive enrollee cost-sharing. In recent years, payors have sought to protect the integrity of their networks by going on offense against providers who engage in such practices. The trend of offensive payor litigation shows no signs of stopping. Recent examples are discussed below.

A. Out-of-network facilities that receive unauthorized referrals from in-network physician owners may face tort liability.

The district court in *Aetna Life Insurance Company v. Huntingdon Valley Surgery Center*, No. 13-03101, 2015 WL 5439223 (E.D.Pa. Sept. 15, 2015) recently held that Aetna could take its tortious interference claims against two physician-owned surgery centers to trial. The surgery centers were out-of-network with Aetna. Their physician owners were in-network, and had agreed in their provider contracts to refer patients only to facilities approved in advance by Aetna. They allegedly breached their contractual obligations by referring patients to their surgery centers (which Aetna had not approved). The surgery centers allegedly induced the breaches by offering the physicians increased equity stakes based on referrals of Aetna members. Additionally, the surgery centers "waived most of the high out-of-pocket payments for Aetna members."

The surgery centers moved for summary judgment, arguing that Aetna's payment of claims and pre-certification of services were tantamount to approvals of the surgery

centers. In opposition, Aetna pointed out that it could have paid past claims for reasons besides approving the surgery centers. Aetna also introduced testimony establishing that pre-certification was simply a verification of coverage under the member's plan, and not an approval. Consequently, the Court denied summary judgment.

B. Cost-sharing waivers by out-of-network providers remain a litigation target.

The district court in *Aetna, Inc. v. Health Diagnostic Laboratory, Inc.*, No. 15-1868, 2015 WL 9460072 (E.D.Pa. Dec. 28, 2015) has permitted Aetna to pursue discovery on its fraud and tortious interference claims against a marketing firm that allegedly participated in a kickback scheme with out-of-network clinical laboratories. According to Aetna, the marketing firm facilitated arrangements whereby: (i) the physicians received fees in return for referring patients to the laboratories, (ii) the laboratories waived member cost-sharing and billed Aetna without disclosing the waivers, (iii) Aetna overpaid the laboratories due to the active concealment of the waivers, and (iv) the marketing firm received a percentage of Aetna's payments as a commission. The marketing firm moved to dismiss on the ground that neither they nor the laboratories made affirmative misrepresentations. The district court denied the motion because Aetna alleged that the marketing firm participated in the scheme, and the laboratories actively concealed their conduct with the intent to deceive.

The district court in *Connecticut General Life Insurance Company and Cigna Health and Life Insurance Company v. Southwest Surgery Center, LLC*, No. 14-CV-08777, 2015 WL 6560536 (N.D.Ill. Oct. 29, 2015) reached a similar conclusion. Cigna alleged that an out-of-network surgery center engaged in "fee-forgiving" by failing to bill

patients for deductibles and coinsurance under the plan terms, and then submitting claims for reimbursement that grossly overstated its actual charges for each patient's care. Such conduct allegedly caused Cigna to overpay more than $800,000 in plan benefits. The district court determined that Cigna's allegations were sufficient to state claims against the surgery center for fraud and negligent misrepresentation.

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[1] Medicare Advantage 2015 Spotlight: Enrollment Market Update, The Henry J. Kaiser Family Foundation, *available at*: http://kff.org/medicare/issue-brief/medicare-advantage-2015-spotlight-enrollment-market-update/ (last visited Feb. 6, 2016).

[2] Total Marketplace Enrollment and Fin. Assistance, The Henry J. Kaiser Family Foundation, *available at*: http://kff.org/health-reform/state-indicator/total-marketplace-enrollment-and-financial-assistance/ (last visited Feb. 6, 2016). HHS does not fund QHPs. Rather, the U.S. Department for the Treasury pays advance premium tax credits to the issuers of QHPs whose members elect to use their annual tax credit to buy down their monthly premiums.

[3] Total Medicaid Managed Care Enrollment, The Henry J. Kaiser Foundation, *available at*: http://kff.org/medicaid/state-indicator/total-medicaid-mc-enrollment/ (last visited Feb. 6, 2016).

