No. 21-2325

In the United States Court of Appeals for the Seventh Circuit

SAINT ANTHONY HOSPITAL,

Plaintiff-Appellant,

v.

THERESA A. EAGLESON, in her official capacity as Director of the Illinois Department of Healthcare and Family Services,

Defendant-Appellee,

and

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

Intervening Defendants-Appellees.

Appeal from the United States District Court
for the Northern District of Illinois, Eastern Division, No. 1:20-cv-02561.
The Honorable **Steven Charles Seeger**, Judge Presiding.

PETITION FOR REHEARING *EN BANC*

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APPEARANCE & CIRCUIT RULE 26.1 DISCLOSURE STATEMENT

Appellate Court No: 21-2325

Short Caption: Saint Anthony Hospital v. Theresa Eagleson

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(1) The full name of every party that the attorney represents in the case (if the party is a corporation, you must provide the corporate disclosure information required by Fed. R. App. P. 26.1 by completing item #3):

Meridian Health Plan of Illinois, Inc.

(2) The names of all law firms whose partners or associates have appeared for the party in the case (including proceedings in the district court or before an administrative agency) or are expected to appear for the party in this court:

Locke Lord LLP

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Centene Corporation

ii) list any publicly held company that owns 10% or more of the party's, amicus' or intervenor's stock:

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(4) Provide information required by FRAP 26.1(b) – Organizational Victims in Criminal Cases:

N/A

(5) Provide Debtor information required by FRAP 26.1 (c) 1 & 2:

N/A

Attorney's Signature: /s/ Steven T. Whitmer Date: August 2, 2022

Attorney's Printed Name: Steven T. Whitmer

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ☑ **No** ☐

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N/A

Attorney's Signature: /s/ Hugh S. Balsam Date: October 6, 2021

Attorney's Printed Name: Hugh S. Balsam

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ☑ **No** ☐

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N/A

(5) Provide Debtor information required by FRAP 26.1 (c) 1 & 2:

N/A

Attorney's Signature: /s/ Ashlee M. Knuckey Date: November 9, 2021

Attorney's Printed Name: Ashlee M. Knuckey

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ☐ **No** ☑

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IlliniCare Health Plan

(2) The names of all law firms whose partners or associates have appeared for the party in the case (including proceedings in the district court or before an administrative agency) or are expected to appear for the party in this court:

Falkenberg Ives LLP

(3) If the party, amicus or intervenor is a corporation:

i) Identify all its parent corporations, if any; and

Aetna Health Holdings, LLC; Aetna Inc.; CVS Pharmacy, Inc and CVS Health Corporation

ii) list any publicly held company that owns 10% or more of the party's, amicus' or intervenor's stock:

(4) Provide information required by FRAP 26.1(b) – Organizational Victims in Criminal Cases:

Not applicable

(5) Provide Debtor information required by FRAP 26.1 (c) 1 & 2:

Not applicable

Attorney's Signature: /s/ Kirstin B. Ives Date: August 2, 2022

Attorney's Printed Name: Kirstin B. Ives

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ☑ **No** ☐

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APPEARANCE & CIRCUIT RULE 26.1 DISCLOSURE STATEMENT

Appellate Court No: 21-2325

Short Caption: Saint Anthony Hospital v. Theresa Eagleston

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Blue Cross and Blue Shield of Illinois, a division of Health Care Service Corporation, a Mutual Legal Reserve Company

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Reed Smith LLP

(3) If the party, amicus or intervenor is a corporation:

i) Identify all its parent corporations, if any; and

None. BCBSIL is an unincorporated division of Health Care Service Corporation.

ii) list any publicly held company that owns 10% or more of the party's, amicus' or intervenor's stock:

No publicly traded corporation owns more than 10% of the stock in Health Care Service Corporation.

