

No. _____

In the Supreme Court of the United States

ATLANTA MEDICAL CENTER, INC., ET AL.,
Petitioners,

v.

CARE IMPROVEMENT PLUS SOUTH CENTRAL
INSURANCE CO.,
Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Medicare Advantage provides Medicare benefits through private insurers known as Medicare Advantage Organizations. Under the relevant regulations, enrollees have a right to “organization determinations” whenever they believe they are entitled to benefits under their Medicare Advantage plans. A multi-step administrative appellate process follows, culminating in judicial review. The Department of Health and Human Services, whose regulations govern the Medicare appeals process, has twice explained in amicus briefs that healthcare providers need not exhaust this Medicare appeals process before suing a Medicare Advantage organization over a refusal to pay the provider when the enrollee no longer has any interest in the outcome. The question presented is as follows:

Whether healthcare providers must exhaust the Medicare appeals process before challenging a Medicare Advantage Organization’s refusal to pay for medical care when the enrollee no longer has any interest in the outcome.

PARTIES TO THE PROCEEDING

Petitioners Atlanta Medical Center, Inc. f/k/a/ Tenet HealthSystem GB, Inc. d/b/a Atlanta Medical Center and Atlanta Medical Center South Campus; North Fulton Medical Center, Inc. d/b/a North Fulton Hospital f/k/a North Fulton Regional Hospital; Spalding Medical Center, Inc. f/k/a/ Tenet HealthSystem Spalding, Inc. d/b/a Spalding Regional Hospital f/k/a Spalding Regional Medical Center; Sylvan Grove Hospital, Inc. f/k/a Tenet HealthSystem SGH, Inc. d/b/a Sylvan Grove Hospital; Coastal Carolina Medical Center, Inc. d/b/a Coastal Carolina Hospital; East Cooper Community Hospital, Inc. d/b/a East Cooper Medical Center; Hilton Head Health System, LP d/b/a Hilton Head Hospital; AMISUB of South Carolina, Inc., d/b/a Piedmont Medical Center; Des Peres Hospital, Inc. f/k/a Tenet HealthSystem DI, Inc. d/b/a Des Peres Hospital; SLH Vista, Inc. f/k/a Tenet HealthSystem SL, Inc. d/b/a St. Louis University Hospital; and AMISUB (SFH), Inc. d/b/a Saint Francis Hospital were the plaintiffs/appellants in the proceedings below.

Respondent Care Improvement Plus South Central Insurance Co. was the defendant/appellee in the proceedings below.

RULE 29.6 STATEMENT

The following petitioners are wholly owned subsidiaries of Tenet HealthSystem Medical, Inc., a wholly owned subsidiary of Healthcare Network Holdings, Inc. f/k/a Tenet HealthSystem Holdings, Inc., which, in turn, is wholly owned by Tenet Healthcare Corporation, a publicly-traded corporation:

Atlanta Medical Center, Inc.; North Fulton Medical Center, Inc.; Spalding Regional Medical Center, Inc.; Sylvan Grove Hospital, Inc.; Coastal Carolina Medical Center, Inc.; East Cooper Community Hospital, Inc.; AMISUB (SFH), Inc.; AMISUB of South Carolina, Inc.; and SLH Vista, Inc.

Des Peres Hospital, Inc. is owned by Tenet Missouri, Inc. which is owned by Tenet Hospitals, Inc., which is owned by Tenet Healthcare Corporation.

Hilton Head Health System, LP is owned by Amisub (Hilton Head), Inc., Tenet Physician Services-Hilton Head, Inc., and Univ. Medical Associates of the University of South Carolina. Amisub (Hilton Head), Inc. is a wholly owned subsidiary of Tenet HealthSystem Medical, Inc. which is owned by Healthcare Network Holdings, Inc., which, in turn, is a wholly owned subsidiary of Tenet Healthcare Corporation.

No publicly held company owns 10 percent of Tenet Healthcare Corporation's stock.

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PETITION FOR A WRIT OF CERTIORARI

Petitioners respectfully petition this Court for a writ of certiorari to review the judgment of the United States Court of Appeals for the Eleventh Circuit.

OPINIONS BELOW

The opinion of the court of appeals (App. 1a-15a) is reported at 875 F.3d 584. The opinion and order of the district court (App. 16a-32a) is reported at 162 F. Supp. 3d 1307. The order of the court of appeals denying rehearing (App. 33a-34a) is unreported.

JURISDICTION

The court of appeals issued its opinion on August 8, 2017. App. 1a. On October 26, 2017, the court of appeals denied a petition for rehearing. App. 33a-34a. On January 19, 2018, Justice Thomas granted petitioners' request for an extension to March 9, 2018 to file a petition for writ of certiorari. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

Relevant statutory and regulatory provisions are reproduced in the appendix to this petition. App. 35a-52a.

INTRODUCTION

This case is a payment dispute between a health insurer and eleven hospitals. The health insurer promised the hospitals that it would pay for the services that they provided to the insurer’s enrollees, and the hospitals promised not to bill the insurer’s enrollees. Years after paying the hospitals for the services provided, the insurer changed its mind and recouped the payments over the hospitals’ objections.

When the hospitals sued the insurer under state law, it insisted that the hospitals had to first exhaust the chronically overburdened Medicare appeals process—a process that can take more than a decade to complete. The insurance plans were Medicare Advantage plans, a kind of health insurance that provides benefits offered under the original Medicare program.

The Department of Health and Human Services (HHS) has twice rejected the notion that purely private provider-insurer payment disputes must proceed through the Medicare appeals process. That process, a creature of the Medicare Act and agency regulations, exists to protect enrollees, not providers. When the dispute will not affect the enrollee’s care or financial interests, HHS explains, there is no administrative exhaustion requirement. The Fifth Circuit and Texas Supreme Court agree, and the Sixth Circuit called the argument that administrative exhaustion applies “dubious” in *dicta*. In this case, however, the Eleventh Circuit rejected HHS’s interpretation of its own regulations and affirmed dismissal for failure to exhaust administrative remedies. It did so without identifying any clear textual mandate—either in the statute or

regulations—that such disputes be administratively exhausted, thus failing to adhere to this Court’s precedents on administrative deference. Instead, it conducted its own independent review of the regulatory regime after incorrectly asserting that HHS had never considered claims by out-of-network providers.

The problems with the decision below do not stop at the doctrinal; the decision portends significant, harmful real-world effects. HHS has warned that requiring administrative exhaustion in cases like this one “would improperly tax, and potentially overwhelm, [its] limited resources.” With the Medicare appeals backlog already causing decade-long delays and expected to reach nearly one million disputes by 2021, the Eleventh Circuit’s decision to expand HHS’s docket over the agency’s well-reasoned objections warrants the Court’s review.

STATEMENT OF THE CASE

A. Statutory and Regulatory Background

1. Through the original Medicare program, the United States pays for medical coverage for millions of Americans. *See* 42 U.S.C. §§ 1395d(a), 1395l(a). Original Medicare’s private-sector counterpart, Medicare Advantage, offers original Medicare benefits to Americans through private insurers. Under Medicare Advantage, insurers (known as “Medicare Advantage Organizations” or “MAOs”) agree to provide at least the same benefits as original Medicare in exchange for a fixed, monthly, per-enrollee payment from the United States. 42 U.S.C. §§ 1395w-22(a)(1), 1395w-23(a). The MAO, not the United States, pays for medical services

consumed, and the MAO bears the risk of services costing more than expected. 42 U.S.C. § 1395w-25(b); 42 C.F.R. § 422.100(a).

Congress designed Medicare Advantage to “utilize innovations that have helped the private market contain costs and expand healthcare delivery options,” hoping that the program would “eventually eclipse” original Medicare. *Balanced Budget Act of 1997*, H.R. Rep. No. 105–217, at 585, 638 (1997) (Conf. Rep.). Thus, Medicare Advantage is not simply original Medicare with a different payer. Within limits, MAOs can establish their own premiums, out-of-pocket maximums, and cost-sharing requirements. 42 U.S.C. § 1395w-24; 42 C.F.R. § 422.100, 422.262. MAOs are also free to offer additional benefits to entice enrollees. 42 U.S.C. § 1395w-22(a)(3); 42 C.F.R. §§ 422.100(c), 422.102.

Like ordinary private health insurers, MAOs can “select the providers from whom the benefits under the [MA] plan are provided,” as long as mandatory services are available “with reasonable promptness” and “continuity” is ensured. 42 U.S.C. § 1395w-22(d). To meet these requirements, MAOs establish networks of providers to serve their enrollees. 42 C.F.R. § 422.112. These providers are often called “in-network” or “contract providers.” *See infra* p. 6 n.1. MAOs may also cover services from providers outside its network (“out-of-network” providers), whether because the MAO must cover those services under the law, *e.g.*, 42 U.S.C. § 1395w-22(d)(1)(E) (requiring coverage of emergency services regardless of contractual relationship), or because the MAO believes it is to its competitive advantage to do so. When Medicare requires services to

be covered, federal law requires the MAO to pay “at least” what original Medicare would pay the out-of-network provider. *Id.* § 1395w-22(a)(2)(A). An MAO and provider may agree that the MAO will pay more, but absent an agreement, the out-of-network provider “shall accept” the original Medicare rate “as payment in full.” *Id.* § 1395w-22(k)(1); 42 C.F.R. § 422.214(a)(1).

2. MAOs must “have a procedure for making determinations regarding whether an individual enrolled with the plan . . . is entitled to receive a health service . . . and the amount (if any) that the individual is required to pay,” known as an “organization determination.” 42 U.S.C. § 1395w-22(g)(1)(A). The MAO must also provide a procedure for reconsideration of the organization determination “upon request by the enrollee involved.” *Id.* § 1395w-22(g)(2)(A). Although the statute does not suggest that anyone other than the enrollee may request an organization determination or seek reconsideration, HHS regulations also permit the enrollee’s healthcare provider and any other “representative” to request an organization determination and reconsideration “on the enrollee’s behalf.” *See* 42 C.F.R. §§ 422.566(c), 422.578. An organization determination binds not just the enrollee, but also his representatives, assignees, and any other party with “an appealable interest in the proceeding.” *Id.* §§ 422.574, 422.575.

HHS regulations establish three levels of administrative appeals post-reconsideration. First, if the MAO continues to deny coverage after reconsideration, appeal follows to an independent review entity retained by the Center for Medicare and Medicaid Services. 42 U.S.C. § 1395w-22(g)(4); 42 C.F.R. § 422.592. Second,

the party may seek review by an administrative law judge. 42 U.S.C. § 1395w-22(g)(5); 42 C.F.R. § 422.602. Third, the ALJ's decision may be challenged before the Medicare Appeals Council. 42 C.F.R. § 422.608. At the end of this process, judicial review is available. 42 U.S.C. § 1395w-22(g)(5); 42 C.F.R. § 422.612.

Importantly, although various parties may pursue appeals, once the enrollee has received services and has no further payment liability, the appellate process ends. *See* 42 C.F.R. § 422.562(c)(2) (“determination . . . not subject to appeal” when “an enrollee has no further liability to pay for [furnished] services”).

3. Although the Medicare Act and HHS regulations do not expressly address under what circumstances, if any, provider-MAO disputes must be administratively exhausted, HHS has twice explained its views in amicus briefs. On both occasions, HHS made clear that administrative exhaustion is not required for post-service provider-MAO payment disputes when the enrollee has no financial stake in the outcome.