[4] Avalere Analysis: Medicaid Managed Care Enrollment Set to Grow by 13.5 Million, *available at*: http://avalere.com/expertise/managed-care/insights/avalere-analysis-medicaid-managed-care-enrollment-set-to-grow-by-13.5-milli (last visited Feb. 6, 2016)

[5] The Skinny on Narrow Networks in Health Insurance, Penn LDI, *available at*: http://ldi.upenn.edu/brief/skinny-narrow-networks-health-insurance-marketplace-plans (last visited Oct. 28, 2015).

[6] Bob Herman, *Network squeeze: Controversies continue over narrow health plans*, Modern Healthcare March 28, 2015

[7] 42 U.S.C. § 1395w–22(a)(1)(A).

[8] 42 C.F.R. § 422.101(b)(1)-(5).

[9] 42 C.F.R. § 422.112(a)(1)(i). The only exception made is for MA regional plans, *i.e.*, plans spanning multiple counties, which may establish availability and accessibility through other means, including reliance on out-of-network providers. 42 C.F.R. § 422.112(a)(1)(ii).

[10] 42 C.F.R. § 422.112(a)(6)(i).

[11] CY2016 MA HSD Provider and Facility Specialties and Network Adequacy Guidance, at p. 1, *available at*: https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2016_MA_HSD_Network_Criteria_Guidance.pdf (last visited Oct. 28, 2015)

[12] 42 C.F.R. § 422.112(a)(6)(i).

[13] 42 C.F.R. § 422.111(b)(3).

[14] 42 C.F.R. § 422.111(e).

[15] Medicare Advantage: Actions Needed to Enhance CMS oversight of Provider Network Adequacy, GAO-15-710 (August 2015)

[16] Announcement of Calendar Year (CY) 2016 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, at Attachment VII, pp. 138-140 (Final Call Letter) (April 6, 2015), *available at*: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents-Items/2016Announcement.html (last visited Oct. 28, 2015).

[17] *Id*. (emphasis added).

[18] *Id*.

[19] *Heckler v. Ringer*, 466 U.S. 602, 614-15 (1984).

[20] *Acquisito v. Secure Horizons*, 504 Fed.App'x. 855, 856 (11th Cir. 2013) (citing *Cochran v. U.S. Health Care Fin. Admin.*, 291 F.3d 775, 778–79 (11th Cir.2002)).

[21] *Hopewell Nursing Home, Inc. v. Heckler*, 784 F.2d 554 (4th Cir. 1986) (citing *Heckler*, 466 U.S. 602).

[22] 42 C.F.R. §§ 422.100(b)(2), 422.216(a)(2), 422.214(a)(1). Providers of services under Section 1861(u) of the Social Security Act would have to accept the original Medicare amount, less any payments for indirect and direct medical education costs under 42 C.F.R. §§ 412.105(g) and 413.76, respectively. 42 C.F.R. 422.214(b). Section 1861(u) providers are hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, and hospice programs.

[23] MA Payment Guide for Out of Network Payments (4/15/2015), https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/OONPayments.pdf.

[24] 42 C.F.R. § 422.566(b)(2)(i)-(ii).

[25] 42 C.F.R. § 422.566(b)(3)

[26] 42 C.F.R. §§ 422.566(c)(1)(i)-(ii).

[27] 42 C.F.R. § 422.574(a), (b), (d).

[28] 42 C.F.R. § 422.576.

[29] 42 C.F.R. §§ 422.582(a), (d); Medicare Managed Care Manual Ch. 13, §§ 10.4.1 – 10.4.3, 60.1, 70.1.

[30] 42 C.F.R. §§ 422.582(a), (d); Medicare Managed Care Manual Ch. 13, §§ 60.1 – 60.1.1, 70.1.

[31] Medicare Managed Care Manual Ch. 13, § 60.1.1.

[32] 42 C.F.R. § 422.592(a), (c).