(4) Provide information required by FRAP 26.1(b) – Organizational Victims in Criminal Cases:

N/A

(5) Provide Debtor information required by FRAP 26.1 (c) 1 & 2:

N/A

Attorney's Signature: /s/ Kevin D. Tessier Date: 8-1-22

Attorney's Printed Name: Kevin D. Tessier

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ☐ **No** ☑

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Appellate Court No: 21-2325

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Not applicable

(4) Provide information required by FRAP 26.1(b) – Organizational Victims in Criminal Cases:

Not applicable

(5) Provide Debtor information required by FRAP 26.1 (c) 1 & 2:

Not applicable

Attorney's Signature: /s/ Martin J. Bishop Date: October 4, 2021

Attorney's Printed Name: Martin J. Bishop

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ☐ **No** ☑

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RULE 35(B)(1) STATEMENT

The four managed-care organization Appellees—Meridian Health Plan of Illinois, Inc., IlliniCare Health Plan, Health Care Service Corporation (a Mutual Legal Reserve Company operating in Illinois as Blue Cross and Blue Shield of Illinois) and Cook County Health & Hospitals System d/b/a CountyCare Health Plan (together, the "MCOs")—respectfully petition the Court to grant rehearing *en banc* pursuant to Fed. R. App. P. 35(b).

Rehearing is warranted for the reasons stated in the State's separate petition, which the MCOs adopt in full. Additionally, rehearing is needed because the panel majority decision presents a "question[] of exceptional importance"—namely, whether arbitration, rather than federal litigation, is the correct forum for initially resolving all contract-based, Medicaid managed-care payment disputes between providers and MCOs. *See* Fed. R. App. P. 35(b)(1)(B).

Arbitration is the established, efficient and direct system for the resolution of all payment disputes between Medicaid providers, like Appellant Saint Anthony Hospital, and MCOs, which pay for providers' services. Had Saint Anthony honored its arbitration obligations, there

would be no need for federal courts to interpose themselves into Medicaid payment disputes or provide a novel expansion of potential liability under 42 U.S.C. § 1983.

The majority, however, rejects this simple, workable approach for an arbitrary subset of these disputes—those purportedly involving amorphously defined "systemic failures"—in favor of a newfound, and ill-defined, expansion of liability under Section 1983. For three reasons, this approach is fatally flawed and merits rehearing.

First, the majority overlooks that all paths for legal relief in connection with "systemic defects" necessarily require arbitration.

Second, the majority's determination that arbitration—an effective, preferred method of conflict resolution—is "unmanageable" in this context is based upon a mistaken and unfounded assumption and one that evinces improper and unlawful hostility to arbitration. The U.S. Supreme Court and this Court have required arbitration for contract-based disputes falling within arbitration provisions. If a "systemic" exception to that unbroken line of authority is going to be declared for Section 1983 claims, the full Court should be the one to do so.

Third, funneling a subset of MCO-provider payment disputes into litigation, instead of arbitration, will severely burden all interested parties (including federal courts), will increase avoidable costs and may well prove to be unworkable, particularly given the lack of direction in the majority's opinion. Moreover, the majority's preference for Section 1983 lawsuits over arbitration directly impacts Illinois' Medicaid managed-care program, for which the State spends more than $12 billion annually. (*See* Majority 4.[1]) The majority's decision might well have a significant impact on the Medicaid programs in all the states, not just Illinois, because nearly seventy percent of Medicaid beneficiaries nationwide are enrolled in managed-care plans. (*See, e.g.*, Elizabeth Hinton & Lina Stoylar, *10 Things to Know About Medicaid Managed Care*, KRR.ORG (Feb. 23, 2022), https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/.)

In sum, before the far-ranging implications of the majority become the law of the Seventh Circuit, the full Court should review this matter.

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[1] We cite the district court record as "R. ____," the majority decision as "Majority ____" and Judge Brennan's opinion consenting in part and dissenting in part as "Dissent ____."

BACKGROUND

A. The Parties' Contracts.

Pursuant to contracts with the State and federal government, the MCOs administer government-sponsored healthcare services to Illinois Medicaid members enrolled in their respective health plans. (R. 1, ¶¶ 22, 26, 34–35.) Under this managed-care arrangement, the State pays each MCO a capitated rate on a per-member, per-month basis, and the MCOs contract with and pay healthcare providers for Medicaid-eligible costs incurred by their members. (*Id.* ¶ 26.)

