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Lessons From 9th Circ.'s Medicare Reimbursement Decision

By **Sara Brinkmann and Glenn Solomon** (May 4, 2022, 5:30 PM EDT)

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On April 8, the U.S. Court of Appeals for the Ninth Circuit affirmed a district court's dismissal for lack of subject matter jurisdiction of an action brought by Global Rescue Jets LLC, which sought recovery of amounts it had billed to an out-of-network Medicare Advantage organization, or MAO, under Medicare Part C.

In an issue of first impression for the Ninth Circuit, the panel determined in Global Rescue Jets LLC v. Kaiser Foundation Health Plan Inc. that as an out-of-network provider seeking reimbursement from an MAO, Global Rescue Jets LLC, was required to exhaust the administrative remedies established by Centers for Medicare & Medicaid Services under the Medicare Act in Title 42 of the U.S. Code, Section 405, prior to being able to file a lawsuit in court.[1]

Background Leading to This Lawsuit

In unrelated incidents, two patients who were enrolled in Medicare Advantage plans offered by Kaiser Foundation Health Plan Inc. fell seriously ill while in Mexico and were unable to receive the care they needed there.

Global Rescue Jets, which does business as Jet Rescue, provided emergency air ambulance services to transport the patients from Mexico to a Kaiser hospital in San Diego. According to Jet Rescue's complaint, at the time of transport, both patients assigned their claims for benefits under Kaiser's plans to Jet Rescue.

Jet Rescue did not have a contract with Kaiser for the services, so Jet Rescue billed Kaiser at its usual and customary rates: $283,500 for one patient, and $232,700 for the other.

Kaiser refused to pay the billed amounts, taking the position that Jet Rescue's air ambulance services would have been covered under original Medicare and thus were payable at the Medicare-approved rate, which Kaiser calculated as $23,096 for the first patient and $17,365 for the second.

Jet Rescue sought reconsideration directly from Kaiser as to one of the two enrollees. Kaiser denied the request for reconsideration. Jet Rescue did not seek further administrative review from Kaiser or CMS as to either enrollee. Instead, it sued Kaiser in state court to recover the additional sums for the services rendered, as the assignees of the beneficiaries. Kaiser then removed the suit to federal court.

Kaiser argued that Jet Rescue's failure to exhaust administrative remedies under the Medicare Act precluded the court from exercising subject matter jurisdiction.

The Ninth Circuit's Reasoning

The Ninth Circuit rejected Jet Rescue's arguments that the Medicare Act's exhaustion requirements in Section 405 were inapplicable because, from its view: (1) an MAO is not an officer or employee of the U.S. or the U.S. Department of Health and Human Services secretary; and (2) the lawsuit did not involve claims arising under the Medicare Act.

The Ninth Circuit instead concluded that the claims asserted by Jet Rescue would ultimately constitute a payment of benefits under Part C of the Medicare Act; and thus the claims asserted arise under the Medicare Act.

Administrative Remedies Must Be Exhausted

Based on the Ninth Circuit's finding that the claims arose under the Medicare Act, the panel determined that Jet Rescue, an out-of-network provider, had to exhaust all of the available administrative remedies for these claims, pursuant to Section 405, before filing suit in district court.

The panel held that the administrative exhaustion requirement imposed by Medicare Part C includes: (1) a nonwaivable presentment requirement; and (2) a waivable requirement that enrollees pursue a claim for benefits through each available level of administrative review.

The panel listed five separate administrative requirements before a lawsuit could be filed by a beneficiary under the Medicare Act to pursue a claim for benefits:

1. An initial determination by the Medicare administrative contractor, or MAC;

2. Redetermination by the MAC;

3. Reconsideration by a qualified independent contractor;

4. A hearing before an administrative law judge if the amount in controversy is $100 or more, adjusted for inflation; and

5. Review by the Medicare appeals council.[2]

If the beneficiary is dissatisfied with the appeals council's decision, he or she may then seek judicial review, but only if the remaining amount in controversy is $1,000.[3]

Jet Rescue had satisfied the nonwaivable presentment requirement, but it had not attempted to use all five levels of administrative review. And while there was no discussion in the opinion addressing whether each of these five review levels were actually available at the time, the Ninth Circuit concluded that it therefore failed to exhaust all of its administrative remedies.

Multilevel Review Process Was Not Exhausted

The Ninth Circuit rejected Jet Rescue's contention that the exhaustion requirement should be excused

here, but it did confirm that it could be excused if three conditions had been satisfied: (1) the plaintiff's claim is wholly collateral to a claim for Medicare benefits; (2) the plaintiff has made a colorable showing of irreparable harm; and (3) exhaustion would be futile. The panel concluded that Jet Rescue failed to meet its burden of proof on the first and third requirements.

As to the first requirement, a claim is deemed collateral in this context when it "is not bound up with the merits so closely that the court's decision would constitute interference with agency process."[4] The Ninth Circuit determined that the exhaustion of administrative remedies would interfere with the agency's opportunity to review those claims.