In 2006, HHS explained that a payment dispute between an MAO and contract provider¹ was not subject to exhaustion requirements. Because “the

¹ Courts generally refer to “contract” and “noncontract” providers interchangeably with “in-network” and “out-of-network” providers, respectively. *E.g.*, App. 6a-7a. As HHS has explained, the term “contract provider” is not “defined by statute or regulation, and lacks specificity.” Ltr. Br. of United States 3 n.2, No. 15-3130, *Ohio State Chiropractic Ass’n v. Humana Health Plan, Inc.* (6th Cir. filed Mar. 14, 2016). That a provider is “out-of-network” or “noncontract” does not mean it cannot “make arrangements

definition [of ‘organization determination’] is directed exclusively at coverage disputes between the organization and *the enrollee*—not contractual disputes between the organization and health care providers”—HHS reasoned, “the administrative review process . . . does not extend to claims in which an enrollee has absolutely no interest.” Br. of U.S. Dep’t of Health & Human Servs. (“*Christus Health Br.*”), *Christus Health Gulf Coast v. Aetna, Inc.*, No. 05-0710, 2006 WL 985225, at *10 (Tex. Filed Mar. 13, 2006) (emphasis in original) (quoting *RenCare Ltd. v. Humana Health of Tex., Inc.*, 395 F.3d 555, 559 (5th Cir. 2004)). Thus, it is “no surprise” that no appeal may be taken once the enrollee “has no further liability to pay for services.” *Id.* at *11-*12 (quoting 42 C.F.R. § 422.562(c)(2)). Recognizing that the enrollee is not the only party to an organization determination under 42 C.F.R. § 422.574, HHS explained that “the definition of the proper parties . . . affects only *who* can seek administrative relief, not *what claims* are subject to relief.” *Id.* at *15 (emphasis in original). In short, “there is no possible basis” to consider a provider-MAO payment dispute as an organization determination “[u]nless a Medicare Advantage organization actually asserts that its enrollee is responsible to pay for a particular service.” *Id.* at *19.

A decade later, HHS reaffirmed that position—this time in a case involving a noncontract provider.

(written or otherwise) . . . for the limited purpose of establishing payment amounts for particular services to be furnished to a given enrollee or to a group of enrollees for some period of time.” *Id.*; see also *infra* p. 17. Nevertheless, for ease of reference, this petition uses the “contract” and “noncontract” terminology.

Ltr. Br. of United States 8 (“*Ohio State Chiropractic Br.*”), No. 15-3130, *Ohio State Chiropractic Ass’n v. Humana Health Plan, Inc.* (6th Cir. filed Mar. 14, 2016) (ECF No. 45); see *Ohio State Chiropractic Ass’n v. Humana Health Plan, Inc.*, 647 F. App’x 619, 620 (6th Cir. 2016) (noting that the provider “had no contract” with the MAO). Again, HHS emphasized that organization determinations and the appeals process protect the rights of enrollees, not healthcare providers, pointing out that under 42 C.F.R. § 422.562(c)(2), “no administrative review [is] available where the enrollee faces no further liability.” *Id.* at 8-9. Because a post-treatment payment dispute would not affect any enrollee’s liability, the dispute was not an organization determination subject to appeal. *Id.* at 9. HHS further warned that “extending an administrative exhaustion requirement to payment disputes purely between an MAO and a provider would improperly tax, and potentially overwhelm, [its] limited resources.” *Id.* at 10.

B. Facts and Procedural History

1. This is a dispute between eleven hospitals (Hospitals) (petitioners) and an MAO, Care Improvement Plus South Central Insurance Co. (CIP) (respondent). App. 2a. Although the Hospitals are not part of CIP’s network, they provided medical services to CIP’s enrollees after CIP approved the services. App. 2a. In exchange for the promised payments, the Hospitals promised not to seek any payments from the CIP enrollees that they treated. App. 7a. Years after CIP paid for the services, it recouped a substantial portion of the payments through offsets. App. 2a.

2. The Hospitals sued CIP, asserting state-law claims for unjust enrichment and quantum meruit. App. 7a. CIP moved to dismiss, arguing that the district court lacked subject-matter jurisdiction because the Hospitals had failed to exhaust administrative remedies under the Medicare appeals process. App. 20a. The district court agreed and dismissed. App. 26a-27a.

3. The Eleventh Circuit affirmed. Its rationale was simple. The payment dispute was an organization determination because the Hospitals had agreed to forego payment from the patients, satisfying the definition of a party that would be bound by an organization determination under 42 C.F.R. § 422.574(b). App. 9a. Under HHS regulations, a “provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service” is considered the enrollee’s “assignee” and a party to any organization determination. 42 C.F.R. § 422.574(b). The court rejected the Hospitals’ argument that they were asserting claims independent from their purported status as an assignee, concluding that HHS regulations prohibited noncontract providers from ever being entitled to anything other than the Medicare rate. App. 11a-13a (citing 42 C.F.R. § 422.214(a)(1)). Finally, the court concluded that, as a matter of policy, there “was no sound reason why reimbursement claims should follow a separate procedural path . . . depending on whether they are asserted by the individual enrollee or by the treatment-providing hospital.” App. 10a. Each of these conclusions conflicts with HHS’s position. *See infra* pp. 16-17.

The court sought to distinguish the Fifth Circuit’s decision in *RenCare* and HHS’s amicus briefs based on the Hospitals’ status as noncontract providers. In the court’s view, this distinction was “critical.” App. 11a-12a. Recognizing that *RenCare* disagreed with the assignee argument, the Eleventh Circuit dismissed the case’s “treatment of the ‘assignee’ argument” as “ cursory.” App. 13a-14a. The court discounted HHS’s amicus briefs, believing—incorrectly—that they “only analyze[d] payment disputes between MAOs and contract providers.” App. 12a. *Contra Ohio State Chiropractic*, 647 F. App’x at 620 (noting that provider “had no contract” with the MAO). Having asserted this incorrect distinction, the court ignored HHS’s contrary analysis of the regulations underlying the court’s holding.

REASONS FOR GRANTING THE PETITION

The decision below exacerbated a pre-existing, acknowledged split over whether administrative exhaustion is required for provider-MAO disputes when an enrollee’s interests are not at stake. The Eleventh Circuit’s decision fails to defer to HHS’s interpretation of its own regulations and threatens to add still more cases to a long-overburdened Medicare appeals process. This will harm not just HHS, which must figure out how to handle the additional appeals, but also the hospitals and other healthcare providers who must wait as much as a decade just to have their day in court. The Court frequently grants certiorari to address administrative-exhaustion issues. *E.g.*, *Fry v. Napoleon Cmty. Schs.*, 137 S. Ct. 743, 752 (2017); *Ross v. Blake*, 136 S. Ct. 1850, 1853 (2016). It should do the same here. The petition should be granted.

A. The Eleventh Circuit’s Decision Adds to an Acknowledged, Pre-Existing Split.

The Eleventh Circuit’s decision adds to a pre-existing split of authority among federal appellate courts and state courts of last resort. Two of those courts, like HHS, have concluded that when a patient has no financial interest in a provider-MAO payment dispute, that dispute is not an organization determination requiring administrative exhaustion. A third has suggested in *dicta* that it would agree. Two courts, including the Eleventh Circuit below, have disagreed.

1. The Fifth Circuit and Texas Supreme Court agree with HHS that provider-MAO payment disputes not implicating an enrollee’s financial interests are not organization determinations, and the Sixth Circuit has suggested its agreement in *dicta*.

In *RenCare*, whose reasoning HHS later adopted in its amicus briefs, the Fifth Circuit concluded that “the administrative review process attendant to [Medicare Advantage] does not extend to claims in which an enrollee has no interest.” *RenCare*, 395 F.3d at 559; *Ohio State Chiropractic Br.*, *supra*, at 8-9; *Christus Health Br.*, *supra*, at *2, *10-*12, *15. After a review of the regulations, the court concluded that “the administrative process focuses on enrollees, not health care providers, and is designed to protect enrollees’ rights to Medicare benefits.” *RenCare*, 395 F.3d at 559. In particular, the court noted that the appeals process does not apply when “the enrollee has no further liability to pay.” *Id.* (quoting 42 C.F.R. § 422.562(c)(2)). Finally, the court rejected the MAO’s argument that the provider was “acting as an assignee”—the same argument

the Eleventh Circuit accepted—because when “no . . . enrollee has been denied benefits or payment,” a provider-MAO dispute is not an organization determination. *Id.* at 560. Because there was a “complete absence of [enrollee] interest”—the enrollees had “already received the services” and bore “no financial risk”—there were “no administrative remedies . . . to exhaust.” *Id.*

Although *RenCare* involved breach of contract and other state-law claims asserted by a contracted provider, 395 F.3d at 556-57, the provider’s status played no role in the court’s analysis. Rather, it was the absence of any enrollee interest in the outcome of the dispute that caused the court to conclude that the dispute was not an organization determination.

Two years later, the Texas Supreme Court reached the same conclusion, “agree[ing]” that “the administrative review process does not extend to claims in which an enrollee has absolutely no interest.” *Christus Health Gulf Coast v. Aetna, Inc.*, 237 S.W.3d 338, 343 (Tex. 2007) (quoting *RenCare*, 395 F.3d at 559). Like *RenCare*, the case involved a contract provider, but also like *RenCare*, that fact played no role in the outcome. Instead, administrative exhaustion was unnecessary because “no enrollee has been denied covered services or been required to pay for a service.” *Id.* at 344. Thus, the court allowed the providers’ claims to proceed. *Id.*

More recently, the Sixth Circuit suggested in *dicta* that it would agree in a case involving a noncontract provider. After calling on the United States to address

the issue,² the court called the MAO's argument that the noncontract provider needed to exhaust administrative remedies "dubious." *Ohio State Chiropractic*, 647 F. App'x at 625 (citing *RenCare*, 395 F.3d at 559).

2. Like the Eleventh Circuit below, the Arizona Supreme Court concluded that administrative exhaustion does apply to provider-MAO payment disputes. *United Behavioral Health v. Maricopa Integrated Health Sys.*, 377 P.3d 315, 320-22 (Ariz. 2016). In doing so, it expressly parted ways with *RenCare* and *Christus Health*. *Id.* at 320-21. Conceding that the "administrative procedures focus on enrollees' interests," it declared that they "also apply to contract providers." *Id.* at 321. In support, it observed that providers can request organization determinations and can be parties bound by organization determinations. *Id.* (citing 42 C.F.R. §§ 422.566(c)(ii), 422.574(b), (d)). The court rejected *RenCare*'s interpretation of 42 C.F.R. § 422.562(c)(2) as terminating the appellate process. *Id.* Although the text speaks to the "determination" not being "subject to appeal" if the "enrollee has no further liability to pay," the Arizona Supreme Court read the provision to apply "only to an enrollee's appeal rights." *Id.* In other words, although the regulation nowhere suggests that some parties would have more appellate rights than others, the "determination" would remain "subject to appeal" for all other parties. *See* 42 C.F.R.

² *See* Ltr. from D. Hunt, Clerk, to D. Letter, *Ohio State Chiropractic Ass'n v. Humana Health Plan, Inc.*, No. 15-3130 (6th Cir. filed Nov. 24, 2015) (ECF No. 38) (asking "whether administrative exhaustion [is] an appropriate requirement for claims like these"). Unlike the Sixth Circuit, the Eleventh Circuit did not seek HHS's input.

§ 422.562(c)(2). The court believed this construction was necessary to avoid depriving parties of the right to appeal and thought it was better “policy” to require administrative exhaustion to allow HHS to maintain control over the interpretation of the Medicare Act. *Id.* at 321-22. Like the decision below, the Arizona Supreme Court did not engage HHS’s analysis of these same regulations; indeed, it is unclear whether the court was aware of HHS’s position.

The result is an acknowledged, expanding split of authority over whether provider-MAO payment disputes must be administratively exhausted when the enrollee’s interests are not at stake.

B. The Eleventh Circuit’s Decision Conflicts with this Court’s Precedents on Deference to Agency Constructions of Their Own Regulations and Is Wrong.