The MCOs and Saint Anthony entered into provider contracts that require: (1) Saint Anthony to provide authorized, covered medical services to the MCOs' members and to submit timely claims for payment in a prescribed manner; and (2) the MCOs to process, adjust, pay or deny the claims in compliance with specified timeframes and other requirements. (*See, e.g.*, R. 28-1; R. 34-1; R. 37-2; R. 45-1, at Exs. 1–2; R. 41-2; R. 47.) The provider contracts also require (or in the case of CountyCare, allow) Saint Anthony to submit to binding arbitration any dispute arising under the contracts. (*E.g.*, R. 78-1, at Ex. A, §§ 6.1–6.2;

R. 79, at Ex. A, § XIII(2); R. 80, at 3–4 (quoting § 11.3); R. 83, at 3–4 (quoting §§ 9.1–9.2).)

B. District Court Proceedings.

In April 2020, Saint Anthony sued the State under Section 1983, alleging that it had violated the Medicaid Act by failing to ensure that the MCOs "ma[d]e timely and accurate payment for Medicaid services." (*See generally* R. 1.) Specifically, Saint Anthony alleges the MCOs were improperly: (1) denying and delaying claim payments; (2) imposing administrative burdens in connection with claims processing; and (3) failing to be transparent about claim payments. (*E.g.*, *id.* ¶¶ 1, 6, 38, 43–57, 60–61, 72.)

The district court allowed the MCOs to intervene as of right. (R. 75.) The MCOs subsequently moved to compel arbitration of Saint Anthony's claims under the arbitration provisions of their provider contracts and to stay the court action insofar as it concerned them. (R. 78–80, 83.)

In the meantime, Meridian filed an arbitration demand against Saint Anthony, contending that all of Saint Anthony's disputes with

Meridian were arbitrable. (R. 28-6.) That arbitration is currently stayed. (R. 96–97.)

In July 2021, the district court dismissed Saint Anthony's complaint, holding that Saint Anthony failed to state a claim because there is no private right of action under the Medicaid Act provisions in question. (*See generally* R. 108.) The court also noted that, if Saint Anthony wanted to assert a right to timely payment against the MCOs, arbitration "is a brightly lit path for doing so." (*Id.* at 29.) The court then denied as moot the MCOs' motions to compel arbitration. (R. 107–09.)

C. The Appeal.

Saint Anthony appealed. (R. 112.) Notably, the MCOs did not appeal, and, despite the majority's confusion on this point (Majority 43–44), have never asked this Court to stay the district court case pending arbitration. (*See, e.g.*, MCO Br. 17.) The MCOs did, however, join the appeal in order to supplement the State's brief by explaining: (1) that Saint Anthony's demands ultimately target the MCOs; and (2) that arbitration is therefore the proper route forward. The MCOs asked only for an affirmance.

On July 5, 2022, a divided panel issued a 2-1 decision that largely reversed the district court's decisions. The majority:

(1) Reversed the dismissal of Count I (failure "to ensure the MCOs meet the timely payment requirements"), holding that 42 U.S.C. § 1396u-2(f) provides a private right of action, (Majority 9–36);

(2) Affirmed the dismissal of Count II (failure "to ensure the MCOs furnish medical assistance with reasonable promptness"), holding that there is no private right of action under 42 U.S.C. § 1396a(a)(8), (Majority 37–39); and

(3) Declined to stay court proceedings in favor of arbitration, (*id.* at 43–44).

Judge Brennan joined the majority in concluding that Count II was properly dismissed and that Section 1396u-2(f) "creates a private right of action." (*E.g.*, Dissent 45.) He disagreed with the majority, however, with respect to "the breadth and substance of the State's duty under" Section 1396u-2(f), concluding that the statute does not contain "a privately enforceable statutory duty to proactively guarantee timely managed care payments." (*E.g.*, *id.*)

REASONS FOR GRANTING THE PETITION

In addition to the reasons set forth in the State's petition, rehearing *en banc* is appropriate for the following three reasons—all of which pertain to the "question[] of exceptional importance" of whether arbitrations should be the sole forum in which to initially resolve all contract-based, Medicaid managed-care payment disputes brought by providers and involving MCOs. *See* Fed. R. App. P. 35(b)(1)(B).

A. The Majority Overlooks That All "Paths" To Legal Relief Necessarily Require Arbitration.

As an initial matter, the majority overlooks that all paths for legal relief in connection with so-called "systemic defects" necessarily involve arbitration.

In its analysis, the majority envisions "two paths to seek legal relief" for the "systemic defects" Saint Anthony alleges exist in the Illinois Medicaid program: (1) sue the MCOs individually for breach of contract, which would "likely require arbitration"; or (2) use a Section 1983 lawsuit to obtain a court order requiring the State "to enforce the MCOs' contractual obligations to make timely and transparent payments." (Majority 7.) But this second path will always run headlong into the mandatory arbitration provisions in the MCOs' provider contracts.

