

Battling the Payers (#NotHopeless)

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- We have no real or perceived conflicts of interest that relate to this presentation.
- The information in these slides and in our presentation is provided for reference and is not to be considered legal advice.
- These are our views, not necessarily the views of our clients.

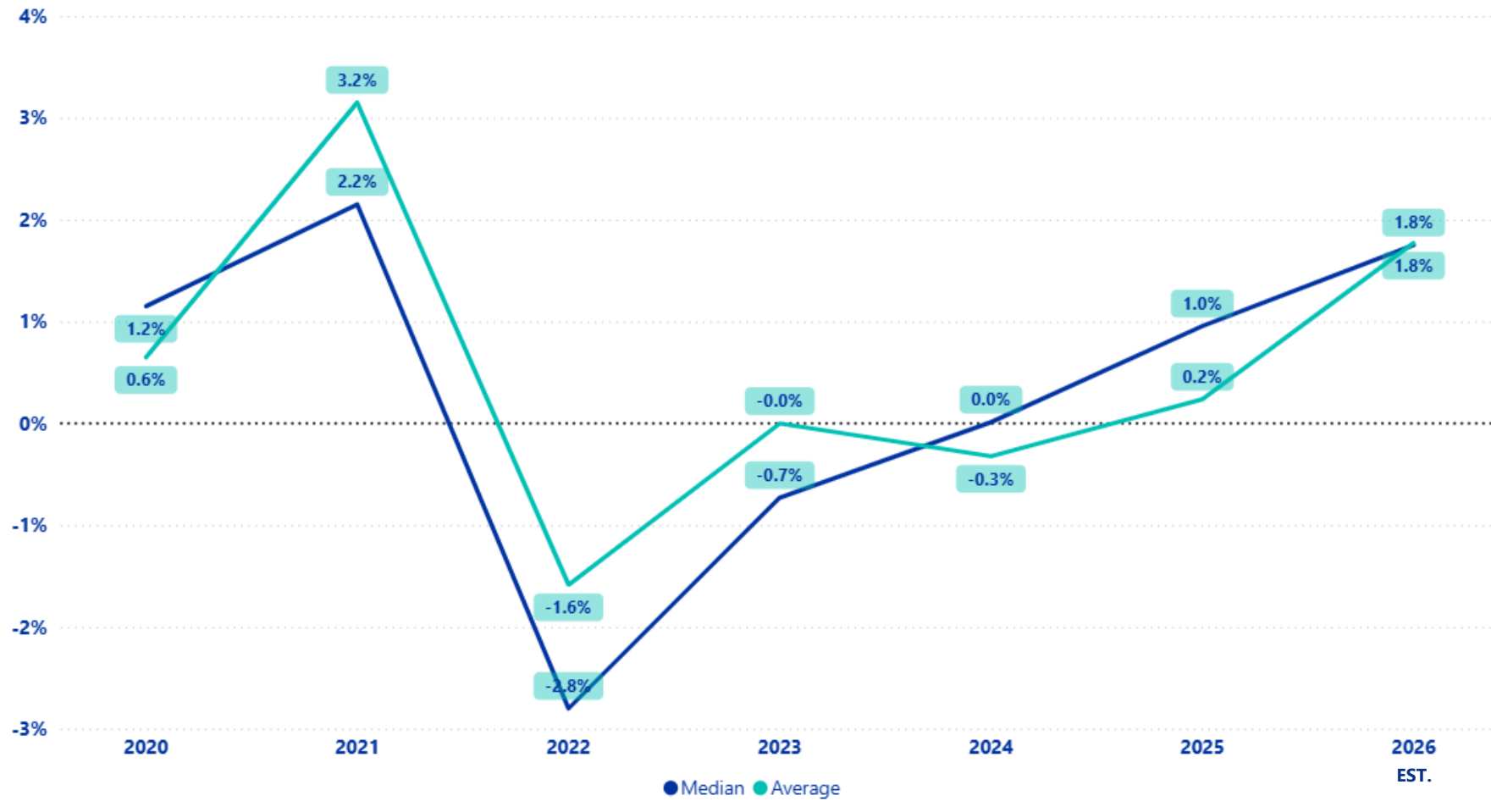
Current State

- Hospital operating margins are mostly negative or barely positive
- 250 hospitals in Ohio; 190 are non-profit or public
- Concentrated health plan market – 8 plans have nearly 90% of market; 3 have over 50%
- Most are for-profit
 - UnitedHealth Group earnings = \$12 BILLION in 2025
 - Elevance Health (Anthem) - \$5 BILLION in 2025
- Resource advantages overwhelmingly in health plans' favor