The Eleventh Circuit’s decision fails to accord the deference to HHS’s interpretation of its own regulations that this Court’s precedents require. Even absent deference, the Eleventh Circuit’s construction of the regulatory regime is incorrect.

1. Courts generally defer to agencies’ construction of their own regulations, including interpretations advanced in amicus briefs, whenever a regulation is ambiguous. *Talk Am. v. Mich. Bell Tel. Co.*, 564 U.S. 50, 59 (2011) (collecting authority). Deference is “all the more warranted” when dealing with “a complex and highly technical program,” such as Medicare. *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512 (1994). When an agency has interpreted its own regulation, a

court’s task is not to “decide which among several competing interpretations best serves the regulatory purpose.” *Id.* Instead, the agency’s interpretation governs unless a different reading is either “compelled by the regulation’s plain language” or indications of the agency’s intent “at the time of the regulation’s promulgation.” *Id.*

The Eleventh Circuit failed to follow this established framework dictated by this Court’s precedent. It identified no language compelling the conclusion that provider-MAO payment disputes that do not implicate an enrollee’s financial interests must be administratively exhausted; no such language exists. Nor did it identify evidence of HHS’s intent when the relevant regulations were promulgated that required rejecting HHS’s views. Instead, it conducted its own independent reading of the regulations and ignored HHS’s two amicus briefs because it erroneously concluded that neither addressed claims by a noncontract provider. That was error. Not only has HHS addressed the specific issue here, but its amicus briefs specifically reject each of the interpretive steps on which the Eleventh Circuit relied. Under this Court’s precedent, the Eleventh Circuit should have deferred to HHS’s views.

a. Contrary to the Eleventh Circuit’s assertion, App. 12a, HHS has addressed whether its regulations require a noncontract provider like the Hospitals to exhaust administrative remedies before proceeding to court on a payment dispute with the MAO when the dispute will not affect the enrollee’s financial interests. Like the Hospitals, the provider in *Ohio State Chiropractic* “had no contract” with the MAO. 647 F. App’x at 620. In fact, the district court recognized that the

facts in this case and *Ohio State Chiropractic* were “strikingly similar”:

There, as here, the plaintiff was a non-contracted provider to an MA organization. Plaintiff claimed that the MA organization . . . attempted to recoup alleged overpayments by deducting amounts from bills later submitted by plaintiff. Plaintiff sought a declaratory judgment, and raised claims of unjust enrichment and breach of implied contract, among other state law claims.

Pet. App. 28a-29a (citations omitted). Although the Sixth Circuit did not ultimately reach the administrative exhaustion issue, HHS’s amicus brief clearly concluded that the “plaintiffs’ claims are not subject to the Medicare Act’s exhaustion requirements.” *Ohio State Chiropractic Br.*, *supra*, at 8 (heading formatting removed). Thus, the Eleventh Circuit’s understanding of the *Ohio State Chiropractic* amicus brief was incorrect, and it was wrong to disregard HHS’s conclusion based on its mistaken distinction.

b. Even had HHS not specifically addressed the issue here, HHS’s amicus briefs specifically reject the three key rationales underlying the decision below.

First, HHS rejects using the definition of parties under 42 C.F.R. § 422.574 to determine whether a dispute involves an organization determination: “the definition of the proper parties . . . affects only *who* can seek administrative relief, not *what claims* are subject to relief.” *Christus Health Br.*, *supra*, at *15 (emphasis in original). The Eleventh Circuit’s holding depends on

its contrary conclusion that any dispute involving someone who may be a party to an organization determination under 42 C.F.R. § 422.574 is necessarily an organization determination. App. 8a-9a. That error alone requires reversal.

Second, “an MAO and an out-of-network provider may reach an agreement regarding payment amounts” that exceeds what Medicare requires the MAO to pay. *Ohio State Chiropractic Br.*, *supra*, at 13; *id.* at 3 n.2 (“an MAO may also make arrangements (written or otherwise) with an ‘out-of-network provider’ for the limited purpose of establishing payment amounts for particular services to be furnished to a given enrollee or to a group of enrollees for some period of time”). As the *Ohio State Chiropractic* amicus brief explains, “Medicare Part C statutory and regulatory standards do not address whether an MAO’s course of conduct may establish an implied contract with its out-of-network providers as to payment rates.” *Id.* But the Eleventh Circuit rejected the Hospitals’ argument that they were not asserting claims as assignees, concluding that under 42 C.F.R. § 422.214(a)(1) “an MAO [cannot] bind itself by oral agreement to pay reimbursement rates to noncontract providers that are higher than the rates required by the Medicare regulations.” App. 12a.

Third, not only is HHS not expert in the laws that govern state-law provider-MAO disputes, “it is unclear whether HHS could invoke its administrative remedy.” *Christus Health Br.*, *supra*, at *16-*17. Thus, the Eleventh Circuit’s conclusion that “there is no sound reason” that provider-MAO disputes should not “follow the same path,” App. 10a, contradicts HHS’s position, as well.

The Eleventh Circuit did not address any of HHS's positions on these issues, because it considered its engagement with the amicus briefs complete after erroneously concluding that HHS had not addressed noncontract providers. Disregarding HHS's views on this basis was error.

2. Even if HHS were not owed deference, the correct outcome would be the same. As HHS and the Fifth Circuit have explained, the Medicare appeals process “focuses on enrollees, not health care providers, and is designed to protect enrollees’ rights to Medicare benefits.” *Ohio State Chiropractic Br., supra*, at 8 (quoting *RenCare*, 395 F.3d at 559). Statutes and regulations must be read in context. *See Kasten v. St.-Gobain Performance Plastics Corp.*, 563 U.S. 1, 7 (2011) (statutes must be construed in context); *INS v. Nat’l Ctr. for Immigrants’ Rights, Inc.*, 502 U.S. 183, 195 (1992) (construing regulation consistent with “the complex regime of immigration law”). And enrollees’ interests are front and center in both the statute and the regulations.

Beginning with the statutory text, the Medicare Act requires organization determinations to consider “whether an individual enrolled with the plan . . . is entitled to receive a health service,” not whether a provider is entitled to be paid. *See* 42 U.S.C. § 1395w-22(g)(1)(A). Reconsideration is available “upon request by the enrollee involved,” not by anyone else. *Id.* § 1395w-22(g)(2)(A).

Similarly, HHS regulations list organization determinations among the “rights of [Medicare Advantage] enrollees,” saying nothing about it being a

right of the provider or MAO. 42 C.F.R. §422.562(b)(2) (heading formatting removed). The definition of organization determinations focuses on coverage determinations when the “*enrollee* believes” he is entitled to care or payment, or to correct delays when “delay would adversely affect the *health of the enrollee*.” 42 C.F.R. § 422.566(b)(2), (3), (5) (emphases added). And whenever an MAO decides to “deny . . . payment in whole or in part,” it must “give the enrollee written notice,” a requirement that makes little sense if the enrollee no longer has any financial exposure. *Id.* § 422.568(d). Why any enrollee in this case, having already received services and free from any potential liability to his healthcare provider, would need notice that CIP had changed its mind years later and recouped its payments is unclear, to say the least. Although providers, like anyone acting as a “representative” of an enrollee, may seek an organization determination and be bound to its results, 42 C.F.R. §§ 422.566(c), 422.574, that does not mean that every dispute between an MAO and a provider is automatically an organization determination. Thus, as HHS has explained, it is “no surprise” that HHS regulations provide that a “determination is . . . not subject to appeal” when “an enrollee has no further liability to pay for [furnished] services.” 42 C.F.R. § 422.562(c)(2); *Christus Health Br., supra*, at *10; *accord Ohio State Chiropractic Br., supra*, at 9 (under 42 C.F.R. § 422.562(c)(2), “no administrative review available where the enrollee faces no further liability”). “[T]he administrative process focuses on enrollees, not health care providers, and is designed to protect enrollees’ rights to Medicare benefits.” *RenCare*, 395 F.3d at 559.

In sum, because there is no plain statutory or regulatory command that a provider-MAO payment dispute like the one here must be administratively exhausted, the Eleventh Circuit erred in rejecting HHS's position. Even had deference not been required, the Eleventh Circuit's decision would have been incorrect. Organization determinations and the appellate process for Medicare Advantage enrollees are designed to protect enrollee rights, not to settle provider-MAO private payment disputes. At a minimum, however, there is enough in the regulations to warrant deference to HHS's position. The Court should grant certiorari and reverse.

C. The Issue Presented Is Important.

The issue presented carries immense practical implications for the United States and healthcare providers. The Medicare appeals process is chronically overburdened, preventing HHS from meeting statutory deadlines for original Medicare appeals, with some appeals expected to languish for more than a decade. The situation has grown so dire that the D.C. Circuit has authorized a D.C. district court to consider whether mandamus relief against HHS is appropriate. Thus, HHS has urged courts not to exacerbate the problem by adding provider-MAO payment disputes to the mix.

Last year, the Office of Medicare Hearings and Appeals, which performs ALJ-level review of original Medicare, Medicare Advantage, and Part D prescription drug appeals, 42 C.F.R. §§ 405.1000, 422.602, 423.2014, had a backlog of 604,402 appeals. *Am. Hosp. Ass'n v. Price*, 867 F.3d 160, 163 (D.C. Cir. 2017). By

2021, HHS expects the backlog to get worse, burgeoning to 950,520 appeals. *Id.* HHS expects that some already-filed claims could take more than a decade to resolve. *Id.*; see also *Am. Hosp. Ass’n v. Burwell*, 812 F.3d 183, 187 (D.C. Cir. 2016) (indicating that HHS receives more appeals every two months than it can process in an entire year). And although HHS is laboring mightily to improve the situation, when a federal judge ordered HHS to eliminate the backlog within four years, HHS responded that doing so would be “impossible.” *Price*, 867 F.3d at 165-66 (vacating mandamus order for failing to establish that the four-year target was achievable and remanding for reconsideration whether mandamus is nonetheless authorized).³

The last thing HHS needs as it attempts to reduce the Medicare appeals backlog is a set of provider-MAO payment disputes in which neither enrollees nor the federal government has a financial interest, and which HHS does not believe its regulations authorize it to hear. As HHS has explained, piling these disputes on top of the existing backlog would “improperly tax, and potentially overwhelm, CMS’s limited resources.” *Ohio State Chiropractic Br.*, *supra*, at 10.

It is not just the federal government that would be harmed by further delays. Patients disputing denials

³ To put the delays in context, original Medicare appeals should only take “a year or so” when complying with relevant statutory deadlines. *Am. Hosp. Ass’n v. Burwell*, 76 F. Supp. 3d 43, 46 (D.D.C. 2014), *rev’d on other grounds* 812 F.3d 183 (D.C. Cir. 2016). Historically, HHS met these deadlines, until an explosion of appeals beginning earlier this decade. *Burwell*, 812 F.3d at 186.

of care or payments must exhaust the Medicare appeals process. *See Heckler v. Ringer*, 466 U.S. 602, 620-21 (1984) (requiring patient seeking to undergo surgery to exhaust administrative remedies). Similarly, “hospitals are forced to wait years to receive reimbursements to which the law entitles them *now*.” *Price*, 867 F.3d at 172 (Henderson, J., dissenting) (emphasis in original). For hospitals, these financial consequences are no mere accounting matter; they are “causing real-world problems.” *Id.* Medicare reimbursements represent well over half of some hospitals’ annual revenues. *See id.* (describing one such hospital). The backlog deprives them of funds and leaves them in some cases unable even to do basic maintenance or pushes them to cut back services. *Id.* Those harms, in turn, are visited upon Americans who need access to healthcare—the very people Medicare was intended to help.