[33] 42 C.F.R. § 422.600(a), 422.602(a), (c); Medicare Managed Care Manual Ch. 13, §§ 100 - 100.2.

[34] 42 C.F.R. § 402.608; Medicare Managed Care Manual Ch. 13, §§ 110 – 110.3.

[35] 42 U.S.C. §§ 1395w-22(g)(5); 42 C.F.R. §§ 405.1006, 405.1136, 422.612(a)-(c); Medicare Managed Care Manual Ch. §§ 120, 121.1.

[36] Federal courts have reached conflicting opinions on whether a claim by a contract provider arises under the Medicare Act. *Compare Assoc. Rehab. Recovery, Inc. v. Humana Med. Plan, Inc.*, 76 F.Supp.3d 1388, 1392-93 (S.D.Fla. 2014) (finding that claim arose under Medicare Act because it required an analysis of MA plan documents and would impact the government financially) *and RenCare, Ltd. v. Humana Health Plan of Texas, Inc.*, 395 F.3d 555 (5th Cir. 2004) (reaching opposite conclusion).

[37] 42 U.S.C. §18031(c)(1)(B).

[38] 45 C.F.R. § 156.230(a)(2).

[39] 45 C.F.R. § 156.230(b).

[40] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017, 80 FR 75,488, 75,549 (proposed Dec. 2, 2015) (to be codified at 45 C.F.R. pt. 156).

[41] *Id*.

[42] *Id*. at 75,550.

[43] *Id*.

[44] Draft 2017 Letter to Issuers in the Federally-facilitated Marketplaces, at p. 26 (Dec. 23, 2015), available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Draft-2017-Letter-to-Issuers-12-23-2015_508.pdf (last visited Feb. 6, 2015).

[45] *Id*. at p. 24.

[46] NAIC Health Benefit Plan Network Access and Adequacy Model Act § 5.A.(1) (Oct. 12, 2015), http://www.naic.org/documents/committees_b_rftf_namr_sg_exposure_revised_draft_proposed_revisions_mcpna_model_act.pdf ("A health carrier providing a network plan shall maintain a network that is sufficient in numbers and appropriate types of providers, including those that serve predominantly low income, medically underserved individuals, to assure that all covered services to covered persons, including children and adults, will be accessible without unreasonable travel or delay.").

[47] *Id*. at § 5.B.(1) – (9).

[48] HHS Notice of Benefit and Payment Parameters for 2017, 80 FR at 75,551.

[49] *Id*. at 75,552.

[50] *Id*. at 75,585.

[51] *Id*.

[52] NAIC Model Act § 6.L.(1).(a)-(b).

[53] *Id*. at § 6.L.(1).(c).

[54] *Id*. at § 6.L.(1).(b).

[55] *Id*. at § 6.L.(2).(c)(i)-(ii).

[56] *Id*. at § 6.L.(2).(c).(iii).(IV).(a)-(e).

[57] *Id*. at § 6.L.(2).(c).(iv).(I)-(II).

[58] HHS Notice of Benefit and Payment Parameters for 2017, 80 FR at 75,586; NAIC Model Act § 6.L.(2).(a).(i).(I)–(IV).

[59] A "life threatening health condition" means "a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted." NAIC Model Act § 6.L.(2).(a).(ii). A "serious acute condition" means "a disease or condition requiring complex ongoing care which the covered person is currently receiving, such as chemotherapy, post-operative visits, or radiation therapy." NAIC Model Act § 6.L.(2).(a).(iii).

[60] HHS Notice of Benefit and Payment Parameters for 2017, 80 FR at 75,551.

[61] HHS Notice of Benefit and Payment Parameters for 2017, 80 FR at 75,586.

[62] *Id*.

[63] NAIC Model Act § 7.B.(1)-(2).

[64] *Id*. at § 8.A.(1)-(2).

[65] *Id*. at § 7.C.(1).

[66] *Id*. at § 7.D.(1)-(5).

[67] *Id*. at § 7.E., F., G.

[68] *Id*. at § 7.I.

[69] N.Y. Pub. Health Law § 24.