OHIO HOSPITAL FINANCIALS

Operating Margin Trend (Median & Average)



Challenges

- Heavy administrative burdens on hospitals:
 - Excessive prior authorizations with delayed responses
 - Frequent policy changes impacting changes to processes for required prior authorizations, coding, etc.
 - Delays or no response to appeals causing re-work
 - Excessive record requests
 - Inconsistent and insufficient denial/payment codes, no cites to utilized policies
 - Utilization of third party vendors for PA, claims, policies, appeals, audits, etc. increasing miscommunications, extra steps
 - Errors in credentialing/processes resulting in out of network denials
- Coverage and payment policies that don't align with Traditional Medicare (MA plans)



The “#NotHopeless” Offer

Three areas of “hope” we intend to offer:

1. Practical tips for contracting with payers, managing contract amendments, and escalating disputes
 - Learn options for dealing with provider credentialing issues, policy changes, and other agreement “amendments”
 - Evaluate options for when and how to escalate disputes over unresolved issues
 - Learn about current antitrust claims, class actions, and legal attempts to address payer practices and behaviors
2. The courtroom battleground – some wins, some challenges
3. Other Options

It All Starts With the Contract

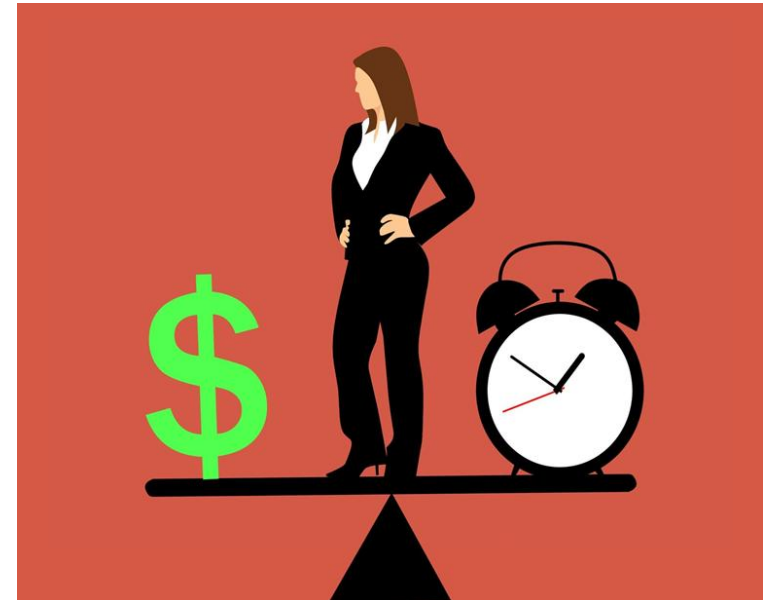
Contracting Basic Best Practices

- Don't just sign
- Benchmark reimbursement rates
- Keep a centralized contract repository
- Establish standardized clauses and processes you want in every contract
- Keep an eye on the data
 - Reimbursement accuracy
 - Claim denial rates
 - Payment cycle times
 - Revenue leakage
- Appeal everything, twice
- Be a fly in the ointment



Contract Terms with Big Impacts

- Credentialing
- Medical necessity
- Audits
- Fee schedules
- EMR access
- Claims submission deadlines
- Offsets
- Changes of ownership or information



Unanticipated Modifications

- Addition and removal of service lines
- Contractual amendments
- Rate amendments
- Policies

Contract or Policy Changes

- “Material amendment” means an amendment to a health care contract that decreases the participating provider's payment or compensation, changes the administrative procedures in a way that may reasonably be expected to significantly increase the provider's administrative expenses, or adds a new product. (O.R.C. 3963.01(K).)
- Non-material amendments – only 15 days notice required (O.R.C. 3963.04(A)(1))
- Material amendments require 90 days notice and must be labeled “Notice of Material Amendment to Contract” (O.R.C. 3963.04(A)(2))
 - Process allowing for Hospital objection and reconciliation of objection of material amendments (O.R.C. 3963.04(A)(3-4))
 - Termination remedy in the absence of reconciliation must be exercised 60 days prior to the effective date of the material amendment