The harm to providers and patients offers a corresponding benefit to MAOs that is impossible to ignore. Instead of paying a provider in cases of doubtful—or even obvious—liability, the MAO can refuse, betting that the provider will not want to appeal individual claims through a process that could last years. Worse still, even after paying, the MAO could do what CIP did here: pay for the services and reverse course years later by recouping against payment for other enrollees’ services. Some providers will endure the costly, drawn-out process of appealing each individual claim and pursuing damages in court, but many others undoubtedly will not. One need not believe that all, most, or even many MAOs will act in this manner to recognize the wisdom of avoiding such an incentive.

Although accepting HHS's correct interpretation of its own regulations will not alone fix the Medicare appeals backlog, rejecting it and forcing still more disputes through the process will undoubtedly make the backlog worse, the financial consequences to providers still more acute, and the incentives for misbehavior even more tempting. The Court should grant certiorari to resolve this important issue.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX

APPENDIX A

[PUBLISH]

IN THE UNITED STATES COURT OF APPEALS

FOR THE ELEVENTH CIRCUIT

No. 16-11176

D.C. Docket No. 1:15-cv-01922-WSD

TENET HEALTHSYSTEM GB, INC.,
d.b.a. Atlanta Medical Center
d.b.a. Atlanta Medical Center South Campus,
NORTH FULTON MEDICAL CENTER, INC.,
d.b.a. North Fulton Regional Hospital,
TENET HEALTHSYSTEM SPALDING, INC.,
d.b.a. Spalding Regional Medical Center,
TENET HEALTHSYSTEM SGH, INC.,
d.b.a. Sylvan Grove Hospital,
COASTAL CAROLINA MEDICAL CENTER, INC.,
d.b.a. Coastal Carolina Hospital,
EAST COOPER COMMUNITY HOSPITAL INC.,
d.b.a. East Cooper Medical Center,
HILTON HEAD HEALTH SYSTEM, LP.,
d.b.a. Hilton Head Hospital,
AMISUB OF SOUTH CAROLINA, INC.,
d.b.a. Piedmont Medical Center,
TENET HEALTHSYSTEM DI, INC.,
d.b.a. Des Peres Hospital,
TENET HEALTHSYSTEM SL, INC.,
d.b.a. Saint Louis University Hospital,

AMISUB (SFH), INC.,
d.b.a. Saint Francis Hospital,

Plaintiffs – Appellants,

versus

CARE IMPROVEMENT PLUS SOUTH
CENTRAL INSURANCE COMPANY,

Defendant – Appellee.

Appeal from the United States District Court
for the Northern District of Georgia

(August 18, 2017)

Before MARCUS, DUBINA, and WALKER,* Circuit
Judges.

WALKER, Circuit Judge:

Plaintiffs-appellants are eleven hospitals (the “Plaintiff Hospitals” or “the Hospitals”) who provided medical care to Medicare Part C enrollees after being authorized to do so by the defendant-appellee, Care Improvement Plus (“CIP”). BB 4-5. CIP is a Medicare Advantage Organization (“MAO”), which is a private

* Honorable John M. Walker, Jr., United States Circuit Judge for the Second Circuit, sitting by designation.

insurance company that manages the Medicare benefits of Part C enrollees. CIP initially reimbursed the Hospitals in full, but several years later it recouped a substantial portion of these payments through offsets, claiming they were not authorized under Part C of the Medicare Act (the “Act”), 42 U.S.C. §§ 1395w-21 to 1395w-29. The Hospitals then filed this lawsuit to recover the recoupments. The district court dismissed the claims for lack of jurisdiction, holding that the Hospitals failed to exhaust their administrative remedies before bringing suit in federal court.

This case requires us to determine whether under the Medicare Act the Plaintiff Hospitals must exhaust their administrative remedies before bringing suit for underpayment by the MAO that manages enrollee benefits. To decide this case it is necessary to understand the relationship of the parties within the statutory context of the pertinent provisions of the Medicare Act.

I.

Under Medicare Part C, Pub. L. No. 105-33, § 4001, 111 Stat. 251 (1997) (codified as amended at 42 U.S.C. §§ 1395w-21 to 1395w-29), MAOs, which are private sector insurers, contract with the Centers for Medicare and Medicaid Services (“CMS”), the branch of the United States Department of Health and Human Services (“HHS”) responsible for administering Medicare, to provide medical treatment to Medicare enrollees. CMS pays MAOs a pre-negotiated lump sum for one year (known as a “capitated payment”) for each enrollee that the MAO agrees to cover. In exchange, the MAO assumes all of the financial risk for treating that enrollee. *See* 42 U.S.C. §§ 1395w-24-25; *see also* RB 4;

BB 5. If the cost of treatment exceeds the amount that the MAO was paid, the federal government is not liable for the cost overruns—the MAO bears the loss. Appx. F at *2. Under Medicare Part C, MAOs provide the same benefits that an enrollee would receive through the traditional, government-administered, fee-for-service programs under Medicare Parts A and B, as well as additional benefits. Appx. F at *2.

As the organizations responsible for administering benefits, MAOs make determinations as to whether a certain type of treatment is covered under the Medicare regulations, and if so at what rate an enrollee may be reimbursed. 42 U.S.C. § 1395w-22(g)(1)(A). When a dispute with an enrollee arises on one of these issues, it is adjudicated according to CMS regulations. The MAO’s initial decision regarding coverage is classified as an “organization determination,” which the Medicare Act defines as a decision “regarding whether an individual enrolled with the plan of the organization under this part is entitled to receive a health service under this section and the amount (if any) that the individual is required to pay with respect to such service.” § 1395w-22(g)(1)(A). Organization determinations also include decisions by an MAO to not cover, reimburse, or provide for a treatment that “the enrollee believes” is covered by Medicare.¹ HHS’s regulations

¹ The Medicare regulations define organization determinations as:

(b) Actions that are organization determinations. An organization determination is any determination made by an MA organization with respect to any of the following:

define potential parties to an “organization determination” as an “enrollee,” the “assignee of an enrollee,” the “legal representative of a deceased enrollee’s estate,” or “[a]ny other provider or entity (other than the MA organization) determined to have an appealable interest in the proceeding.” 42 C.F.R. § 422.574.

If any one of the foregoing parties wishes to challenge any aspect of an organization determination, that party must exhaust its administrative remedies by following a specific procedure for administrative appeal prescribed by the Medicare Act and its implementing

(1) Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services.

(2) Payment for any other health services furnished by a provider other than the MA organization that the enrollee believes—

(i) Are covered under Medicare; or

(ii) If not covered under Medicare, should have been furnished, arranged for, or reimbursed by the MA organization.

(3) The MA organization’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.

(4) Reduction, or premature discontinuation, of a previously authorized ongoing course of treatment.

(5) Failure of the MA organization to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

42 C.F.R. § 422.566.

regulations. *See* 42 U.S.C. § 1395w-22(g); 42 C.F.R. §§ 422.560–422.622. A party may only bring suit in an Article III court to challenge an organization determination once all of the administrative remedies provided by the Act and its regulations have been exhausted. *See* 42 U.S.C. § 405(g) (authorizing judicial review of “any final decision of the Commissioner of Social Security”); 42 U.S.C. 1395w-22(g)(5) (making 42 U.S.C. § 405(g) applicable to appeals of benefits denials under Medicare Part C); *see also* *Heckler v. Ringer*, 466 U.S. 602, 617 (1984) (noting that administrative exhaustion is a “prerequisite to jurisdiction” under 42 U.S.C. § 405(g)). This is the sole pathway through which a party can obtain judicial review of any claim “arising under” the Medicare Act. 42 U.S.C. § 405(h); 42 U.S.C. § 1395ii (applying 42 U.S.C. § 405(h) to Medicare Part C); *see also* *Ringer*, 466 U.S. at 614-15 (noting that 42 U.S.C. § 405(h) and 42 U.S.C. § 1395ii, provide that § 405(g), “to the exclusion of” Congress’s provision for federal question jurisdiction under 28 U.S.C. § 1331, “is the sole avenue for judicial review for all ‘claim[s] arising under’ the Medicare Act” (alteration in original)).

MAOs pay third-party healthcare providers to treat enrollees. This can be done in one of two ways. One option is for the MAO to enter into an express, written contract with a third-party provider, whereby it agrees to pay certain rates for certain categories of treatments. *See* 42 U.S.C. § 1395w-25(b)(4). The Medicare Act permits these types of contracts, and provides very few limitations on how they can be drafted. *See, e.g.*, 42 C.F.R. § 422.520(b) (requiring contracts between MAOs and providers to contain a prompt payment provision). The third-party providers that are

parties to these agreements are called “contract providers.” The second option is for a healthcare provider that is outside of an MAO’s network of contract providers to provide treatment to a Medicare Part C enrollee, and then seek reimbursement from the MAO at a later date. These out-of-network providers are called “non-contract providers.”

The Plaintiff Hospitals in this case are noncontract providers. Appx. F at *2-3. According to their Complaint, the Hospitals agreed to provide treatment to certain enrollees that were covered by CIP. Before delivering treatment, the Hospitals contacted CIP and received both authorization to provide the services at issue and a guarantee that CIP would reimburse the Hospitals for the services provided. Appx. F at *3. In exchange for CIP’s guarantees, the Hospitals signed waivers holding the enrollees financially harmless for any costs of care and delivered the agreed-upon treatment. Appx. F at *3. The Hospitals were then paid in full for their services. Years later, after conducting an internal audit, CIP determined that it had overpaid the Plaintiff Hospitals for their services. Appx. F at *3. CIP recouped what it determined to be the amount of its overpayment by offsetting subsequent payments. Appx. F at *3.

Following CIP’s recoupment, the Hospitals brought the instant action in the district court for the Northern District of Georgia on May 28, 2015, asserting claims sounding in unjust enrichment and quantum meruit for the recouped payments. BB 7. On February 11, 2016, the district court dismissed the Hospitals’ Complaint pursuant to Federal Rule of Civil

Procedure 12(b)(1) for lack of subject matter jurisdiction. The district court held that because the Hospitals' claims were inextricably intertwined with the Medicare Act Appx. F at *13, the Hospitals were required to exhaust their administrative remedies before bringing suit in federal court, which they had not done. BB 8-9.

The Hospitals now timely appeal the district court's dismissal.

II

We review a district court's grant of a motion to dismiss *de novo*. *Zelaya v. United States*, 781 F.3d 1315, 1321 (11th Cir. 2015). The sole issue on appeal is whether the Hospitals, who are challenging CIP's recoupment decision, are parties to an "organization determination" who are subject to the administrative exhaustion requirements of the Medicare Act. We hold that they are, and therefore affirm the district court's dismissal.

III

CIP argues that its recoupment decision is an "organization determination" because the Medicare regulations define that term to include a dispute regarding coverage between an MAO and the assignee of a Medicare enrollee's claims.² RB 23-26. Because the Hospitals agreed to treat the enrollees and to hold

² CIP advances a number of other arguments as to why the Hospitals are subject to the Medicare Act's exhaustion requirement. Because we hold that the Hospitals are subject to the requirement by virtue of their status as assignees, we need not address these issues here.

them financially harmless in exchange for a right to recover their reimbursements, CIP argues that the Hospitals are “assignees” of Medicare Part C benefits within the meaning of the regulations and therefore subject to the Medicare Act’s exhaustion requirements. We agree.

