

No. 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

REPLY BRIEF FOR PETITIONERS

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INTRODUCTION

Respondent's brief following the Court's call for response does not meaningfully dispute the reasons for granting certiorari in this case.

As explained in the petition, the Fifth Circuit and Texas Supreme Court hold that a provider of health care need not exhaust the administrative appeals process before bringing a payment dispute with a Medicare Advantage Organization (MAO) to court when the dispute will not prevent the enrollee from receiving treatment or affect his financial obligations. The rationale was the same in both cases. Because the appeals process exists to protect enrollee interests, it is not available when the enrollee's interests are not at stake.

As the Department of Health and Human Services (HHS) has explained, that rationale holds when the provider has a contract with the MAO and when it does not. Thus, HHS relied on the same reasoning from the Fifth Circuit and Texas Supreme Court's decisions—which both involved contract providers—in a 2016 brief concluding that a non-contract provider was not required to exhaust administrative remedies, either. The decision below was incorrect when it asserted that HHS had not addressed its regulations' application in a case involving a non-contract provider—a key analytical flaw that respondent does not dispute.

Nor is there any denying the already dire status of the Medicare appeals process that would absorb these and similar claims. Twice, HHS has urged courts not to saddle it with claims like these, and the years-long appellate backlog is only getting worse. Adding provider-

MAO disputes like these would only make a bad situation worse: one-third of Americans receiving Medicare benefits get them through Medicare Advantage plans.

Instead, respondent attempts to reconcile irreconcilable outcomes by pointing to factual differences in individual cases unrelated to the courts' or HHS's reasoning. Respondent does not even attempt to marry the distinctions it cites to the reasoning in those decisions and briefs, which was discussed at length in the petition. That choice speaks volumes.

There is now a well-developed split between courts requiring administrative exhaustion for provider-MAO disputes that do not implicate enrollee interests and courts that, consistent with HHS's position, do not. Given the practical implications for the Medicare Advantage program and HHS, this case merits the Court's review. The petition should be granted.

ARGUMENT

A. The Split About Provider-MAO Dispute Exhaustion Is Real.

There is no denying that individual cases have individual facts, but the decisions holding that administrative exhaustion is not required when an enrollee's interests are not at stake cannot be reconciled with those holding that exhaustion is mandatory. Respondent's attempt to distinguish the cases in the petition overlooks this fundamental incompatibility and relies on distinctions without a difference. Its claim that there is no split to be resolved thus falls flat.

1. In respondent's view, the key fact separating this case from *RenCare, Ltd. v. Humana Health Plan of Texas, Inc.*, 395 F.3d 555 (5th Cir. 2004) and *Christus Health Gulf Coast v. Aetna, Inc.*, 237 S.W.3d 338 (Tex. 2007) is that this case involved a non-contract provider whereas *RenCare* and *Christus Health* involved contract providers. But to focus on that distinction is to miss the point. It was the absence of enrollee interest, not the presence of a contract, that led both courts to conclude that administrative exhaustion was not required.

Respondent's assertion that "[t]he presence of a contract drove the *RenCare* decision," BIO 9, has no support in *RenCare*'s text. To start, respondent's cherry-picked quotations about the provider-MAO contract, BIO 8, come from *RenCare*'s analysis of a separate issue: whether the provider's claims arose under the Medicare Act, 395 F.3d at 558-59 (discussion under heading "RenCare's Claims do not Arise under the Medicare Act," which includes both quotes at page 8 of respondent's brief). The quotations are the last sentences of the second and final paragraphs of that section. Respondent's brief cites those quotations as appearing on pages 559-60, which is *RenCare*'s administrative exhaustion discussion. BIO 8. That citation, like the suggestion that the contract was relevant to *RenCare*'s administrative exhaustion analysis, is incorrect.

