

Nos. 17-1283

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**

BRIEF IN OPPOSITION

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QUESTION PRESENTED

Did the court of appeals correctly decide that when a non-contracted, out-of-network healthcare provider treats a Medicare Advantage enrollee and is assigned that enrollee's rights to benefits, the provider must exhaust Medicare's administrative remedies before challenging an adverse benefit determination in federal court?

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

Care Improvement Plus South Central Insurance Company is a wholly-owned subsidiary of XLHealth Corporation, a wholly-owned subsidiary of United HealthCare Services, Inc. UnitedHealth Group Incorporated is the parent corporation for United HealthCare Services, Inc. and owns 10% or more of its stock.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
PARTIES TO THE PROCEEDING.....	ii
RULE 29.6 STATEMENT.....	iii
OPINIONS BELOW.....	1
JURISDICTION.....	1
INTRODUCTION	1
STATEMENT OF THE CASE.....	3
REASONS FOR DENYING THE PETITION.....	7
I. THERE IS NO SPLIT ON THE DISCRETE ISSUE PRESENTED.	8
II. PETITIONERS' POLICY CONCERNS DO NOT SUPPORT CERTIORARI.....	12
CONCLUSION.....	15

TABLE OF AUTHORITIES

Page(s)

Cases

<i>Badaracco v. Comm’r</i> , 464 U.S. 386 (1984).....	13
<i>Christus Health Gulf Coast v. Aetna, Inc.</i> , 237 S.W.3d 338 (Tex. 2007)	10, 11, 12
<i>Ohio State Chiropractic Ass’n v. Humana Health Plan Inc.</i> , 647 F. App’x 619 (6th Cir. 2016)	10, 11
<i>RenCare, Ltd. v. Humana Health Plan of Texas, Inc.</i> , 395 F.3d 555 (5th Cir. 2004).....	<i>passim</i>
<i>Tataranowicz v. Sullivan</i> , 959 F.2d 268 (D.C. Cir. 1992).....	13
<i>United Behavioral Health v. Maricopa Integrated Health Sys.</i> , 377 P.3d 315 (Ariz. 2016)	11
<i>Weinberger v. Salfi</i> , 422 U.S. 749 (1975).....	13

Statutes

28 U.S.C. § 1254(1).....	1
42 U.S.C. § 405(g).....	5
42 U.S.C. § 1395cc(a)(1)(O)	4

Pub. L. No. 105-33, § 4001, 111 Stat. 251 (Aug. 5, 1997)	3
---	---

Pub. L. No. 108-173, § 201, 117 Stat. 2066 (Dec. 8, 2003).....	3
---	---

Regulations

42 C.F.R. § 422.100(b)(2)	4
42 C.F.R. § 422.214(b).....	4
42 C.F.R. § 422.566(b).....	4, 5
42 C.F.R. § 422.574	5
42 C.F.R. § 422.574(b).....	6, 9
42 C.F.R. § 422.578	5
42 C.F.R. § 422.582(d).....	5
42 C.F.R. § 422.592(c)	5
42 C.F.R. § 422.608	5
42 C.F.R. § 422.612	5
42 C.F.R. § 422.616(a).....	4

Rules

S. Ct. R. 10.....	8, 12
-------------------	-------

Other Authorities

63 Fed. Reg. 34968 (June 26, 1998).....	4
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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-15a) is reported at 875 F.3d 584. The opinion of the district court (Pet. App. 16a-32a) is reported at 162 F. Supp. 3d 1307. The court of appeals' order denying rehearing is unreported and reproduced in the appendix to the petition for a writ of certiorari (Pet. App. 33a-34a).

JURISDICTION

The court of appeals issued its opinion on August 18, 2017. On September 22, 2017, the petitioners filed their motion for rehearing, which was denied on October 26, 2017. After receiving an extension, petitioners filed the petition for a writ of certiorari on March 9, 2018. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

INTRODUCTION

Petitioners incorrectly portray this matter as a purely private dispute between a provider and a health plan outside the reach of the Medicare Act's exhaustion requirement. Petitioners, however, ignore the fact that they do not have contracts with respondent and are assignees of Medicare Advantage enrollees' benefit and reimbursement rights under the Medicare Advantage regulations. As assignees, petitioners are required to exhaust administrative remedies when challenging "organization determinations" as defined by Medicare.