To start with, the majority articulates the enforceable right at issue as "a right to timely payment from the MCOs" on "the 30/90 pay schedule." (*Id.* at 14.) But the only way for courts to ascertain if the factual predicate for State intervention—"systemic failures by MCOs to comply with the 30/90 payment schedule with reasonably transparent payment information" (*id.* at 31)—is present is by determining which claims (how many? what proportion?) are unpaid, paid late or paid with less transparency. (*See* Dissent 56 ("[A] district court can hardly decide if an MCO has systemically underperformed if it does not examine claims for untimely payment on the merits, and then determine whether the 'systemic' threshold has been reached."); Majority 44 (acknowledging that "factual issues related to the MCOs appear intertwined with Saint Anthony's claim against HFS").)

These latter determinations fall squarely within the broad arbitration provision in each provider contract. The provider contracts govern *all aspects* of the MCO-Saint Anthony relationship, including whether, when and how the MCO must pay claims that Saint Anthony submits. (*See* R. 74, at 2–9.)

For example, determining whether claims are "clean" and therefore payable requires an evaluation of claims based upon provider contract terms. *See, e.g.*, 42 U.S.C. §§ 1396a(a)(a)(37), 1396u-2(f); 42 C.F.R. §§ 447.45, 447.46. If Saint Anthony establishes "clean" claims, the process and timing for billing, paying, rejecting or adjusting those claims also hinges on the provider contracts. *See, e.g.*, 42 U.S.C. § 1396u-2(f); 42 C.F.R. § 447.46(c)(2); R. 74, at 7–8 & n. 10–13. Moreover, as explained above, each arbitration provision requires (or in the case of CountyCare, allows) Saint Anthony to submit to binding arbitration any dispute arising under the provider contracts.

Accordingly, all paths to legal resolution of these contract-based disputes require arbitration to determine whether the MCO has complied with the requirements of its particular provider contract.

B. The Majority Incorrectly Assumes That Arbitration Is "Unmanageable" In This Context.

The majority's determination that arbitration—an effective, preferred method of conflict resolution—is not a manageable alternative to the creation of new Section 1983 claims is based upon a mistaken assumption and evinces improper hostility to arbitration.

1. Arbitration Is A Favored Dispute-Resolution Mechanism.

It is well-established that arbitration is an effective, favored method of conflict resolution. As the Supreme Court has long emphasized, there is a "liberal federal policy favoring arbitration agreements," and parties should be held to their agreement to arbitrate unless Congress has evinced an intention to preclude a waiver of judicial remedies for statutory rights. *E.g.*, *Moses H. Cone Mem'l Hosp. v. Mercury Constr. Corp.*, 460 U.S. 1, 24 (1983); *Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc.*, 473 U.S. 614, 626–28 (1985).

The majority points to nothing in the legislative history of Medicaid's prompt-pay rule that suggests Congress made a judgment that arbitration cannot effectively address disputes over MCOs' compliance with Medicaid's prompt-pay rule. (*See* Majority 1–44.) In fact, the opposite is true. Title 42 U.S.C. § 1396u-2(f) mandates that contracts between states and MCOs include a provision requiring MCOs to comply with prompt-pay rules, which suggests that Congress intended these issues to be addressed by contract, not through Section 1983 claims. (*See* Dissent 51 ("By requiring contractual provisions that MCOs make timely payments, § 1396u-2(f) enables a healthcare provider like Saint

Anthony to privately enforce their contractual rights against MCOs directly through arbitration or litigation.").)

2. The Majority's Rejection Of Arbitration Rests On A Mistaken Assumption.

Ignoring arbitration's preferred status, the majority also suggests that arbitration is an unworkable alternative to Section 1983 claims, at least for issues involving purported "systemic failures." (*E.g.*, Majority 35.) This conclusion, however, proceeds from a mistaken and unfounded assumption and evinces an improper and unlawful judicial hostility to arbitration.

The majority's determination that arbitration is unworkable rests on the assumption that every disputed claim is subject to its own full-blown arbitration. (*E.g.*, *id.* (stating that arbitration "represents a claim-by-claim adjudication on the individual provider-MCO level, across many thousands of claims, all in their own arbitrations"); *id.* at 7 ("Arbitration provisions in [provider] contracts would likely require arbitration for each individual claim in dispute, which could easily involve many thousands of individual claims each year.").) Not even Saint Anthony advanced this thousands-of-arbitrations argument, and the majority

cites nothing to support it. This assumption is incorrect for three reasons.