Payer Payment Policies

- Inpatient bundling
- Multiple procedures
- Multiple diagnostic imaging
- Tech-assisted surgeries
- 3D radiology services
- Observation services
- Sepsis and newborn DRG submissions
- Non-participating provider penalty



Medicare Advantage – Contract Terms Wish List

Payment and Medical Necessity Determinations. Notwithstanding any provision of this Agreement or the applicable Product Addendum or Service and Rate Schedule, or any Policies, procedures, practices, utilization management function, or any other internal practice to the contrary, Company shall:

- Follow applicable traditional Medicare coverage NCDs, LCDs, statutes, regulations, and manuals when making medical necessity determinations;
- Create publicly accessible internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature when payment and coverage criteria are not fully established in applicable Medicare NCDs, LCDs, statutes, regulations, and manuals;
- Not make any medical necessity determination by applying benefit, coverage, or payment policies or criteria that are more restrictive than traditional Medicare;
- Not use precertification/prior authorization processes other than to: (1) confirm the presence of diagnoses or other medical criteria that are the basis for coverage determinations for the item or service; or (2) to ensure that an item or service is medically necessary;

Medicare Advantage Wish List (Con't)

- If Company has approved a precertification/prior authorization/pre-service determination of coverage or approved a claim, not retroactively review, reopen, withdraw, audit, deny, or recoup payment on the basis of lack of medical necessity or reopen such a decision except for “good cause”;
- Issue and ensure validity of precertifications/prior authorizations for as long as medically necessary to avoid disruptions in care, in accordance with applicable coverage criteria, the patient’s medical history, and the treating provider’s recommendation and ensure a minimum 90-day transition period for coverage changes;
- In the event Hospital fails to obtain precertification, Company will agree to review the case upon appeal to determine if Covered Services would have been approved as Medically Necessary had Hospital obtained precertification. When Covered Services are Medically Necessary, Company shall reimburse Hospital for such services.
- Otherwise strictly comply with the requirements of 42 CFR 422.100-.128.

Dispute Resolution

- Appeals submission deadlines
- Appeals and reconsideration processes
- Dispute resolution
- Mandatory arbitration
 - AAA (i.e., national) benefits national payers; Most providers benefit from resort to local dispute resolution forums and resources.
- Escalation



Contractual Issues Resolution

- Joint operating committee to address contract and claims issues
 - Credentialing and contract load errors
 - Technical failures
 - Rate updates
 - Application of policies

Activity in the Courts

OhioHealth Lawsuit

Filed Feb. 20, 2026



- DOJ to Court – help protect the interests of health plans in negotiating with health system
 - Requiring inclusion of all facilities and locations in payer contract
 - Requiring OhioHealth services be featured at the most favored benefits level in each plan network
- Relief requested: enjoin OhioHealth from beneficial contracting
- Similar suit in NYC vs. NY Presbyterian

**IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION**

UNITED STATES OF AMERICA, U.S. Department of Justice Antitrust Division 450 Fifth Street, NW, Suite 4100 Washington, DC 20530)	Case No.: 2:26-cv-207
)	Judge:
)	Magistrate Judge:
and)	COMPLAINT
STATE OF OHIO, 30 East Broad Street, 26th Floor Columbus, OH 43215)	
<i>Plaintiffs,</i>)	
v.)	
OHIOHEALTH CORPORATION, 3430 OhioHealth Parkway Columbus, OH 43202)	
<i>Defendant.</i>)	

Public breach of contract notice

- April 14, 2026 press release
- Greene County General Hospital – CAH
- Anthem
- \$1 million claim for:
 - Recharacterized claims as out-of-network
 - Slow and non responses from Anthem
 - Acknowledgment that there is an issue



Multiplan Health Plan Litigation

- Combined class action – 317 plaintiffs, 35 defendants
- Combining 6 suits from CA, NY and Illinois
- Attack against out-of-network payer conspiracy
- June, 2025 denial of payers’ motion to dismiss
 - “Realities” of health plan power
 - “True” purchasers of health services, not patients or employers
 - Providers have no option but to accept what payers force on them
- Discovery phase next
- Helpful facts, helpful comments from judge, key precedent



Anthem Out-of-Network Policy

- Jan. 1, 2026
- “Facility Administrative Policy: Use of a Nonparticipating Provider”
- 11 states, including Ohio
- All inpatient and outpatient services must be in-network providers, or else:
 - 10% penalty on hospital/in-network facility provider, or
 - Termination of agreement
- Even if providers are independent of the hospital
- Exceptions for emergencies, pre-approved services, rural/CAH/safety-net hospitals