Similarly, petitioners contend that the court of appeals failed to identify "any clear textual mandate—either in the statute or regulations—that

such disputes be administratively exhausted.” Pet. 2-3. Again, petitioners ignore the court of appeals’ reliance on the definitions of “organization determinations” and “assignees” in the text of the Medicare Advantage regulations. Tellingly, petitioners do not mention the word “assignee” until page nine of the petition, even though it is the foundation of the court of appeals’ decision. As the court below noted, petitioners acknowledge in their complaint that they are assignees and are challenging organization determinations. Accordingly, petitioners stepped into the shoes of the enrollees by virtue of the assignments, and the administrative exhaustion requirements apply to the petitioners just as they would have applied to the enrollees had the enrollees not assigned their rights.

There is no circuit split on this issue. Petitioners continue to argue that the court of appeals’ decision below conflicts with the decision in *RenCare, Ltd. v. Humana Health Plan of Texas, Inc.*, 395 F.3d 555 (5th Cir. 2004). But *RenCare* addressed a materially different scenario: a dispute between a contracted provider and an insurer, where no assignment occurred and no organization determination was at issue. The other authorities petitioners cite, including amicus briefs filed by the Department of Health and Human Services in unrelated and inapposite cases, also address different factual circumstances and legal issues, rendering these authorities inapplicable to this case. Finally, petitioners repeat their displeasure with the policies Congress enacted requiring administrative experts to first address these arcane Medicare benefit disputes before further burdening the already inundated courts. These policy-based

arguments should be addressed to Congress, not this Court. As a result, there is neither a conflict nor any other compelling reason for this Court to issue a writ of certiorari.

STATEMENT OF THE CASE

Petitioners are eleven hospitals that do not have contracts with Respondent Care Improvement Plus South Central Insurance Company (“CIP”), but provided medical treatment to CIP’s Medicare Advantage enrollees. Petitioners seek review of the unanimous court of appeals’ decision that the Medicare laws and regulations require administrative exhaustion of claims where Medicare Advantage enrollees assign their right to benefits to non-contracted providers and such providers, as assignees, challenge the Medicare Advantage Organization’s (“MAO”) organization determinations adversely affecting benefits rights.

1. In 1997, Congress enacted Medicare Part C, *see* Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4001, 111 Stat. 251 (Aug. 5, 1997), then known as Medicare+Choice and now known as Medicare Advantage, *see* Medicare Prescription Drug, Improvement, and Modernization Act, Pub. L. No. 108-173, § 201, 117 Stat. 2066 (Dec. 8, 2003). Before 1997, the Medicare program included only Part A and Part B, under which the federal government reimbursed directly physicians and hospitals for treatment provided to Medicare-eligible enrollees. Under Medicare Advantage, private health insurers provide benefits to Medicare-eligible enrollees. The Centers for Medicare and Medicaid Services (“CMS”), a department of the Department of Health and Human Services (“HHS”), promulgated

extensive regulations governing Medicare Advantage. See Medicare Program; Establishment of the Medicare+Choice Program, 63 Fed. Reg. 34968 (June 26, 1998).

Participating private insurers, otherwise known as MAOs, contract with CMS to provide health insurance to Medicare enrollees. MAOs contract with healthcare providers—known in such instances as “in-network” or “contracted” providers—who are reimbursed by the MAO for services rendered to Medicare enrollees pursuant to the terms of a written contract with the MAO.

Enrollees may also receive treatment from providers outside of the MAO’s network, i.e. “out-of-network” or “non-contracted” providers. The relationships between MAOs and non-contracted providers are governed by the Medicare Act. Under the Medicare Act, MAOs must reimburse non-contracted providers at standard Medicare rates. 42 U.S.C. § 1395cc(a)(1)(O); 42 C.F.R. §§ 422.100(b)(2), 422.214(b).

Medicare regulations define “organization determinations” to include various decisions by an MAO, including decisions to pay for services covered by Medicare or to not pay for services believed to be covered by Medicare. 42 C.F.R. § 422.566(b). An MAO may “reopen” an organization determination for any reason, including assessing whether the services rendered were medically necessary or the care provided was appropriate. *Id.* § 422.616(a).

