KING & SPALDING

Client Alert

Healthcare Practice Group

May 13, 2016

California Court Rules Medicare Does Not Preempt Hospital Claims Against Payer

On April 27, 2016, a California state court judge in a Complex Litigation department for the County of Los Angeles, ruled in favor of 13 of our hospital clients on an important matter involving substantive and financial rights: Whether hospitals must exhaust administrative remedies under Medicare law before they may seek reimbursement directly against Medicare Advantage ("MA") plans in court. After concluding that express and implied preemption do not apply to hospital claims for emergency services against a non-contracted MA plan, Judge Jane Johnson ruled that the such hospital claims do not "arise under" the Medicare Act and therefore, the hospitals are not required to appeal each denial administratively before filing a lawsuit. Without this ruling, the hospitals would only be able to pursue payment for emergency services rendered to MA beneficiaries (or defend alleged overpayments) by filing thousands of individual appeals and pursuing them through multiple levels – an extremely costly and administratively burdensome process – only to end up filing or defending the claims in lawsuits once administrative remedies were exhausted.

Courts are split on this issue. For example, courts in Georgia,[1] Florida,[2] and Ohio,[3] have found that hospitals must exhaust administrative remedies, while courts in Alabama,[4] Texas,[5] and New York[6] have ruled to the contrary.

The courts that ruled exhaustion was not required generally followed the reasoning in *RenCare, Ltd. v. Humana Health Plan of Tex.*, 395 F.3d 555, 557 (5th Cir. 2004), which held that once medical services have been provided to an enrollee covered under Medicare Part C, hospitals are free to pursue their state court remedies against the health plan because the government's risk has been extinguished.[7] That is, under Medicare Part C, the Medicare Advantage program,[8] the private companies and HMOs ("MA organizations") with which the Centers for Medicare and Medicaid Services ("CMS") contracts to provide health care benefits to Medicare beneficiaries,[9] take the risk that their costs for providing care will exceed the amount CMS pays them. 42 C.F.R. § 422.304(a); 42 U.S.C. § 1395w-22(a)(1)-(2). If the costs of providing covered services to beneficiaries exceed the amount of the per-member-per-month payments, MA organizations lose money. If the costs are less than CMS pays, MA organizations make money. Thus, CMS contractually shifts the financial risk of providing benefits to private organizations in that the private organizations assume "full financial risk on a prospective basis for the provision of the health care services for which

For more information, contact:

Marcia L. Augsburger
+1 916 321 4803
maugsburger@kslaw.com

King & Spalding
Sacramento
621 Capitol Mall
Suite 1500
Sacramento, CA 95814
Tel: +1 916 321 4800
Fax: +1 916 321 4900

www.kslaw.com

benefits are required to be provided" to the enrollee. 42 U.S.C. § 1395w-25(b). That is, once the funds move from CMS's coffers to MA organizations' bank accounts, the federal government has no further interest in those funds.

Courts on both sides of the split began questioning the RenCare analysis after CMS initiated new capitation rate calculation processes for MA plans in 2006. In short, CMS's payments to MA organizations can now be "risk-adjusted," i.e., they may vary according to each enrollee's overall health status,[10] and the amount of the payments can change from one year to another depending on how an MA organization's bid, which includes consideration of its costs, compares to a benchmark.[11] The potential effect of these processes on payment caused some courts to conclude that recoveries against MA plans may somehow affect government funding or benefits. We argued to the contrary, and the California court ultimately agreed, that *RenCare* was still valid, and that even if the method used by CMS to establish the capitation rate had changed, that did not give the government an interest in the money at stake since the government had already shifted the full financial risk to the health plan.

---

[1] *Tenet Healthsystems GB, Inc. v. Care Improvement Plus South Central Insurance Co.*, 2016 WL 590222 (N.D. Ga. Feb. 11, 2016).
[2] *Associates Rehabilitation Recover, Inc., v. Humana Medical Plan, Inc*., 76 F. Supp. 3d 1388 (S.D. Fla. 2014).
[3] *Ohio State Chiropractic Ass'n v. Humana Health Plan, Inc*., 2015 WL 350391 (N.D. Ohio Jan. 26, 2015).
[4] *Main & Assocs., Inc. v. Blue Cross and Blue Shield of Ala*., 776 F. Supp. 2d 1270, 1280 (M.D. Ala.2011)
[5] *Christus Health Gulf Coast v. Aetna*, 237 S.W.3d 338, 344 (Tex. 2007)
[6] *Canandaigua Emerg. Squad, Inc. v. Rochester Area Health Maint. Org., Inc*., 780 F. Supp. 2d 313, 320 (W.D.N.Y. 2011).
[7] *See, e.g., Christus*, 237 S.W.3d at 344.
[8] Medicare Part C was initially added to the Medicare program by the Balanced Budget Act of 1997 under the name Medicare+Choice. 63 Fed. Reg. 34968 (June 26, 1998). Medicare Advantage replaced Medicare+Choice in 2005. 70 Fed. Reg. 4588, 4589 (January 28, 2005).
[9] 42 U.S.C. § 1395w-27.
[10] 42 C.F.R. §422.310(g) (effective October 1, 2008).
[11] 42 C.F.R. § 422.308 (effective June 6, 2011).