Calif. Hospital Association Challenge

- Calif. Hosp. Assn. vs. Anthem (State Court)
- Block planned enforcement of policy as of June 1, 2026
- Violation of multiple state statutes and unfair business practice
- Filed May 4, 2026



Legacy LifePoint Health et al v. Anthem Health Plans of Kentucky

- W.D.Ky., Dec. 19, 2025, 3:25-CV-00792
- Alleges Anthem breached the parties' contract which provides that Anthem will pay based on percent of charges (based on hospitals' respective chargemasters), but Anthem engaged in improper payment practices in breach of such agreement requirements amounting in over \$11,000,000 in denials and underpayments
- Highlights charges related to procedures for hip and knee replacements
- Alleges Anthem violated the Kentucky Unfair Claims Settlement Practices Act
- Alleges Anthem violated the Kentucky Prompt Pay Act

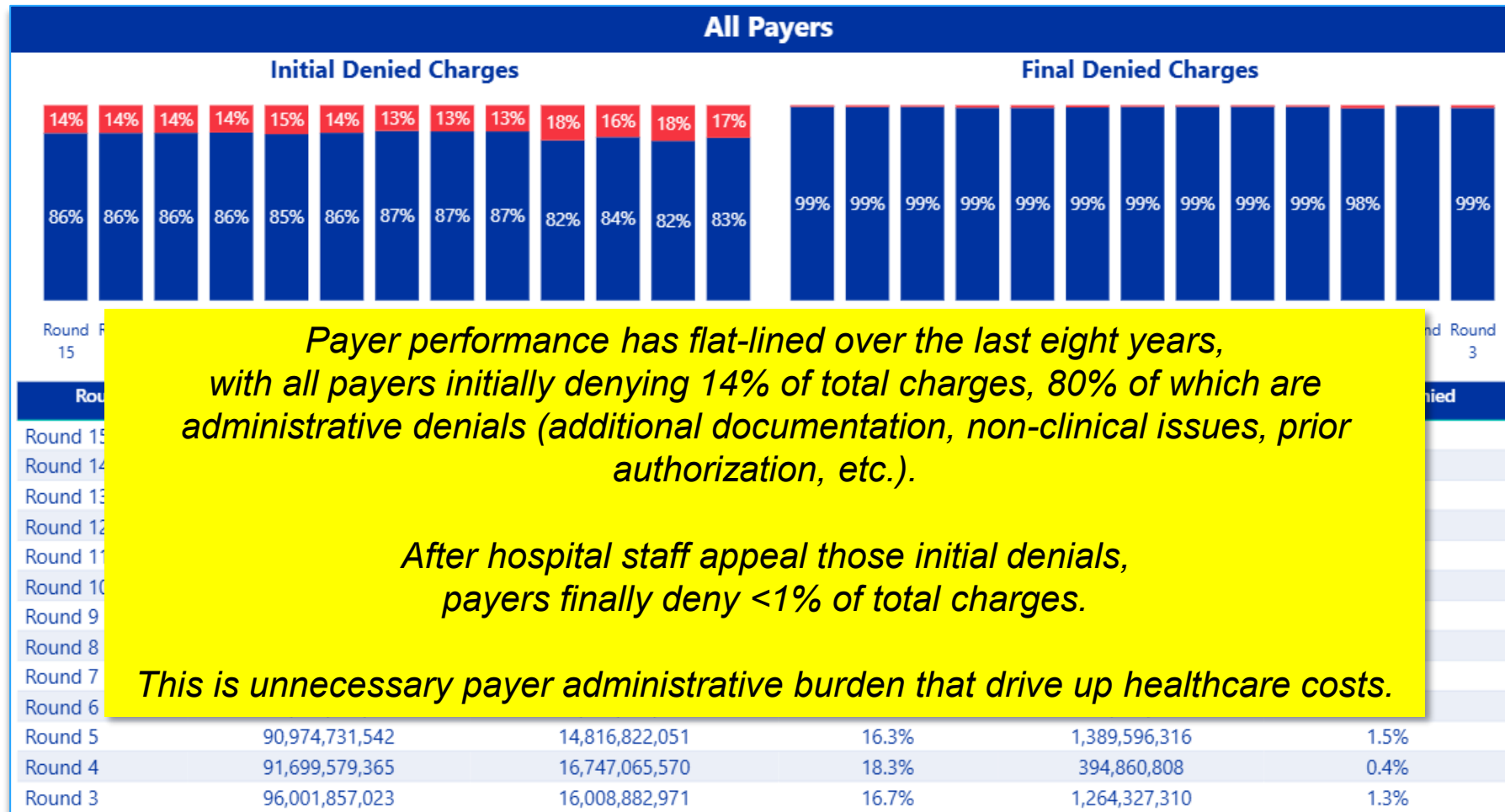
The Litigation Strategy

- Mandatory and confidential arbitration clauses limit this strategy, where they exist
 - Negotiate them out or carve-outs to them when you can
 - Negotiate to local arbitration rather than national (*see Stephens vs. AAA (D. Ariz.) case*)
- Deeper pockets problem
- Best way to get results, changes in behavior
- You're not alone ...

Other Options

OHA Payer Scorecard

Eight Years of Payer Performance Data



Know Your Rights

- Rights under the terms of the Contract
- Rights under federal law – for Medicare Advantage plans, 42 C.F.R. Part 422
- Rights under State law – e.g.:
 - H.B. 125 (June, 2008), enacting O.R.C. Chapter 3963
 - Ohio Prompt Pay Act, O.R.C. 3901.38
 - Emergency Services Coverage, O.R.C. 1753.28
 - Ohio Medicaid Managed Care, Ohio Adm. Code Chapter 5160-26
 - Health plan contracts with 340B Program Participants, O.R.C. 3902.71
 - Ohio Department of Insurance complaint process
 - Ohio Department of Medicaid complaint process

Claims Processing

Rights under Ohio Prompt Pay Law (O.R.C. 3901.381 and following):

- Pay or deny claims within 30 days