A mandatory administrative appeal process governs disputes arising from adverse organization determinations, including an MAO’s non-payment

for services. Any party to an organization determination may appeal an adverse decision of the MAO, which is subject to three levels of administrative review. *Id.* §§ 422.578, 422.582(d), 422.592(c), 422.608. Parties include both the Medicare enrollee and her assignee, which is defined as a provider who treated the enrollee but waived the enrollee’s payment obligations. *Id.* § 422.574. Only after exhausting all levels of administrative review may a party seek judicial review. 42 U.S.C. § 405(g); 42 C.F.R. § 422.612.

2. The present litigation involves what are alleged to be “hundreds” of separate claims for petitioners’ treatment of enrollees in CIP’s Medicare Advantage plan. *See* Brief of Appellant at 9, *Tenet Healthsystem GB, Inc. v. Care Improvement Plus S. Cent. Ins. Co.*, No. 16-11176-CC (11th Cir. June 23, 2016). CIP is an MAO, and petitioners are healthcare providers who did not contract with CIP to provide services to its Medicare enrollees within CIP’s insurance plans.

Petitioners’ complaint admits that they are not contracted with CIP, are assignees of the enrollees they treated, and are challenging CIP’s organization determinations. The first allegation in petitioners’ complaint states that they “seek redress against CIP for CIP’s failure to pay the plaintiff hospitals the full amount owed for services rendered by [petitioners] to those patients covered by insurance issued by CIP.” This allegation tracks the regulatory definition of an organization determination. *See* 42 C.F.R. § 422.566(b) (defining organization determinations to include the “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”). The complaint further admits that petitioners are assignees as defined by Medicare, alleging that they “executed waivers of liability that hold the CIP Insureds harmless on each of the Patient Accounts.” *See* 42 C.F.R. § 422.574(b) (defining an enrollee’s assignee 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”).

3. On May 28, 2015, petitioners filed this action in the United States District Court for the Northern District of Georgia, alleging claims for unjust enrichment, quantum meruit, and declaratory relief. *See* Pet. App. 7a. Petitioners alleged that CIP failed to pay the full amounts owed for services rendered, by virtue of a recoupment when post-payment audits showed that the petitioners’ records did not reflect the appropriate level of care. Petitioners did not exhaust the Medicare administrative appeal process before filing this action.

The district court granted CIP’s motion to dismiss for lack of subject matter jurisdiction, finding the petitioners’ claims are “inextricably intertwined with the Medicare Act, and are subject to its exhaustion requirements.” Pet. App. 8a, 27a. The district court rejected petitioners’ arguments that the claims did not involve organization determinations, and emphasized petitioners’ status as non-contracted providers whose relationships

with CIP were governed by the Medicare laws and regulations. Pet. App. 26a-27a.

4. The court of appeals affirmed in a unanimous published opinion. Pet. App. 1a. The court noted that, under petitioners' allegations and Medicare's regulations, petitioners "stand in the shoes of the enrollees, assert the enrollees' claims and are subject to the [Medicare] Act's exhaustion requirement." Pet. App. 9a. The court of appeals agreed that the petitioners were assignees as defined by the Medicare regulations. Pet. App. 10a-11a. Rejecting the petitioners' arguments that they may be entitled to payment exceeding Medicare rates, the court noted that the Medicare Act requires non-contracted providers to accept the Medicare reimbursement rates. Pet. App. 12a. As a result, the Medicare Act governed the parties' relationships, and petitioners could not avoid the Medicare Act's exhaustion requirement. Pet. App. 12a-14a.

REASONS FOR DENYING THE PETITION

The petition for a writ of certiorari should be denied. First, no circuit split exists on the issue decided by the court of appeals. The authority petitioners cite is factually and legally distinct from this case, and thus addresses issues not presented here. The reasoning and rulings of those courts were readily distinguished by the court below, and properly so. Second, petitioners' policy arguments not only fail to justify certiorari but also underscore why such concerns are appropriate for resolution by other branches of government.

I. THERE IS NO SPLIT ON THE DISCRETE ISSUE PRESENTED.

The petitioners' claim of an "acknowledged, pre-existing circuit split" falters upon a comparison of the facts here with those addressed by the Fifth Circuit and other authority petitioners cite. Only the decision below addressed the requirements pertaining to non-contracted, out-of-network providers who challenge coverage decisions after being assigned enrollees' claims for benefits. This fundamental factual and legal difference nullifies petitioners' claim that this petition concerns a split in the circuits on "the same important matter" addressed by the court of appeals below. *See* S. Ct. R. 10(a).