First, the assumption that the parties' arbitration provisions require thousands of arbitrations has no support in the record. In particular, it has no basis in the text of the parties' arbitration provisions. Consider, for example, the arbitration clause in the Blue Cross-Saint Anthony provider contract:

> In order to avoid the cost and time consuming nature of litigation, any dispute between Plan and Contracting Provider arising out of, relating to, involving the interpretation of, or in any other way pertaining to this Agreement or any prior Agreement between Plan and Contracting Provider shall be resolved using the alternative disputes resolution procedures described in this Section instead of litigation.

(*E.g.*, R. 79, ¶ 8 (emphasis added); *see also*, *e.g.*, R. 28-1, § 6.2.2; R. 84, at 3–4.) As this language demonstrates, whether an MCO is complying with prompt-pay requirements is a "dispute" that could be resolved in a single arbitration with the MCO. Nothing limits an arbitration to a single Medicaid claim.

Second, the majority's assumption is inconsistent with Medicaid's prompt-payment rule, which is based upon claim aggregates, not

individual claims. 42 U.S.C. § 1396a(a)(37)(A) (requiring payment of 90% of clean claims within thirty days and payment of 99% of clean claims within ninety days). In order to evaluate compliance with this rule, a factfinder must look at individual claims, but this rule cannot be violated based upon one claim alone—a fact the majority acknowledges. (*See* Majority 33 (stating that "perfection is not required" under the prompt-pay rule).)

Third, the majority's assumption is inconsistent with practical realities. Arbitration is a far more direct and effective way for enforcing prompt pay than the Section 1983 claim the majority envisions, which indirectly seeks relief from the MCOs through the intermediary of nebulous claims against the State. (*See generally id.* at 9–36.) Rational parties seeking to maximize efficiency and minimize expense would initiate a process providers regularly utilize: *one* arbitration in which they could resolve *all* outstanding claims between them. Here, that would mean there would be only four separate arbitrations—one for each MCO. In each arbitration, arbitrators would address and resolve all purported MCO underperformance issues Saint Anthony raised.

3. The Majority's Disparagement Of Arbitration Is Unfounded.

The majority's disparagement of arbitration as a workable means of correcting purported "systemic failures" is also unfounded.

The majority suggests that arbitration cannot correct "systemic failures." (*Id.* at 31 ("If as Saint Anthony alleges, the plan has been failing to [timely pay claims], repeatedly and systematically, we would not be surprised if provider-MCO arbitrations would do little to correct that problem on a systemic basis.")). But the majority provides no foundation for this supposition, and the record on appeal does not support it.

First, Saint Anthony never even attempted to demand arbitration of its present disputes. Instead, Saint Anthony is seeking to use Section 1983 to bypass arbitration altogether. (Dissent 45.) But, as explained above, in the provider contracts, Saint Anthony agreed to arbitrate any disputes with the MCOs arising under those contracts, including disputes over whether the MCOs are paying on a timely basis. The Federal Arbitration Act obligates federal courts to honor parties' contractual expectations and to enforce valid arbitration provisions that

cover the parties' disputes. *E.g.*, *AT&T Mobility LLC v. Concepcion*, 563 U.S. 333, 344, 351 (2011) (citation omitted).

Second, in order to avoid arbitration and avail itself of the Section 1983 mechanism, Saint Anthony must show that Congress intended to preclude arbitration of such disputes. *See Gilmer v. Interstate/Johnson Lane Corp.*, 500 U.S. 20, 26 (1991) (citations omitted). Nothing in the majority opinion suggests that is the case. There is nothing inherent in Saint Anthony's contract-based Section 1983 claim, or in the parties' dispute regarding whether the MCOs are complying with Medicaid's prompt-pay rule, that takes these disputes outside of arbitration.

Third, the scope of arbitrators' powers indicates that there is no basis for concluding that arbitration of all of the parties' disputes is unworkable. Arbitrators can provide much or all of the relief that the majority envisioned a federal court providing because they enjoy broad power to fashion an award. For example, certain of the parties agreed to adopt the American Arbitration Association's Rules to govern any arbitration. (*E.g.*, R. 78, at 9–10.) Under those Rules, arbitrators "may grant any remedy or relief that [they] deem[] just and equitable and within the scope of the agreement of the parties, including, but not

limited to, specific performance of a contract." (Am. Arb. Ass'n, Commercial Arb. Rules, Rule R-47(a), https://adr.org/sites/default/files/Commercial%20Rules.pdf.) Moreover, "[i]n addition to a final award, the arbitrator may make other decisions, including interim, interlocutory, or partial rulings, orders, and awards." (*Id.* Rule R-47(b).) Consequently, arbitrators can decide that MCOs are not paying on a timely basis and order them to do so.