Under CMS’s regulations implementing the Medicare Act’s administrative review process, 42 C.F.R. § 422.574, the “parties” to an organization determination include “[t]he enrollee” and the enrollee’s “assignee.” *Id.* An “assignee” is defined as “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.” 42 C.F.R. § 422.574(b). This definition accurately reflects what occurred in the series of transactions leading to the present lawsuit. There was no actual assignment to the hospitals signed by the enrollees, but none is required by 42 C.F.R. § 422.574(b). The Hospitals agreed to treat certain Medicare enrollees, and agreed to hold those enrollees harmless for any costs incurred in connection with their medical treatments, which is all that is required to effect the assignment. In exchange, the Hospitals assumed the enrollees’ right to Medicare reimbursement. The Hospitals then attempted to enforce that right to reimbursement against CIP, just as the enrollees would have done had there been no assignment. Under these circumstances, the Hospitals, who stand in the shoes of the enrollees, assert the enrollees’ claims and are subject to the Act’s exhaustion requirements.

This result is consistent with the exhaustion requirement’s goal of promoting the “efficient

functioning” of CMS by allowing the agency to apply its policy “expertise” to disputes arising under the act. *Tataranowicz v. Sullivan*, 959 F.2d 268, 275 (D.C. Cir. 1992). There is no sound reason why reimbursement claims should follow a separate procedural path prior to being adjudicated depending on whether they are asserted by the individual enrollee or by the treatment-providing hospital “assignee.” The benefits of the exhaustion requirement are the same in either case. CMS has extensive experience in determining the appropriate Medicare reimbursement rates for different procedures, and billing disputes that require application of the Medicare regulations can be resolved more efficiently if they are submitted to the agency in the first instance.

The Hospitals contend that they are not assignees of the enrollees’ claims, and make two separate arguments in this regard. First, they argue that they are not assignees because their Complaint does not assert their rights as the assignees of Medicare entitlements, but rather as claimants under state contract law. GB 13. This argument is meritless: the relevant question is not whether the Hospitals define *themselves* as assignees in their Complaint, but whether the Medicare Act and its implementing regulations define them as assignees for the purpose of calculating the reimbursements they are entitled to. The Medicare Act requires certain benefits claims to follow a particular procedural pathway as a matter of law. Whether the Hospitals are asserting such claims as the assignees of enrollees (and are therefore subject to the Act’s exhaustion requirements) is a matter of statutory interpretation, and is not determined by reference to the Hospitals’ pleadings.

The Hospitals next argue they are not assignees even under the terms of the Act, because they are not seeking to recover reimbursements at the rate that the enrollees would have been reimbursed based on Medicare regulations. Rather, the Hospitals argue that CIP bound itself orally to pay them at a higher rate, regardless of what benefits the enrollees were entitled to. They insist that they are seeking to recover this higher rate of reimbursement through claims sounding in the state law of quasi-contract, which would be adjudicated without reference to the Medicare Act. Because these claims do not depend on the application of Medicare rates, the Hospitals argue that the administrative exhaustion requirement does not apply.

In support of their argument, the Hospitals cite to two amicus briefs filed by HHS in lawsuits touching on similar claims, in which HHS unequivocally expresses its belief that third-party contract providers (rather than noncontract providers like the Hospitals) are not the assignees of Medicare enrollees' rights to benefits. *See* [Appellant Br. Appx. A at *6] (arguing that third-party hospitals "are *not* assignees of enrollees' claims") (emphasis added). In those briefs, HHS argued that "[a]n assignee is someone who has been assigned . . . a claim or right that originally belonged to someone else," which is not the case with contract providers. [Appellant Br. Appx. A at *6] (emphasis omitted).

But the distinction between contract providers and noncontract providers is critical. In billing disputes between MAOs and contract providers, the provider is pursuing a claim for reimbursement that only ever belonged to itself—the claim that arose under the express terms of its contract with the MAO. *Id.* Because these

amicus briefs only analyze payment disputes between MAOs and contract providers, they do not address the question that is before the Court in this appeal, and therefore cannot compel a particular interpretation of the Medicare regulations.

Ultimately, the Hospitals' argument turns on whether the Medicare Act allows an MAO to bind itself by oral agreement to pay reimbursement rates to non-contract providers that are higher than the rates required by the Medicare regulations. If MAOs can be bound by oral agreement, then the Hospitals' theory is that they are not assignees of the enrollees' claims because they are not pressing the enrollees' statutory right to recover benefits, but rather their own right, under state law of quasi-contract, to recover different rates that CIP agreed to. The fatal flaw in this theory is that, under the Medicare regulations, noncontract providers cannot charge more than Medicare reimbursement rates, and thus may not assert higher independently contracted rates. Specifically, CMS has promulgated the following regulation:

Any provider . . . that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA coordinated care plan, an MSA plan, or an MA private fee-for-service plan must accept, as payment in full, the amounts that the provider could collect if the beneficiary were enrolled in original Medicare.

42 C.F.R. § 422.214(a)(1). This regulation prohibits noncontract providers like the Hospitals from seeking reimbursement at rates that are higher than those that

could be sought by a Medicare enrollee. The only way a treatment provider can obtain rates different than those available under the Medicare Act is by entering into an express, written contract with an MAO pursuant to 42 C.F.R. § 422.520(b). Thus, the only viable claim the Hospitals can pursue is their right to recover the same reimbursements that the enrollees were entitled to receive under the Medicare Act, and that claim is subject to the Act's administrative exhaustion requirement. To the extent that the Hospitals seek to pursue entirely separate claims sounding in quantum meruit, the text of 42 C.F.R. § 422.214 makes clear that those claims are not permitted under federal law, and we see no point in permitting such a plainly meritless cause of action to proceed past the pleading stage.

The Hospitals contend that the Fifth Circuit's opinion in *RenCare, Ltd. v. Humana Health Plan of Texas, Inc.*, 395 F.3d 555 (5th Cir. 2004), addressed the same question at issue here and reached a contrary result.³ Not so. *Rencare* addressed claims brought by contract providers against an MAO for breach of the

³ The Hospitals also cite to an unpublished opinion of the Sixth Circuit, *Ohio State Chiropractic Ass'n v. Humana Health Plan Inc.*, 647 F. App'x 619 (6th Cir. 2016), which they claim supports their position. The Hospitals' reliance on this decision is misplaced. *Ohio State Chiropractic* addressed a question not before us: whether an MAO can remove a suit to federal court under 28 U.S.C. § 1442(a) on the grounds that it "act[s] under" the authority of CMS, and that its decisions are therefore subject to federal question jurisdiction. *Id.* at 622-23. While the defendant in that case did argue that noncontract providers under Medicare Part C are required to exhaust their administrative remedies before bringing suit in federal court, the Sixth Circuit declined to address that issue on appeal. *Id.* at 625.

express provisions of a written contract. *Id.* at 557. While the *Rencare* court did hold that contract providers are not assignees of their patients' claims, *id.* at 560, this holding is distinguishable because again the Medicare regulations treat noncontract providers differently than contract providers. As the *Rencare* court noted, the Medicare Act explicitly allows contract providers and MAOs to define the terms of their own agreements without reference to the Medicare regulations. *Id.* at 559 (noting that "contracts between [Medicare Advantage] organizations and providers are subject to very few restrictions" under 42 C.F.R. § 422.520(b)). A contract provider's claims are determined entirely by reference to the written contract, not the Medicare Act. The Medicare Act and its implementing regulations make no such exception for equitable claims sounding in quantum meruit or quasicontract, and indeed expressly forbid noncontract providers from raising such claims. In any event, the *Rencare* court's treatment of the "assignee" argument was confined to a single cursory paragraph at the end of its opinion, *id.* at 560, and it neither quoted nor analyzed the language of 42 C.F.R. § 422.574(b), which we conclude unambiguously defines the noncontract providers in this case as assignees, or 42 C.F.R. § 422.214, which limits noncontract providers to recovering only those payments explicitly authorized by the Medicare Act in exchange for treating enrollees.

We are sympathetic to the concern HHS has expressed in amicus briefs filed in other appeals that "extending an administrative exhaustion requirement to payment disputes purely between an MAO and a provider would improperly tax, and potentially overwhelm, CMS's limited resources." [Appellant Br. Appx.

B at *10]. However, the language of the Medicare Act and its implementing regulations is clear that billing disputes between MAOs and noncontract provider assignees qualify as “organization determinations,” and are therefore subject to the Act’s exhaustion requirement. If this result strains the resources of CMS, any solution must come from Congress or the agency. We are not “authorized to rewrite a statute because [we] might deem its effects susceptible of improvement.” *Harris v. Garner*, 216 F.3d 970, 976 (11th Cir. 2000) (quoting *Badaracco v. Comm’r*, 464 U.S. 386, 398 (1984)).

We have considered the Hospitals’ remaining arguments, and we find them unavailing. For the foregoing reasons, we AFFIRM the judgment of the district court.

AFFIRMED.

APPENDIX B
IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

**TENET HEALTHSYSTEM GB,
INC., d/b/a ATLANTA
MEDICAL CENTER and AT-
LANTA MEDICAL CENTER
SOUTH CAMPUS, et al.,**

Plaintiffs,

v.

**CARE IMPROVEMENT PLUS
SOUTH CENTRAL INSUR-
ANCE COMPANY,**

Defendant.

**1:15-cv-1922-
WSD**

OPINION AND ORDER

This matter is before the Court on Defendant Care Improvement Plus South Central Insurance Company's ("Defendant") Motion to Dismiss Plaintiffs' Complaint [9] ("Motion to Dismiss").

I. BACKGROUND

Defendant is a Medicare Advantage (“MA”) organization. MA organizations, such as Defendant, enter into contracts with the Centers for Medicare and Medicaid Services (“CMS”) to provide health insurance plans to Medicare beneficiaries (“Defendant’s Insureds”). (Compl. [1] ¶ 17). Medicare-eligible individuals enroll in Defendant’s health plan and, as Defendant’s Insureds, receive coverage for benefits provided by traditional Medicare as well as additional benefits not provided by Medicare. (Id.).

Under Medicare Part C, CMS pays Defendant a fixed amount each month based on the number of Medicare enrollees it covers, and Defendant must use those payments to provide for healthcare services rendered to Defendant’s Insureds. Defendant is required to pay for the care provided to its Insureds regardless of whether CMS’s monthly payments adequately cover those costs. (Id. ¶¶18-20).

Plaintiffs¹ are eleven (11) hospitals that provide healthcare services to Defendant’s Insureds. (Id. ¶¶ 2-12, 23). An MA organization typically has a network of

¹ Tenet Healthsystem GB, Inc., d/b/a Atlanta Medical Center and Atlanta Medical Center South Campus; North Fulton Medical Center, Inc., d/b/a North Fulton Regional Hospital; Tenet Healthsystem Spalding, Inc., d/b/a Spalding Regional Medical Center; Tenet Healthsystem SGH, Inc., d/b/a Sylvan Grove Hospital; Coastal Carolina Medical Center, Inc., d/b/a Coastal Carolina Hospital; East Cooper Community Hospital, Inc., d/b/a East Cooper Medical Center; Hilton Head Health System, LP, d/b/a Hilton Head Hospital; Amisub of South Carolina, Inc., d/b/a Piedmont Medical Center; Tenet Healthsystem DI, Inc., d/b/a Des Peres Hospital; Tenet Healthsystem SL, Inc., d/b/a Saint Louis University Hospital; AMISUB (SFH), Inc., d/b/a Saint Francis Hospital (collectively, “Plaintiffs”).

contracting providers, known as in-network providers, that are reimbursed for the services they provide to members of the MA organization's health plan under the terms of their respective contracts. (Id. ¶¶ 21-23). Plaintiffs do not have written contracts with Defendant, but certain of Defendant's Insureds experienced medical conditions that required them to receive treatment at Plaintiffs' hospitals. (See Id. ¶¶ 21-23).

Plaintiffs allege that, before treating Defendant's Insureds, Plaintiffs obtained authorizations from Defendant to provide the services at issue. In return, Defendant promised Plaintiffs that it would reimburse them for the services provided to Defendant's Insureds. Based upon these promises, Plaintiffs provided the required care. (Id. ¶¶ 24-26). Because of these promised payments, Plaintiffs allege they waived their right to direct payment from Defendant's Insureds to whom they provided medical services. (Id. ¶ 36).