In *RenCare, Ltd. v. Humana Health Plan of Texas, Inc.*, the Fifth Circuit addressed a dispute between an MAO and an in-network provider operating pursuant to a contract. 395 F.3d 555, 556 (5th Cir. 2004). The opinion noted that the dispute was "based on the parties' privately-agreed-to payment plan," and that the claims were "[a]t bottom . . . for payment pursuant to *a contract between private parties*." *Id.* at 559-560 (emphasis added). Unlike this case, *RenCare* did not involve an assignment of an enrollee's interest. *See id.* at 560 (finding that the Medicare beneficiaries "d[id] not have a claim to assign").

The Eleventh Circuit recognized and relied on these differences. The court below noted that *RenCare* "addressed claims brought by contract providers against an MAO for breach of the express provisions of a written contract." Pet. App. 13a-14a. As such, *RenCare* "is distinguishable because [] the

Medicare regulations treat noncontract[ed] providers differently than contract[ed] providers.” Pet. App. 14a. In addition, the Eleventh Circuit found that this dispute involves organization determinations plainly subject to Medicare’s administrative appeal process—another fact that was absent in *RenCare*. Pet. App. 8a, 15a. Finally, there was no assignment of claims in *RenCare*. Pet. App. 14a.

The petition urges this Court to ignore the impact of these differences. Petitioners argue that the contracted provider status “played no role in the [*RenCare*] court’s analysis” and that the Fifth Circuit concluded that, where such an enrollee’s interest in the dispute is absent, exhaustion does not apply. Pet. 12.

But as the court of appeals explained below, Medicare ties an enrollee’s interest to a provider’s status where the provider waives its right to payment from the enrollee and thus acts as the enrollee’s assignee. Pet. App. 9a; *see also* 42 C.F.R. § 422.574 (b). The presence of a contract drove the *RenCare* decision; the absence of one, combined with other facts not before the Fifth Circuit, alters the calculus here. Indeed, the *RenCare* decision noted the absence of an assignment in that case. 395 F.3d at 560. For these reasons, the court below explained that to resolve *this* case, “it is necessary to understand the relationship of the parties within the statutory context of the pertinent provisions of the Medicare Act.” Pet. App. 3a.

Nothing in the court of appeals’ decision suggests it would have decided *RenCare* differently, as *RenCare* did not address whether non-contracted

providers must exhaust administrative remedies when disputing organization determinations. This dispute does not turn on the terms of an express, written contract between the parties. The CIP enrollees' interests, by virtue of their assignment to the non-contracted petitioners, and CIP's organization determinations remained at issue below. Conversely, there was no assignment in *RenCare*, let alone an assignment to a non-contracted provider, nor was there an organization determination at issue. Both decisions may stand in harmony without creating conflict or confusion among lower courts.

Other decisions that petitioners cite are similarly distinguishable. Petitioners acknowledge their reliance on *dicta* from an unpublished Sixth Circuit decision that declined to address the issue presented here. *See* Pet. 12; Pet. App. 13a n.3. Furthermore, the facts before the Sixth Circuit did not involve a coverage dispute—i.e., an organization determination. *See Ohio State Chiropractic Ass'n v. Humana Health Plan Inc.*, 647 F. App'x 619, 625 (6th Cir. 2016) (noting that “the parties [did not] contest whether Medicare covers the chiropractic services . . . provided”).

As the petition acknowledges, the Texas Supreme Court addressed a dispute involving a contracted provider and an MAO. Pet. 12. That circumstance also did not involve an “organization determination.” *See Christus Health Gulf Coast v. Aetna, Inc.*, 237 S.W.3d 338, 344 (Tex. 2007) (noting that the dispute “concern[ed] not whether the services were covered under Medicare, but rather

who should bear the loss associated with [the insolvent third party's] failure to pay").

For many of the same reasons, petitioners' deference arguments, based on the HHS amicus briefs filed in *Christus* and *Ohio State*, are meritless. Given the facts in those cases, the amicus briefs did not address the legal question at issue here. The amicus brief in *Christus* noted the absence of assignment and acknowledged that the contracted providers' claims never belonged to the Medicare enrollees. Brief for U.S. Dep't of Health and Human Services as Amicus Curiae at 9, *Christus Health Gulf Coast v. Aetna, Inc.*, No. 05-0710 (Tex. Mar. 13, 2006), 2006 WL 985225, at *13.