 - But can contractually agree to shorter time period
- Denials state “with specificity” why a claim is denied
- Process for “supporting documentation” denials
- Process for handling “untimely” claims
- Prohibits any business practice that unfairly or unnecessarily delays the processing of a claim or the payment of any amount due (O.R.C. 3901.385)
- No overpayment recoupment after expiration of claims finality of 2 years (O.R.C. 3901.388)
- Broad exception provision (O.R.C. 3901.3814) – self-funded plans, MA plans, Medicaid MCO plans
 - => BUT you can contractually agree to compliance with the Ohio Prompt Pay requirements

Know Your Rights - *example*

Prior Authorization in the Emergency Department

O.R.C 1753.28(B) provides:

(B) A health insuring corporation policy, contract, or agreement providing coverage of basic health care services shall cover emergency services for enrollees with emergency medical conditions without regard . . . to whether the enrollee, the hospital's emergency department . . . , or an emergency physician treating the enrollee, obtained prior authorization for the emergency services.



“Emergency Services” include both screening and such further medical examination and treatment that are required by federal law to stabilize an emergency medical condition.

The Plan (a) cannot require prior authorization for emergency services and (b) cannot exclude the hospital from a limited panel of providers for specialty diagnostic services (e.g. advanced imaging) for emergency services.

Complaint Process – ODI

- Prompt Pay Complaints

<https://insurance.ohio.gov/consumers/surprise-billing/resources/file-prompt-pay-complaint>

Provider Complaint Unit

Ohio Department of Insurance
50 W. Town Street
Third Floor - Suite 300
Columbus, Ohio 43215

Phone: 800-686-1526
Fax: 614-644-3744



WHAT IS ODI? INSURANCE & MEDICARE AGENTS & SERVICES FOR
ABOUT US CONSUMERS AGENCIES COMPANIES

ODI / Insurance & Medicare Consumers / Surprise Billing / Resources / File a Prompt Pay Complaint