After the Defendant's Insureds were discharged, Plaintiffs submitted bills to Defendant for the authorized services, and Defendant paid the bills in full. Several months, and sometimes years, after the payments, Defendant conducted post-payment audits and "unilaterally recouped substantial sums from the Plaintiff[s]." (Id. ¶ 34). Plaintiffs allege that they challenged Defendant's recoupment decisions, but that Defendant refused to return the payments to Plaintiffs. (Id. ¶ 35). They allege that all efforts to resolve Defendant's wrongful actions have been exhausted, excused or waived, and as a result this action was filed. (Id.). In

their Complaint, Plaintiffs allege claims for unjust enrichment and quantum meruit.² (Id. ¶¶ 40-56).

On July 22, 2015, Defendant filed its Motion to Dismiss. In it, Defendant argues: (1) the Court lacks subject-matter jurisdiction over Plaintiffs' claims because Plaintiffs failed to exhaust their administrative remedies; (2) the Medicare Act preempts Plaintiff's state common law claims; and (3) Plaintiffs fail to state a claim upon which relief can be granted because Plaintiffs fail to identify which laws are applicable to their claims.

II. DISCUSSION

A. Legal Standard

Rule 12(b)(1) of the Federal Rules of Civil Procedure permits a party to move for dismissal when the court lacks jurisdiction over the subject matter of the dispute. "If the court determines at any time that it lacks subject-matter jurisdiction, the court must dismiss the action." Fed. R. Civ. P. 12(h)(3).

A motion to dismiss for lack of subject matter jurisdiction under Rule 12(b)(1) may be either a "facial" or "factual" attack. Morrison v. Amway Corp., 323 F.3d

² Plaintiffs also allege that, in conducting the post-payment audits, Defendant demanded Plaintiffs provide voluminous medical records for certain patient accounts. (Compl. ¶ 32). Plaintiffs seek a declaratory judgment under 28 U.S.C. § 2201 that they are not required to comply with Defendant's demands for medical records, and that Defendant may not recoup any monies from Plaintiffs in connection with or as a result of their requests to produce medical records. (Id. ¶¶ 57-64).

920, 924-25 n.5 (11th Cir. 2003). A facial attack challenges subject matter jurisdiction on the basis of the allegations in a Complaint, and the district court takes the allegations as true in deciding whether to grant the motion. Id.

Factual attacks challenge subject matter jurisdiction in fact. Id. When resolving a factual attack, the Court may consider extrinsic evidence, such as testimony and affidavits. Id. In a factual attack, the presumption of truthfulness afforded a plaintiff under Federal Rule of Civil Procedure 12 (b)(6) does not apply, Scarfo v. Ginsberg, 175 F.3d 957, 960-61 (11th Cir. 1999). The plaintiff has the burden to prove that jurisdiction exists. Elend v. Basham, 471 F.3d 1199, 1206 (11th Cir. 2006).

B. Analysis

Defendant argues that the Court lacks subject-matter jurisdiction over this action because Plaintiffs failed to exhaust their administrative remedies under the Medicare Act.

The Medicare program, which provides medical insurance for the aged and disabled, is administered by CMS, a division of the U.S. Department of Health and Human Services (“HHS”).³ The Medicare Act, 42 U.S.C. §§ 1395-1395ggg, consists of three parts, labeled Parts A, B, and C, that are relevant to the discussion

³ The Court’s summary of the Medicare statutory and regulatory framework borrows from the summary provided by the court in Doctors Med. Ctr. of Modesto, Inc. v. Kaiser Found. Health Plan, Inc., 989 F. Supp. 2d 1009, 1014 (E.D. Cal. 2013).

below. Congress established the MA program under Part C, 42 U.S.C. §§ 1395w-21 to 1395w-28. The MA program allows eligible individuals to elect to receive Medicare benefits directly from a private health plan, such as the one offered by Defendant. 42 U.S.C. §§ 1395W-21, -22. Under the MA program, instead of using the Part A traditional fee-for-service program, HHS pays MA organizations like Defendant on a monthly, or capitated, basis for each Medicare beneficiary enrolled in the plan. 42 U.S.C. §§ 1395w-21, -23 & -24. Because the MA organization receives the same payment regardless of the number of times an enrollee needs care, Medicare's financial exposure is transferred to the MA plan. 42 U.S.C. § 1395w-22(a)(2)(A). The amount of the monthly payment is based on the contract between the MA organization and CMS. 42 U.S.C. § 1395w-27.

The Medicare Act requires MA plans to cover emergency services provided by non-contracted providers, like Plaintiffs. 42 U.S.C. § 1395w-22(d)(1)(E). Payment amounts due to a non-contracted emergency provider are limited to what "the provider would collect if the beneficiary were enrolled in original Medicare." 42 C.F.R. § 422.214(a). The Medicare Act further provides that where the MA organization is made a secondary payer, as defined by 42 U.S.C. § 1395y(b)(2)(A), the MA organization may charge the primary plan. 42 U.S.C. § 1395w-22(a)(4); 42 C.F.R. § 422.108. An MA organization becomes a secondary payer where "payment has been made or can reasonably be expected to be made . . . under an automobile or liability insurance policy or plan (including a self insured plan) or under no fault insurance." 42 U.S.C. § 1395y(b)(2)(A)(ii).

Title 42 U.S.C. § 405(h), made applicable to the Medicare Act by 42 U.S.C. § 1395ii, provides that 42 U.S.C. § 405(g) is “the sole avenue for judicial review” for claims “arising under’ the Medicare Act.” Heckler v. Ringer, 466 U.S. 602, 614-15 (1984). CMS regulations provide an administrative appeal process that allows a provider that furnishes services to an enrollee to request an “organization determination,” a determination “with respect to . . . [p]ayment for any . . . health services furnished by a provider other than the MA organization that the enrollee believes are covered under Medicare.” 42 C.F.R. § 422.566(b)(2)(I). After the MA organization renders its organization determination regarding payment, any party to the organization determination, including “[a]ny other provider or entity (other than the MA organization) determined to have an appealable interest in the proceeding,” may seek reconsideration of the organization determination. Id. §§ 422.574, 422.582. After reconsideration of the organization determination, any party to the reconsideration may request a hearing before an administrative law judge (“ALJ”). Id. § 422.600. After the ALJ renders a decision, any party to the hearing may request a review by the Medicare Appeals Council. Id. § 422.608. After the Medicare Appeals Council makes its final decision, a party may seek judicial review in federal court. 42 U.S.C. § 405(g); 42 U.S.C. § 1395w-22(g)(5); 42 C.F.R. § 422.612(c).

The Eleventh Circuit has recognized that a lawsuit that seeks to recover on any claim “arising under” the Medicare Act must first be brought through the HHS administrative appeals process before it can be

taken to federal court. Lifestar Ambulance Serv., Inc. v. HHS, 365 F.3d 1293, 1296 (11th Cir. 2004); Cochran v. U.S. Health Care Fin. Admin., 291 F.3d 775, 778-79 (11th Cir. 2002). “This nearly absolute channeling requirement serves important governmental interests in administrative efficiency and judicial economy, and assures the agency greater opportunity to apply, interpret, or revise policies, regulations, or statutes.” Lifestar, 365 F.3d at 1296 (internal quotation marks omitted). Claims presented under state law may be construed as “arising under” the Medicare Act if (1) the standing and substantive basis for presentation of the claim are the Medicare Act, or (2) a claim is inextricably intertwined with a claim for reimbursement of medical benefits. Heckler, 466 U.S. at 623.

At the outset, the Court notes that the parties do not cite to—and the Court is unable to find—binding precedent on the issues presented by the parties. The Court thus looks to persuasive authority in reaching its conclusion.

Plaintiffs argue that the payment decisions at issue were not “organization determinations,” and therefore there are no Medicare administrative appeals processes that apply to their claims. In support of this argument, Plaintiffs primarily rely on the Fifth Circuit’s decision in RenCare, Ltd. v. Humana Health Plan of Tex., Inc., 395 F.3d 555 (5th Cir. 2004). In RenCare, a kidney dialysis provider sued an MA organization for reimbursement of services provided to the MA organization’s members under a contract between the provider and the MA organization. Id. at 556. The Fifth Circuit held that, because the provider’s

claims for breach of contract, detrimental reliance, fraud, and violations of state law were not “inextricably intertwined with a claim for Medicare benefits,” those claims did not arise under the Medicare Act. Id. at 560. In reaching this holding, the Fifth Circuit contrasted the claims in RenCare with the claims brought in Heckler. First, the Fifth Circuit noted that, unlike in Heckler, there were “no enrollees seeking Medicare benefits.” Id. at 558. Next, the Fifth Circuit noted that the government did not have any financial interest in the outcome of RenCare because it paid the insurance company a flat rate under Part C of Medicare, but it had a financial interest in Heckler because the enrollees were seeking benefits to be paid by the government itself under Parts A or B of Medicare. Id. The Fifth Circuit also emphasized that, under Part C:

the [MA] organization assumes responsibility and full financial risk for providing and arranging healthcare services for [MA] beneficiaries, sometimes contracting health care providers to furnish medical services to those beneficiaries. Such contracts between [MA] organizations and providers are subject to very few restrictions; generally, the parties may negotiate their own terms.

Id. at 559 (internal citations omitted).

Defendant argues that RenCare does not apply here, including because the parties in RenCare entered into a provider contract. (Reply at 10-11). Defendant argues that the Fifth Circuit in RenCare turned to the contract to resolve the dispute, but, in the absence of a

contract, “the only way to determine if [Defendant] owes Plaintiffs money is to look at the Medicare regulations.” (*Id.* at 8, 10-11). Defendant urges the Court to adopt the reasoning of the court in Doctors Med. Ctr. of Modesto, Inc. v. Kaiser Found. Health Plan, Inc., 989 F. Supp. 2d 1009, 1014 (E.D. Cal. 2013).

In Kaiser, the court found that, whereas the parties in RenCare were bound by a contract, “[i]n this case . . . the Hospital does not allege that it had an express written contract . . . [and] the dispute over [the MA organization]’s payment obligation turns on the standards provided by the Medicare Act and CMS regulations for paying non-contracted emergency providers when a primary payer may be liable.” *Id.* at 1014-15 (citing 42 U.S.C. § 1395w-22(d)(1)(E); 42 C.F.R. §§ 422.214, 422.108, and 422.566). In dismissing the plaintiff’s state law claims, the court explained, “[a]lthough, as in RenCare, the government’s risk has been extinguished by its monthly capitation payments to [the MA organization], the Hospital’s claims for reimbursement . . . are still ‘inextricably intertwined’ with the Medicare Act and are subject to its exhaustion requirements.” *Id.* at 1015 (citing Heckler, 466 U.S. at 615).

The Southern District of New York, in a case involving related legal issues, reached a conclusion similar to the one reached by the Kaiser court, which noted the importance of a contractual relationship in deciding if a dispute was within or without the Medicare Act and the CMS regulations. In New York City Health and Hosps. Corp. v. WellCare of New York, Inc.,

769 F. Supp. 2d 250, 258 (S.D.N.Y. 2011), the court explained: “The RenCare court emphasized that contracts between MA Organizations and Contracted Providers are subject to very few restrictions, and that the contracting parties can generally negotiate their own terms. By contrast, the parties here had no contractual relationship and reimbursement is governed by a complex federal regulatory scheme.”⁴ The Southern District of New York noted that CMS has “enhanced regulatory authority over matters involving Non-Contracted Providers as compared to Contracted Providers.” New York City Health and Hosps. Corp. v. WellCare of New York, Inc., 801 F. Supp. 2d 126, 139 (S.D.N.Y. 2011).⁵

The Court finds the Kaiser⁶ and WellCare courts’ reasoning sound. It is critical here that Plaintiffs are non-contracting providers under the MA

⁴ The Wellcare court analyzed RenCare in the context of a motion to remand, rather than a motion to dismiss, and the issues before the court in WellCare thus were different than those presently before the Court. The WellCare court’s reasoning with respect to RenCare is, nevertheless, similar to what is required here.