In fact, the contract had nothing to do with the Fifth Circuit's administrative exhaustion analysis. As the first sentence of the discussion explains, the MAO's exhaustion argument failed because the administrative process "does not extend to claims in which an

enrollee has absolutely no interest.” *RenCare*, 395 F.3d at 559. After reviewing the regulations, the Fifth Circuit reiterated that “the administrative review process focuses on enrollees, not health care providers, and it is designed to protect enrollees’ right to Medicare benefits.” *Id.* at 559. Because no enrollee was being denied service or required to pay for a service, there was a “complete lack of [enrollee] interest” necessary for administrative exhaustion to apply. *Id.* at 560.¹

HHS shares this view of *RenCare*. In 2016, it told the Sixth Circuit in an amicus brief that the case teaches that the “mandatory administrative review process does not extend to . . . [provider-MAO disputes] in which ‘Medicare beneficiaries were not denied services or reimbursement for services’ by an MAO.” Ltr. Br. of United States 9 (“*Ohio State Chiropractic Br.*”), No. 15-3130, *Ohio State Chiropractic Ass’n v. Humana Health Plan, Inc.* (6th Cir. filed Mar. 14, 2016) (quoting *RenCare*, 395 F.3d at 558). That is also how HHS viewed *RenCare* a decade before, when it called *RenCare*’s recognition that administrative exhaustion is not required when the “enrollee has absolutely no interest” in the dispute “correct.” 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 *10-11 (Tex. filed Mar. 13, 2006) (quoting *RenCare*, 395 F.3d at 559).

Likewise, respondent’s assertion that “*RenCare* did not involve an assignment of an enrollee’s interest,”

¹ As here, the provider had agreed not to seek payment from the enrollee. *Id.* at 558.

BIO 9, fails to acknowledge that under *RenCare*'s reasoning, this case does not either. In *RenCare*, as here, the provider had agreed not to seek payment from the enrollees, as required to be an assignee under 42 C.F.R. § 422.574(b). *RenCare*, 395 F.3d at 558. Nevertheless, the enrollees in *RenCare* did “not have a claim to assign,” because the enrollees had not “been denied benefits or payment under the Medicare Act.” *Id.* at 560. In other words, when the enrollee has no interest in the outcome of a dispute, the administrative appeals process is not available, so it does not matter whether a provider could be an assignee under 42 C.F.R. § 422.574(b). Thus, the decision below was left to dismiss *RenCare*'s “treatment of the ‘assignee’ argument” as “limited to a single cursory paragraph at the end of its opinion” that “neither quoted nor analyzed the language of” 42 C.F.R. § 422.574(b) or 42 C.F.R. § 422.214. Pet. App. 14a. That is the language of disagreement, not distinction, and it confirms that *RenCare* and the decision below are irreconcilable.

In sum, *RenCare*'s analysis focuses on the *enrollee*—that is, whether the enrollee has any interest in the outcome of the provider-MAO dispute. So long as the provider will not seek payment from the enrollee and the enrollee risks no service denial, *RenCare*'s rule is not concerned with the provider at all, including whether it has a contract with the MAO. Respondent does not address how the Fifth Circuit's actual analysis could be harmonized with the decision below. It cannot. Under *RenCare*'s reasoning, administrative exhaustion is not required here, because no enrollee has any interest in the outcome.

Because *RenCare* cannot be reconciled with the decision below, it follows that *Christus Health* cannot be, either. *Christus Health*, after all, agreed with and adopted *RenCare*'s conclusion that administrative review is not available when the enrollee has no interest in a dispute's outcome. Pet. 12.

2. Like the decision below, the Arizona Supreme Court's decision in *United Behavioral Health v. Maricopa Integrated Health Systems*, 377 P.3d 315 (Ariz. 2016) cannot be reconciled with *Christus Health* and *RenCare*. As with *RenCare*, respondent seeks to distinguish *United Behavioral Health* based on factors discussed when analyzing whether the claims at issue arose under the Medicare Act. BIO 12; *United Behavioral Health*, 377 P.3d at 320. Looking to the correct section of the opinion, the conflict is clear. Under the heading "Are Medicare administrative review procedures available to Providers?" the Arizona Supreme Court identified *RenCare* and *Christus Health*'s conclusion that administrative review is unavailable "[i]f the enrollee has no further obligation to pay for furnished services." *United Behavioral Health*, 377 P.3d at 320. It then explained why it believed that rule was wrong. The explanation addressed why, in the court's view, the regulations did not prevent the provider from following the appeals process, even when the enrollee had nothing at stake. *Id.* at 321-22. In other words, *United Behavioral Health* reached a different outcome from *RenCare* and *Christus Health* because it disagreed with those cases' analysis, not because it viewed the cases as distinguishable.