Surprise Billing

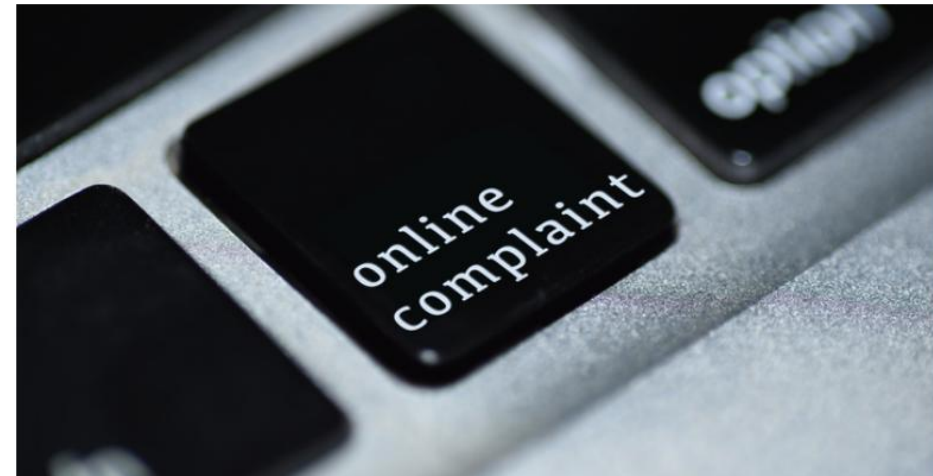
WELCOME

NEWS

RESOURCES

CONTACT US

File a Prompt Pay Complaint



The Ohio Department of Insurance is committed to assuring the prompt processing and payment of healthcare claims. [Ohio's Prompt Pay law](#) establishes strict time frames for the processing and payment of claims. In addition, the law requires (health insurers, third-party payers, health insuring corporations, and third-party administrators) to inform healthcare providers of routinely required information; to establish a claim status check system; and to pay interest on late claims. The law establishes notice requirements and certain limitations on the recovery of overpayments.

Complaint Process – ODI

- Provider Help Center

<https://insurance.ohio.gov/about-us/complaint-center/provider-help-center>

The screenshot shows the Ohio Department of Insurance website. At the top right, there is a navigation menu with links: WHAT IS ODI?, ABOUT US, INSURANCE & MEDICARE, CONSUMERS, AGENTS & AGENCIES, and SERVICES FOR COMPANIES. Below the navigation is a breadcrumb trail: ODI / About Us / Complaint Center / Provider Help Center. The main heading is "Provider Help Center". Below the heading is a large image of a hand typing on a keyboard. On the left side of the page, there is a circular logo for the Ohio Department of Insurance and a link labeled "About Us". At the bottom left, there is a vertical menu with links: FORMS, BULLETINS, REPORTS, and OH|ID APPLICATIONS. The main content area contains the following text: "or has issues pertaining to credentialing and contractual matters in accordance with Ohio Revised Code Chapter [3963](#)." Below this text, there is a paragraph: "The Provider Help Center is designed to help healthcare providers who believe a third-party payer/ insurance company has violated [Ohio's Prompt Pay Law](#) or has issues pertaining to credentialing and contractual matters in accordance with Ohio Revised Code Chapter [3963](#)." At the bottom of the main content area, there is another paragraph: "Issues related to claim handling, marketing & sales, and anything beyond prompt pay or credentialing and contractual inquiries, can be directed to our Consumer Services Division by filling out this [online form](#)."

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Complaint Process – Medicaid

- Medicaid Managed Care Provider Resource Center

<https://medicaid.ohio.gov/resources-for-providers/managed-care>



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Provider Inquiries

Providers should contact the associated managed care entity (MCE) for assistance before submitting a complaint (see hyperlink below) to the Ohio Department of Medicaid (ODM).

Providers should contact the [MCE's provider services line](#) and/or their regional provider relations representative. Providers are encouraged to use the appeals, grievance, or arbitration processes as outlined in their individual contract with that MCE. If the MCE or MCE's representative does not return a provider's call within five business days, the provider may complete the provider complaint form below. Providers should also check the MCE's Claims Payment Systemic Errors (CPSE) report for the issue in question.

All complaints submitted are sent immediately to the corresponding MCE for response. Please note the MCEs will have up to 15 business days to respond. ODM staff review each complaint received along with the MCE response in order to identify issues and trends.

Submission Tips: Providers may add supporting documentation directly to the provider complaint form. Up to five attachments may be uploaded on a single complaint. To upload documents, you will need to select "Yes, involves specific member(s)" and then "Add attachment for patient information." If multiple individuals are affected by a single issue with a plan, the provider is to submit only one complaint for all individuals. Individual information may be uploaded via attachments or manually. In the event there is a reoccurrence of a previously resolved complaint, providers should submit a new complaint, mark the question "Is this complaint related to any previously submitted complaints?" on the complaint form as yes, and enter the previous complaint's number.

Keep up the good fight !!

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Questions?

Thank you for attending today! If you need to reach us:

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