⁵ In response to a payment dispute between a contracted provider and an MA organization, CMS wrote: “the existence of provider contracts that can be enforced by the courts is why the Congress limited [CMS]’s regulatory authority in comparison to those afforded non-contracted providers.” Christus Health Gulf Coast v. Aetna, Inc., 237 S.W.3d 338, 340-41 (Tex. 2007) (quoting Letter from Acting Director of the CMS Medicare Managed Care Group to Plaintiffs (Mar. 30, 2001)).

⁶ In their Response, Plaintiffs incorrectly state that the Kaiser court found that a provider’s state law claims were not subject

program, because Medicare regulations provide the standards governing their relationship with Defendant, including the standards governing Plaintiffs' claims. See Kaiser, 989 F. Supp. 2d at 1014 (finding that MA organization's payment obligation with respect to non-contracting hospitals "turns on" Medicare Act and CMS regulations); Wellcare, 769 F. Supp. 2d at 258 (because there is no contract, "reimbursement is governed by a complex federal regulatory scheme"). Mindful that the "channeling of virtually all legal attacks through the [DHS] . . . serves important governmental interests in administrative efficiency and judicial economy," Lifestar, 365 F.3d at 1296 (internal quotation marks omitted), the Court finds that, under these circumstances, Plaintiffs' claims are inextricably intertwined with the Medicare Act, and are subject to its exhaustion requirements. See Heckler, 466 U.S. at 615; Kaiser, 989 F. Supp. 2d at 1015.

Defendant next argues that Assocs. Rehabilitation Recovery, Inc. v. Humana Med. Plan, Inc., 76 F. Supp. 3d 1388 (S.D. Fla. 2014)⁷ provides an independent basis for dismissal of Plaintiffs' claims for lack of subject-matter jurisdiction. In Assocs. Rehabilitation, the court noted that the regulations in place at the time of the Fifth Circuit's RenCare decision had changed, altering the way MA organizations are paid. Id. at 1392 (citing 42 USC § 1395w-24(a)(1)(A)). The Assocs. Rehabilitation court explained:

to the exhaustion requirement. (Resp. at 10 n.14). As explained above, Kaiser stands for the exact opposite proposition.

⁷ Plaintiffs incorrectly state that the Assocs. Rehabilitation decision is unpublished. (Resp. at 16).

Under the new framework, MA organizations must now submit a bid estimating its costs for the following year. Decisions on whether payments should or should not be made affect the estimated medical expenses for the following year, which in turn affect the government's savings and the enrollee's premiums and benefits received. Therefore, the way in which claims for benefits are resolved will have a financial impact on the government and enrollees.

Id. The court concluded, in light of the new framework, that a plaintiff's claims were "inextricably intertwined with a claim for reimbursement of medical benefits" where "a health care provider[] provided medical treatment to Medicare enrollees and is now seeking reimbursement for services rendered to those enrollees." Id. at 1393. The court found that RenCare did not apply even though the MA organization and the healthcare provider entered into a contract. See id.

In Ohio State Chiropractic Ass'n v. Humana Health Plan, Inc., No. 5:14CV2313, 2015 WL 350391, at *3 (N.D. Ohio Jan. 26, 2015), the Northern District of Ohio agreed with the Assocs. Rehabilitation court's reasoning. The facts of Ohio State Chiropractic are strikingly similar to the case before the Court. There, as here, the plaintiff was a non-contracted provider to an MA organization. Id. at *2. Plaintiff claimed that the MA organization, Humana, attempted to recoup alleged overpayments by deducting amounts from bills

later submitted by plaintiff. Id. Plaintiff sought a declaratory judgment, and raised claims of unjust enrichment and breach of implied contract, among other state law claims. Plaintiff relied on RenCare to support its argument that payment disputes between an MA organization and providers are not properly construed as claims for Medicare benefits, and are not subject to the exhaustion requirement. See id. Relying on Assocs. Rehabilitation, the court found that, under the new framework, “any resolution of whether Humana has a right to recover . . . alleged repayments will have a direct financial impact on the federal government,” because a “ruling in Plaintiffs’ favor will alter the estimated medical expenses for Humana moving forward, in turn affecting the government’s savings and enrollees’ premiums.” Ohio State Chiropractic, 2015 WL 350391, at *3. The court concluded that the plaintiff’s claims “are inextricably intertwined with a claim for Medicare benefits,” and “must be administratively exhausted before they are presented to a District Court for review.” Id.

Plaintiffs argue that the court’s reasoning in Assocs. Rehabilitation is flawed, because “the possibility that decisions on current claims *might* affect bids in future years is beyond speculative,” and contend that, with respect to their claims, “the government’s risk was extinguished by its capitated payments to [Defendant].” (Resp. at 16). Plaintiffs note that “[n]umerous courts have continued to cite RenCare as authoritative long after the 2006 Medicare Advantage amendments. (Id. at 17 (citing cases)).

The Court acknowledges that several district courts have applied RenCare after the 2006 MA amendments. See, e.g., Main & Assocs., Inc. v. Blue Cross and Blue Shield of Ala., 776 F. Supp. 2d 1270, 1280 (M.D. Ala. 2011) (“The dispute here is between a private [healthcare] provider . . . and [an MA organization]. Neither the government, nor any Medicare enrollees are parties to this action . . . [and] no government funds are at risk . . .”).⁸ In the absence of controlling authority, and after a review of the relevant legal and regulatory framework, the Court finds the reasoning in Assocs. Rehabilitation and Ohio State Chiropractic compelling and applies it in this matter.

The Court disagrees with Plaintiffs’ argument that “the possibility that decisions on current claims *might* affect bids in future years is beyond speculative.” (Resp. at 16). As the Third Circuit explained:

If an MA plan provides CMS with a bid to cover Medicare-eligible individuals for an amount less than the benchmark amount calculated by CMS, it must use seventy-five percent of that savings to provide additional benefits to its enrollees. 42 U.S.C. § 1395w-24(b)(1)(C)(i), (b)(3)(C), (b)(4)(C). The remaining twenty-five percent of the savings is retained by the Medicare Trust Fund. Accordingly, when MA[organizations] spend less on providing coverage for their enrollees, as they

⁸ The Court notes that the Main & Assocs. court ultimately granted plaintiff’s motion to remand on the ground that plaintiff’s state law claims did not provide a sufficient basis for the exercise of federal jurisdiction. Id. at 1281.

will if they recover efficiently from primary payers, the Medicare Trust Fund does achieve cost savings . . . [and] that savings results in additional benefits to enrollees not covered by traditional Medicare.

In re Avandia Mktg., Sales Practices & Prods. Liab. Litig., 685 F.3d 353, 364-65 (3d Cir. 2012). The Avandia court’s explanation of the interests and factors at issue further supports that “a ruling in Plaintiffs’ favor will alter the estimated medical expenses for [Defendant] moving forward, in turn affecting the government’s savings and enrollees’ premiums.” Ohio State Chiropractic, 2015 WL 350391, at *3.⁹

For these additional reasons, the Court concludes that Plaintiffs’ claims “are inextricably intertwined with a claim for Medicare benefits,” and “must be administratively exhausted before they are presented to a District Court for review.” Id.¹⁰

III. CONCLUSION

For the foregoing reasons,

⁹ Though the Avandia court addressed issues different than those presently before the Court, its explanation of the regulatory scheme supports the concrete effect this litigation will have on Defendant’s future bids, on the Medicare Trust Fund, and on enrollees’ benefits.

¹⁰ Because the Court concludes that it lacks subject-matter jurisdiction over this action, the Court does not reach Defendant’s other grounds for dismissal.

IT IS HEREBY ORDERED that Defendant Care Improvement Plus South Central Insurance Company's Motion to Dismiss Plaintiffs' Complaint [9] is **GRANTED**.

IT IS FURTHER ORDERED that this action is **DISMISSED**.

SO ORDERED this 11th day of February, 2016.

/s/ William S. Duffey
WILLIAM S. DUFFEY, JR.
UNITED STATES DISTRICT JUDGE

APPENDIX C

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 16-11176-CC

TENET HEALTHSYSTEM GB, INC.,
d.b.a. Atlanta Medical Center
d.b.a. Atlanta Medical Center South Campus,
NORTH FULTON MEDICAL CENTER, INC.,
d.b.a. North Fulton Regional Hospital,
TENET HEALTHSYSTEM SPALDING, INC.,
d.b.a. Spalding Regional Medical Center,
TENET HEALTHSYSTEM SGH, INC.,
d.b.a. Sylvan Grove Hospital,
COASTAL CAROLINA MEDICAL CENTER, INC.,
d.b.a. Coastal Carolina Hospital,
EAST COOPER COMMUNITY HOSPITAL INC.,
d.b.a. East Cooper Medical Center,
HILTON HEAD HEALTH SYSTEM, LP.,
d.b.a. Hilton Head Hospital,
AMISUB OF SOUTH CAROLINA, INC.,
d.b.a. Piedmont Medical Center,
TENET HEALTHSYSTEM DI, INC.,
d.b.a. Des Peres Hospital,
TENET HEALTHSYSTEM SL, INC.,
d.b.a. Saint Louis University Hospital,
AMISUB (SFH), INC.,
d.b.a. Saint Francis Hospital,

Plaintiffs - Appellants,

versus

CARE IMPROVEMENT PLUS SOUTH
CENTRAL INSURANCE COMPANY,

Defendant – Appellee.

Appeal from the United States District Court
for the Northern District of Georgia

BEFORE: MARCUS, DUBINA, and WALKER,* Circuit
Judges.

PER CURIAM:

The petition(s) for panel rehearing filed by Appellants is
DENIED.

ENTERED FOR THE COURT:

/s/ SM
UNITED STATES CIRCUIT JUDGE

* Honorable John M. Walker, Jr., United States Circuit
Judge for the Second Circuit, sitting by designation.

ORD-41

APPENDIX D

42 U.S.C. § 1395w-22. Benefits and Beneficiary protections

(g) Coverage determinations, reconsiderations, and appeals

(1) Determinations by organization

(A) In general

A Medicare Choice organization shall have a procedure for making determinations regarding whether an individual enrolled with the plan of the organization under this part is entitled to receive a health service under this section and the amount (if any) that the individual is required to pay with respect to such service. Subject to paragraph (3), such procedures shall provide for such determination to be made on a timely basis.

(B) Explanation of determination

Such a determination that denies coverage, in whole or in part, shall be in writing and shall include a statement in understandable language of the reasons for the denial and a description of the reconsideration and appeals processes.

(2) Reconsiderations

(A) In general

The organization shall provide for reconsideration of a determination described in paragraph (1)(B) upon request by the enrollee involved. The reconsideration shall be within a time period specified by the Secretary,

but shall be made, subject to paragraph (3), not later than 60 days after the date of the receipt of the request for reconsideration.

(B) Physician decision on certain reconsiderations

A reconsideration relating to a determination to deny coverage based on a lack of medical necessity shall be made only by a physician with appropriate expertise in the field of medicine which necessitates treatment who is other than a physician involved in the initial determination.

(3) Expedited determinations and reconsiderations

(A) Receipt of requests

(i) Enrollee requests

An enrollee in a Medicare Choice plan may request, either in writing or orally, an expedited determination under paragraph (1) or an expedited reconsideration under paragraph (2) by the Medicare Choice organization.