[70] *Id.*

[71] N.Y. Fin. Servs. Law at §§ 606, 607(a), 607(b).

[72] N.Y. Ins. Law § 3241(c); N.Y. Fin. Servs. Law §§ 605(a)-(b).

[73] *Id.* at §§ 605(a)-(b), 607(a)-(b).

[74] Press Release, A.G. Schneiderman Announces Agreements With NYC & Long Island Urgent Care Centers To Improve Disclosure Of Accepted Insurance Plans (Oct. 16, 2015)**,** http://www.ag.ny.gov/press-release/ag-schneiderman-announces-agreements-nyc-long-island-urgent-care-centers-improve.

[75] 42 C.F.R. § 438.206(b)(1).

[76] 42 C.F.R. § 438.206(c)(1)(i)-(iii).

[77] 42 C.F.R. § 438.207(b)(1).

[78] 42 C.F.R. § 438.207(b)(2).

[79] 42 C.F.R. § 428.207(c)(2)(i)-(ii).

[80] Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability, Proposed Rules, 80 FR 31,098, 31,147 (June 1, 2015) (to be codified at 42 C.F.R. pt. 438).

[81] The seven provider types are: (1) Primary care, adult and pediatric; (ii) OB/GYN; (iii) Behavioral health; (iv) Specialist, adult and pediatric; (v) Hospital; (vi) Pharmacy; and (vii) Pediatric dental. *Id*. at 31,271.

[82] The factors would include the numbers and types of providers required to furnish the services, the number and types of providers who are not accepting new Medicaid patients, and the geographic location of health care providers and Medicaid enrollees (considering the distance, travel time, and means of transportation ordinarily used by such enrollees). *Id*.

[83] *Id*. at 31,145.

[84] *Id*. at 31,148.

[85] U.S. Department of Health and Human Services—Office of Inspector General, OEI-02-11-00320, State Standards for Access to Care in Medicaid Managed Care (2014).

[86] U.S. Department of Health and Human Services—Office of Inspector General, OEI-2-13-00670, Access to Care: Provider Availability in Medicaid Managed Care (2014).

[87] 42 U.S.C. § 1396u-2(b)(2)(D).

[88] 42 C.F.R. § 438.206(b)(4).

[89] 42 C.F.R. § 438.206(b)(5).

[90] *See, e.g.*, Tex. Admin. Code § 353.4(c)(1) ("[T]he MCO must reimburse an out-of-network, in-area service provider the Medicare fee-for-service (FFS) rate in effect on the date of service less five percent, unless the parties agree to a different reimbursement amount.").

[91] *See, e.g.*, Georgia Department of Community Health, Georgia DCH/CMO Contract, § 4.8.19.2, *available at*: https://dch.georgia.gov/care-management-organizations-cmo (last visited Feb. 3, 2016).

[92] *Premiertox, Inc. v. Kentucky Spirit Health Plan, Inc.*, No. 1:12CV-00010-JHM, 2012 WL 1950424, at *2-3 (W.D. Ky. May 30, 2012) (remanding provider's action against MCO after finding no federal question or substantial federal question jurisdiction); *Baptist Hosp. of Miami, Inc. v. Wellcare of Florida, Inc.*, No. 10-22858-CIV, 2011 WL 2084003, at *1-6 (S.D.Fla. May 23, 2011) (same); *cf. Veneruso v. Mount Vernon Neighborhood Health Ctr.*, 933 F.Supp.2d 613 (S.D.N.Y. 2013) (remanding Medicaid plan's action against provider after finding no federal question, substantial federal question or other federal jurisdiction).

[93] *Appalachian Reg'l Healthcare v. Coventry Health and Life Ins. Co.*, No. 5:12-cv-114, 2013 WL 1314154, at *4 (E.D.Ky. Mar. 28, 2013); *River Park Hosp., Inc. v. BlueCross BlueShield of Tennessee, Inc.*, 173 S.W.3d 43, 60 (Tenn.Ct.App. 2003); *Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alternatives, Inc.*, 832 A.2d 501 (Pa.Super. 2003).