Based on the "uncontested facts" in *Ohio State*, HHS found "no coverage determination, or 'organization determination,' at issue." Brief for U.S. Dep't of Health and Human Services as Amicus Curiae at 8, *Ohio State Chiropractic Ass'n v. Humana Health Plan Inc.*, No. 15-3130 (6th Cir. Mar. 14, 2016). As the agency explained, the parties there agreed that the services rendered were covered under the relevant Medicare Advantage plan, and the alleged recoupments were not the result of adverse coverage determinations. *Id.* Furthermore, HHS agreed that a provider must exhaust administrative remedies if it is an assignee. *Id.* at 5. Petitioners ignore HHS' validation of CIP's position and the court of appeals' decision requiring assignees to exhaust administrative remedies.

Petitioners attempt to manufacture a certiorari-worthy split by citing an Arizona Supreme Court decision that did not follow *RenCare*. *United*

Behavioral Health v. Maricopa Integrated Health Sys., 377 P.3d 315 (Ariz. 2016). But *United Behavioral* is distinct from *RenCare*: unlike *RenCare*, *United Behavioral* involved both assignments of enrollees’ interests and coverage disputes. *See id.* at 320 (distinguishing *RenCare* and *Christus*). Thus, because the providers in that case were, as here, assignees asserting coverage disputes that could not be resolved by applying contractual provisions, Medicare’s exhaustion requirement applied. *Id.*

Petitioners’ authority does not establish a conflict between courts of appeal or between a court of appeals and a state court of last resort on a question of federal law.¹ *See* S. Ct. R. 10(a), (c). No case supporting petitioners’ views involved non-contracted, out-of-network assignees challenging an organization determination. The varied outcomes of these cases speak to differences in facts, not any circuit split or “misapplication of a properly stated rule of law.” S. Ct. R. 10.

II. PETITIONERS’ POLICY CONCERNS DO NOT SUPPORT CERTIORARI.

Further counseling against certiorari is the petition’s appeal to policy considerations. The court

¹ Even assuming, *arguendo*, a split with *RenCare*, the lack of published authority from other courts of appeal weighs against certiorari. The alleged split involves only two of the circuits and does not present a need to resolve the alleged conflict. The issues presented here or in *RenCare* are better permitted to percolate unless and until a conflict justifying this Court’s intervention arises.

of appeals addressed these policy-based pleas, explaining that Congress and HHS, through its regulations, chose to channel Medicare benefits disputes through administrative review before judicial review, and only Congress or HHS can change that structure. Pet. App. 10a. By funneling coverage disputes—which implicate coverage and rates under Medicare—through the administrative process, the courts permit HHS to apply “its policy ‘expertise’ to disputes arising under the [Medicare Act].” Pet. App. 10a (quoting *Tataranowicz v. Sullivan*, 959 F.2d 268, 275 (D.C. Cir. 1992)). Indeed, this Court has long acknowledged the benefits of administrative review and in permitting agencies the opportunity to “correct [their] own errors [and] afford the parties and courts the benefit of [their] experience and expertise.” *Weinberger v. Salfi*, 422 U.S. 749, 765 (1975).

Accordingly, and as the court of appeals recognized, the policy considerations raised here are more appropriately resolved by Congress or HHS. Pet. App. 14a-15a (noting that even if, as the petitioners contend, the exhaustion requirement “strains the resources of CMS, any solution must come from Congress or the agency”). The court of appeals noted correctly that the judiciary is “not authorized to rewrite a statute because [we] might deem its effects susceptible of improvement.” Pet. App. 14a-15a.; *see also* *Badaracco v. Comm’r*, 464 U.S. 386, 398 (1984). But that is what the petition demands: that this Court usurp Congressional and agency prerogative and appoint the courts, rather than the administrative agency with the experience and expertise, as the gatekeeper for these claims governed by the complex contours and application of

Medicare. That demand is inconsistent with the design and benefits of Medicare's administrative review scheme.

CONCLUSION

For the foregoing reasons, this Court should deny the petition for a writ of certiorari.

Respectfully submitted,

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