Properly understood, there is an irreconcilable disagreement between the Fifth Circuit and the Texas

Supreme Court, on the one hand, and the Arizona Supreme Court and the Eleventh Circuit, on the other, about whether an administrative exhaustion requirement applies to providers when the enrollee has no interest in the outcome of the dispute.

B. The Eleventh Circuit’s Decision Failed to Defer to HHS’s Interpretation of Its Own Regulations and Would Be Wrong Even If No Deference Were Owed.

Respondent offers only the feeblest defense of the decision below on the merits. It does not dispute that HHS’s construction of its regulations is entitled to deference. *See* Pet. 14-15. Nor does it dispute that the *Ohio State Chiropractic* brief did, contrary to the decision below, address administrative exhaustion in a case involving a non-contract provider. *See* Pet. 15-16. That HHS concluded no exhaustion was required in that brief is also undisputed. *See* Pet. 16. And nowhere does respondent address the other parts of the regulatory scheme that show the administrative appellate process exists only to protect enrollee interests. *See* Pet. 18-19. Instead, respondent misreads HHS’s amicus briefs.

Respondent claims that HHS’s *Ohio State Chiropractic* brief “agrees that a provider *must* exhaust administrative remedies if it is an assignee.” BIO 11 (emphasis added). Actually, the brief says (in the background, not the analysis) that “a non-contract provider *may* be an assignee, and therefore *may* be able to appeal an adverse organization determination through the administrative process” if it waives the right to seek payment from the enrollee. *Ohio State*

Chiropractic Br., *supra*, at 5 (emphases added). That text does not support respondent’s position.

That a non-contract provider may appeal in some circumstances does not mean it must or even can in all circumstances, such as when the enrollee has no interest in the outcome of a provider-MAO dispute. “By definition,” the *Ohio State Chiropractic* brief explained, “organization determinations resolve coverage disputes between enrollees and their MAOs.” *Ohio State Chiropractic Br.*, *supra*, at 8. Thus, when an “enrollee faces no further liability for a furnished service,” “no administrative review [is] available.” *Id.* at 9 (citing 42 C.F.R. § 422.562(c)(2)). The kind of “MAO decision [that] constitutes an adverse determination that can be appealed by the enrollee (or her assignee)” is one that leaves the enrollee “faced with forgoing the service or covering the unpaid costs.” *Id.* at 8-9. But when enrollees “were not denied services or reimbursement for services,” the “mandatory administrative review process does not” apply. *Id.* at 9 (quoting *RenCare*, 395 F.3d at 559-60). Respondent never addresses this analysis, including HHS’s reliance on 42 C.F.R. § 422.562(c)(2), which provides for no appeal when “an enrollee has no further liability to pay for services.”

The absence of a dispute about coverage did not drive HHS’s conclusion in *Ohio State Chiropractic*, either. *See* BIO 11. The agreement about coverage was noted in passing in the middle of the two-page explanation that the administrative process was not available because the provider-MAO dispute would not cause an enrollee to pay for or be denied service. *Ohio State Chiropractic Br.*, *supra*, at 8-9. Indeed, HHS had previously warned against treating “‘coverage’ as a

magic word that can trigger administrative review rights by its mere utterance.” *Christus Health Br.*, *supra*, at *18. Yet, that is precisely what respondent does here.²

Likewise, the absence of an assignment was not outcome-determinative for HHS in *Christus Health*. See BIO 11. Only after explaining that the dispute was not an organization determination did HHS also note as an alternative basis that the provider did not fit the definition of an assignee. *Christus Health Br.*, *supra*, at *13-*14. The primary basis for the agency’s conclusion that no exhaustion was required, however, remained that no enrollee was “impacted by a decision to deny coverage for a particular service.” *Id.* at *11-12.