(ii) Physician requests

A physician, regardless whether the physician is affiliated with the organization or not, may request, either in writing or orally, such an expedited determination or reconsideration.

(B) Organization procedures

(i) In general

The Medicare Choice organization shall maintain procedures for expediting organization determinations and reconsiderations when, upon request of an enrollee, the organization determines that the application of the normal time frame for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

(ii) Expedition required for physician requests In the case of a request for an expedited determination or reconsideration made under subparagraph (A)(ii), the organization shall expedite the determination or reconsideration if the request indicates that the application of the normal time frame for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

(iii) Timely response In cases described in clauses (i) and (ii), the organization shall notify the enrollee (and the physician involved, as appropriate) of the determination or reconsideration under time limitations established by the Secretary, but not later than 72 hours of the time of receipt of the request for the determination or reconsideration (or receipt of the information necessary to make the determination or reconsideration), or such longer period as the Secretary may permit in specified cases.

(4) Independent review of certain coverage denials

The Secretary shall contract with an independent, outside entity to review and resolve in a timely manner reconsiderations that affirm denial of coverage, in whole or in part. The provisions of section 1395ff (c)(5) of this title shall apply to independent outside entities under contract with the Secretary under this paragraph.

(5) Appeals

An enrollee with a Medicare Choice plan of a Medicare Choice organization under this part who is dissatisfied by reason of the enrollee's failure to receive any health service to which the enrollee believes the enrollee is entitled and at no greater charge than the enrollee believes the enrollee is required to pay is entitled, if the amount in controversy is \$100 or more, to a hearing before the Secretary to the same extent as is provided in section 405 (b) of this title, and in any such hearing the Secretary shall make the organization a party. If the amount in controversy is \$1,000 or more, the individual or organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 405 (g) of this title, and both the individual and the organization shall be entitled to be parties to that judicial review. In applying subsections (b) and (g) of section 405 of this title as provided in this paragraph, and in applying section 405 (l) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively. The provisions of section 1395ff (b)(1)(E)(iii) of this title shall apply with respect to dollar amounts specified in the first 2 sentences of this

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paragraph in the same manner as they apply to the dollar amounts specified in section 1395ff (b)(1)(E)(i) of this title.

APPENDIX E

42 C.F.R. § 422.562 General provisions.

(a) Responsibilities of the MA organization.

(1) An MA organization, with respect to each MA plan that it offers, must establish and maintain—

(i) A grievance procedure as described in § 422.564 for addressing issues that do not involve organization determinations;

(ii) A procedure for making timely organization determinations;

(iii) Appeal procedures that meet the requirements of this subpart for issues that involve organization determinations; and

(2) An MA organization must ensure that all enrollees receive written information about the—

(i) Grievance and appeal procedures that are available to them through the MA organization; and

(ii) Complaint process available to the enrollee under the QIO process as set forth under section 1154(a)(14) of the Act.

(3) In accordance with subpart K of this part, if the MA organization delegates any of its responsibilities under this subpart to another entity or individual through which the organization provides health care services, the MA organization is ultimately responsible for ensuring that the entity

or individual satisfies the relevant requirements of this subpart.

(4) An MA organization must employ a medical director who is responsible for ensuring the clinical accuracy of all organization determinations and reconsiderations involving medical necessity. The medical director must be a physician with a current and unrestricted license to practice medicine in a State, Territory, Commonwealth of the United States (that is, Puerto Rico), or the District of Columbia.

(b) Rights of MA enrollees. In accordance with the provisions of this subpart, enrollees have the following rights:

(1) The right to have grievances between the enrollee and the MA organization heard and resolved, as described in § 422.564.

(2) The right to a timely organization determination, as provided under § 422.566.

(3) The right to request an expedited organization determination, as provided under § 422.570.

(4) If dissatisfied with any part of an organization determination, the following appeal rights:

(i) The right to a reconsideration of the adverse organization determination by the MA organization, as provided under § 422.578.

(ii) The right to request an expedited reconsideration, as provided under § 422.584.

(iii) If, as a result of a reconsideration, an MA organization affirms, in whole or in part, its adverse organization determination, the right to an automatic reconsidered determination made by an independent, outside entity contracted by CMS, as provided in § 422.592.

(iv) The right to an ALJ hearing if the amount in controversy is met, as provided in § 422.600.

(v) The right to request Council review of the ALJ hearing decision, as provided in § 422.608.

(vi) The right to judicial review of the hearing decision if the amount in controversy is met, as provided in § 422.612.

(c) Limits on when this subpart applies.

(1) If an enrollee receives immediate QIO review (as provided in § 422.622) of a determination of noncoverage of inpatient hospital care the enrollee is not entitled to review of that issue by the MA organization.

(2) If an enrollee has no further liability to pay for services that were furnished by an MA organization, a determination regarding these services is not subject to appeal.

(d) When other regulations apply.

(1) Unless this subpart provides otherwise and subject to paragraph (d)(2) of this section, the regulations in part 405 of this chapter (concerning the administrative review and hearing processes and

representation of parties under titles II and XVIII of the Act) apply under this subpart to the extent they are appropriate.

(2) The following regulations in part 405 of this chapter, and any references thereto, specifically do not apply under this subpart:

(i) Section 405.950 (time frames for making a re-determination).

(ii) Section 405.970 (time frames for making a reconsideration following a contractor redetermination, including the option to escalate an appeal to the OMHA level).

(iii) Section 405.1016 (time frames for deciding an appeal of a QIC reconsideration, or escalated request for a QIC reconsideration, including the option to escalate an appeal to the Council).

(iv) The option to request that an appeal be escalated from the OMHA level to the Council as provided in § 405.1100(b), and time frames for the Council to decide an appeal of an ALJ's or attorney adjudicator's decision or an appeal that is escalated from the OMHA level to the Council as provided in § 405.1100(c) and (d).

(v) Section 405.1132 (request for escalation to Federal court).

(vi) Sections 405.956(b)(8), 405.966(a)(2), 405.976(b)(5)(ii), 405.1018(c), 405.1028(a), and 405.1122(c), and any other reference to requiring a determination of good cause for the introduction

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of new evidence by a provider, supplier, or a beneficiary represented by a provider or supplier.

APPENDIX F

42 C.F.R. § 422.566 Organization determinations.

(a) Responsibilities of the MA organization. Each MA organization must have a procedure for making timely organization determinations (in accordance with the requirements of this subpart) regarding the benefits an enrollee is entitled to receive under an MA plan, including basic benefits as described under § 422.100(c)(1) and mandatory and optional supplemental benefits as described under § 422.102, and the amount, if any, that the enrollee is required to pay for a health service. The MA organization must have a standard procedure for making determinations, in accordance with § 422.568, and an expedited procedure for situations in which applying the standard procedure could seriously jeopardize the enrollee's life, health, or ability to regain maximum function, in accordance with §§ 422.570 and 422.572.

(b) Actions that are organization determinations. An organization determination is any determination made by an MA organization with respect to any of the following:

(1) Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services.

(2) Payment for any other health services furnished by a provider other than the MA organization that the enrollee believes—

(i) Are covered under Medicare; or

(ii) If not covered under Medicare, should have been furnished, arranged for, or reimbursed by the MA organization.

(3) The MA organization'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.

(4) Reduction, or premature discontinuation, of a previously authorized ongoing course of treatment.

(5) Failure of the MA organization to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

(c) Who can request an organization determination.

(1) Those individuals or entities who can request an organization determination are—

(i) The enrollee (including his or her representative);

(ii) Any provider that furnishes, or intends to furnish, services to the enrollee; or

(iii) The legal representative of a deceased enrollee's estate.

(2) Those who can request an expedited determination are—

(i) The enrollee (including his or her representative); or

(ii) A physician (regardless of whether the physician is affiliated with the MA organization).

(d) Who must review organization determinations. If the MA organization expects to issue a partially or fully adverse medical necessity (or any substantively equivalent term used to describe the concept of medical necessity) decision based on the initial review of the request, the organization determination must be reviewed by a physician or other appropriate health care professional with sufficient medical and other expertise, including knowledge of Medicare coverage criteria, before the MA organization issues the organization determination decision. The physician or other health care professional must have a current and unrestricted license to practice within the scope of his or her profession in a State, Territory, Commonwealth of the United States (that is, Puerto Rico), or the District of Columbia.

APPENDIX G

42 C.F.R. § 422.568 Standard timeframes and notice requirements for organization determinations.

(a) Method and place for filing a request. An enrollee must ask for a standard organization determination by making a request with the MA organization or, if applicable, to the entity responsible for making the determination (as directed by the MA organization), in accordance with the following:

(1) The request may be made orally or in writing, except as provided in paragraph (a)(2) of this section.

(2) Requests for payment must be made in writing (unless the MA organization or entity responsible for making the determination has implemented a voluntary policy of accepting verbal payment requests).

(b) Timeframe for requests for service. Except as provided in paragraph (b)(1) of this section, when a party has made a request for a service, the MA organization must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after the date the organization receives the request for a standard organization determination.

(1) Extensions. The MA organization may extend the timeframe by up to 14 calendar days if—

(i) The enrollee requests the extension;

(ii) The extension is justified and in the enrollee's interest due to the need for additional medical evidence from a noncontract provider that may change an MA organization's decision to deny an item or service; or

(iii) The extension is justified due to extraordinary, exigent, or other non-routine circumstances and is in the enrollee's interest.

(2) Notice of extension. When the MA organization extends the timeframe, it must notify the enrollee in writing of the reasons for the delay, and inform the enrollee of the right to file an expedited grievance if he or she disagrees with the MA organization's decision to grant an extension. The MA organization must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than upon expiration of the extension.

(c) Timeframe for requests for payment. The MA organization must process requests for payment according to the “prompt payment” provisions set forth in § 422.520.

(d) Written notice for MA organization denials. The MA organization must give the enrollee a written notice if—

(1) An MA organization decides to deny service or payment in whole or in part, or reduce or prematurely discontinue the level of care for a previously authorized ongoing course of treatment.

(2) An enrollee requests an MA organization to provide an explanation of a practitioner's denial of an item or service, in whole or in part.

(e) Form and content of the MA organization notice. The notice of any denial under paragraph (d) of this section must—

(1) Use approved notice language in a readable and understandable form;

(2) State the specific reasons for the denial;

(3) Inform the enrollee of his or her right to a reconsideration;

(4)(i) For service denials, describe both the standard and expedited reconsideration processes, including the enrollee's right to, and conditions for, obtaining an expedited reconsideration and the rest of the appeal process; and

(ii) For payment denials, describe the standard reconsideration process and the rest of the appeal process; and

(5) Comply with any other notice requirements specified by CMS.

(f) Effect of failure to provide timely notice. If the MA organization fails to provide the enrollee with timely notice of an organization determination as specified in this section, this failure itself constitutes an adverse organization determination and may be appealed.

APPENDIX H

42 C.F.R. § 422.574 Parties to the organization determination.

The parties to the organization determination are—

- (a) The enrollee (including his or her representative);
- (b) 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);
- (c) The legal representative of a deceased enrollee's estate; or
- (d) Any other provider or entity (other than the MA organization) determined to have an appealable interest in the proceeding.

APPENDIX I

42 C.F.R. § 422.578 Right to a reconsideration.

Any party to an organization determination (including one that has been reopened and revised as described in § 422.616) may request that the determination be reconsidered under the procedures described in § 422.582, which address requests for a standard reconsideration. A physician who is providing treatment to an enrollee may, upon providing notice to the enrollee, request a standard reconsideration of a pre-service request for reconsideration on the enrollee's behalf as described in § 422.582. An enrollee or physician (acting on behalf of an enrollee) may request an expedited reconsideration as described in § 422.584.