In short, the majority's speculation that arbitration will not work here is conclusory and unfounded and rests upon the sort of judicial hostility to arbitration that the Federal Arbitration Act was designed to prevent. *E.g.*, *Viking River Cruises, Inc. v. Moriana*, 142 S. Ct. 1906, 1917 (2022) ("The FAA was enacted in response to judicial hostility to arbitration."); *Moses H. Cone Mem'l Hosp.*, 460 U.S. at 24 (recognizing the "liberal federal policy favoring arbitration agreements"); *Zurich Am. Ins. Co. v. Watts Indus.*, 466 F.3d 577, 580 (7th Cir. 2006) ("The FAA is Congress's manifestation of a national policy favoring arbitration and results in the placement of arbitration agreements on equal footing with all other contracts." (citation omitted)).

C. The Majority's Approach Would Severely Burden All Parties And Unnecessarily Embroil Federal Courts In Payment Disputes.

As a result of the majority's opinion, federal courts in this Circuit will now become embroiled in litigation over Medicaid payment disputes, and federal judges will become the arbiters of any MCO-provider disputes that providers can frame as involving "systemic failure." But federal courts have "repeatedly declined to create private rights of action" in this area for good reason. (*See* Dissent 47 (citations omitted).) As the entire panel recognized, this expansion of private rights of action "threatens to put a tremendous burden on states and the judiciary" and "would strain judicial resources." (*See* Majority 29; Dissent 50.)

Moreover, this approach will inject chaos and instability into Medicaid programs, as providers will begin addressing disputes with MCOs indirectly through Section 1983 claims brought against the State.

The majority compounds these problems by providing little tangible guidance on crucial issues for these new Section 1983 claims, leaving both the courts and all of the participants in the Medicaid program adrift without any meaningful standards or guardrails. For example, the majority does not explain *when* Section 1983 claims are available to

providers, as the majority declines to define what its judicially created "systemic failure" standard means or what plaintiffs must plead in order to establish a "systemic failure." (*E.g.*, Majority 34 ("We need not and should not adopt a mathematical definition of 'systemic' failures at the pleading stage.").) Consequently, it is anyone's guess whether and when there is a "systemic failure" sufficient to justify a Section 1983 claim.

Similarly, the majority offers no meaningful guidance regarding the *remedies* that are available under the new Section 1983 claims. The majority merely stated that it could "imagine some poor ways to handle this case going forward in the district court," but was "confident that the district court could craft injunctive relief to require [the State] to do *something* to take effective action." (*Id.* at 2, 29 (emphasis in original).)

In short, if its decision is allowed to stand, the majority will have ensured that federal courts in this Circuit, the State, MCOs and providers are ensnared in years of costly litigation over the nature and scope of claims that, under settled legal precedents, could and should have been submitted to cost-effective arbitration in the first instance.

CONCLUSION

For the foregoing reasons, the Court should grant rehearing *en banc*, and, upon rehearing, affirm the judgment of the district court.

Dated: August 2, 2022

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

The undersigned certifies that the foregoing Petition for Rehearing complies with the type-volume limitation of Fed. R. App. P. 32(c)(2) and Fed. R. App. P. 35(b)(2)(A) because it contains 3,461 words, excluding the parts of the Petition exempted by Fed. R. App. P. 32(f).

The undersigned further certifies that this petition complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type-style requirements of Fed. R. App. P. 32(a)(6) because this Petition has been prepared in a proportionally spaced typeface using Microsoft Word Version 2016 in 14-point Century Schoolbook style font.

Dated: August 2, 2022

/s/ Hugh S. Balsam
Hugh S. Balsam

CERTIFICATE OF SERVICE

I hereby certify that on August 2, 2022, the Petition for Rehearing *En Banc* was filed with the Clerk of the Court for the United States Court of Appeals for the Seventh Circuit by using the appellate CM/ECF system. All participants who are registered with CM/ECF will be served via the CM/ECF system.

/s/ Hugh S. Balsam
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