This basic insight—that the appeals process protects the interests of the enrollee, not providers—is the key concept in *RenCare* and *Christus Health* and in HHS’s interpretation of its regulations. It is true regardless whether the provider is a contract or non-contract provider, it is true regardless whether the provider may be an assignee of an enrollee’s claim, and it is true regardless whether the dispute is one over “coverage.” None of these factors has anything to do with the presence or absence of enrollee interest in the dispute. That is why the Fifth Circuit, the Texas Supreme Court, and HHS have concluded that administrative

² In any event, this case is not a coverage dispute, either. As the Eleventh Circuit recognized, petitioners seek recovery not based on Medicare statutes or regulations, but instead respondent’s promise to pay for the services under state-law theories of unjust enrichment and quantum meruit. Pet. App. 7a-8a.

exhaustion is not required when the enrollee has no interest. The Eleventh Circuit’s contrary decision thus expands a split of authority, disregards HHS’s interpretation of its own regulations, and is wrong.

C. The Court Should Address This Issue Now.

The question presented is of significant and immediate practical importance, and it is ripe for review.

The decision below forces claims that HHS believes do not belong into the Medicare appeals process. That might not be so significant, practically, if that process had capacity to expand, but it does not. *See* Pet. 20-23. As HHS recently explained, the Office of Medicare Hearings and Appeals (OMHA) “has undertaken all reasonable efforts to increase adjudicatory capacity”; yet, annual incoming appeals “continue to far exceed OMHA’s adjudication capacity, even putting aside the preexisting backlog.” Def.’s MSJ Mem. 10, *Am. Hosp. Ass’n v. Hargan*, Civ. A. No. 14-cv-00851 (JEB) (D.D.C. Nov. 3, 2017) (ECF No. 66-1). This year, OMHA expects twice as many new appeals as it can handle in a single year, and the annual rate of new appeals is expected to increase. *Id.* Forcing provider-MAO disputes like these through the Medicare appeals process will make matters far worse. In 2017, approximately 19 million Americans received Medicare benefits through Medicare Advantage plans—one-third of all Medicare beneficiaries. Kaiser Family Found., *Medicare Advantage*, <https://kaiserf.am/2BkLlpQ> (last visited June 30, 2018). Such a “flood of claims,” as HHS has described it, would be bad for the agency, bad for patients, and bad for providers,

but good for insurers who do not want to pay claims. *Christus Health Br.*, *supra*, at *18; Pet. 20-23.

Respondent does not dispute any of this. Instead, it says that these “policy considerations . . . are more appropriately resolved by Congress or HHS.” BIO 13. But HHS already resolved these “policy considerations,” both by promulgating regulations that do not require administrative exhaustion of provider-MAO disputes like these and twice confirming this interpretation of its regulations to courts. HHS first warned courts about the consequences of forcing provider-MAO disputes through the administrative process in 2006, and it reiterated its views in 2016. Pet. 6-8. In both amicus briefs, HHS explained that its regulations do not require provider-MAO disputes to be administratively exhausted when an enrollee can neither be denied nor required to pay for treatment because of the dispute. *Id.* HHS should not have to engage in rule-making just to clarify what its regulations already provide, what its amicus briefs have consistently explained, and what the Fifth Circuit and Texas Supreme Court have recognized: that HHS regulations do not require providers to exhaust the Medicare appeals process when an enrollee is not being denied service or required to pay for a service.³

Finally, there is no reason to delay review to allow other courts to consider the issue, as respondent suggests in a footnote. BIO 12 n.1. Existing decisions offer

³ Respondent’s argument that it would be better for HHS to consider these claims before the courts is thus misplaced. *See* BIO 13-14. HHS made a different choice, and “only Congress or HHS can change [the existing regulatory] structure.” BIO 13.

well-developed and irreconcilable views of the relevant regulations, HHS has consistently explained its position, and it is undisputed that the Medicare appeals process has no room to spare for claims like these.

CONCLUSION

The petition should be granted.

Respectfully submitted,

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