As to the third requirement, because administrative review would allow the agency to apply its expertise and assemble the relevant record, the panel found that such review would not have been futile.[5]

Considerations For Out-of-Network Providers

The multilevel administrative review process outlined by the Ninth Circuit places an onerous burden on any out-of-network provider seeking reimbursement from a Medicare Advantage plan via an assignment of benefits.[6]

An out-of-network provider, however, may want to engage in that process to avoid what happened to Jet Rescue. This otherwise burdensome process has at least two potential benefits to an out-of-network provider. First, perhaps the provider will succeed at one of the administrative levels. Second, going through the process could help establish futility.

Further, once the relevant record is assembled and the agency has considered the claim, it becomes easier for an out-of-network provider to argue futility on similarly situated claims, since it arguably would no longer provide value to any of the parties, including the administrative adjudicators throughout the appeals process, to repeat the exhaustion exercise.

Furthermore, this might be something that can be established through a test claim, or multiple test claims, depending on the circumstances. Whether one or more test claims makes sense depends on the specific factual situation. This is especially true for administrative appeals to CMS, as CMS's administrative appeals programs are already burdened with a large, growing docket, and may reveal themselves as futile for appeals by out-of-network providers.

Attempting to utilize the administrative process also might establish futility if one or more steps contemplated by the Ninth Circuit do not actually exist in the real world when attempted. For example, the Medicare Advantage plan or CMS might not be operating one or more of the steps at the time the provider attempts the appeals. A nonoperating process is another method of supporting a futility argument to get an administrative process requirement excused.

Contracted Providers Would Likely Have a Different Result

Notably, a number of courts have distinguished the situation for in-network, contracted providers, determining that, where a contracted provider seeks payment from a Medicare Advantage plan, the claims for payment under the private contract do not arise under the Medicare Act and, therefore, are not subject to the exhaustion requirement.

- In RenCare Ltd. v. Humana Health Plan of Texas Inc. et al., the U.S. Court of Appeals for the Fifth Circuit explained in 2004 that a dispute between an in-network contracted provider and a Medicare Advantage plan is solely between the two private parties that contracted for benefits. It found that the contracted claims are not at all "intertwined, much less 'inextricably intertwined," with a claim for Medicare benefits, and thus, to the claims did not arise under the Medicare Act and exhaustion of remedies was not required.[7]

- In CHRISTUS Health Gulf Coast v. Aetna Inc.,[8] the Texas Supreme Court concluded in 2008 that hospitals did not need to exhaust administrative remedies to assert a claim against a Medicare Advantage Plan that concerned payment for indisputably covered services.

- Similarly, in Liberty Dialysis-Hawaii LLC v. Kaiser Found. Health Plan Inc. in 2017, the U.S. District Court for the District of Hawaii — which is within the Ninth Circuit — confirmed that the contracted provider was not required to exhaust administrative remedies and the dispute did not arise under the Medicare Act, explaining:

The test requires that a claim be inextricably intertwined with a claim for benefits before the exhaustion requirement applies. And where, as here, a claim for payment may be determined entirely by reference to a private contract, and requires no analysis or application of the Medicare Act, policies or regulations, no consideration of plan documents or benefits, and no redetermination of a benefits decision, it simply cannot be said to be inextricably intertwined with a claim for Medicare benefits.[9]

The U.S. Court of Appeals for the Sixth Circuit went one step further in Ohio State Chiropractic Association v. Humana Health Plan Inc. in 2016, suggesting in dicta, but not addressing, that RenCare's reasoning might also apply to disputes between an MAO and noncontract providers.[10]

Furthermore, HHS has filed amicus briefs in support of the position that requiring in-network providers to exhaust administrative remedies would turn the administrative appeals process on its head.[11]

In the Jet Rescue case, the Ninth Circuit knew about the distinction between contracted and noncontracted providers, noting that the court did not need to decide whether a different conclusion would be warranted in a case involving a contract provider, citing RenCare.[12]

Thus, it is reasonable to conclude that a contracted provider, with claims arising under a privately negotiated contract that was not merely a promise to comply with the Medicare Act, would have had a different result in the Ninth Circuit than the experience of Jet Rescue.

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[1] Global Rescue Jets, LLC v. Kaiser Found. Health Plan, Inc., -- F.4th -- 2022 WL 1052671 (9th Cir. 2022).

[2] Global Rescue Jets, LLC, 2022 WL 1052671 at *4.

[3] Id.

[4] See Johnson v. Shalala, 2 F.3d 918, 922 (9th Cir. 1993) (internal quotation marks and brackets omitted).

[5] See Kaiser v. Blue Cross of California, 347 F.3d 1107, 1115 (9th Cir. 2003).

[6] A similar result occurred in a decision from the Eleventh Circuit. Tenet Healthsystem GB, Inc. v. Care Improvement Plus S. Central Ins. Co., 875 F.3d 584, 588 (11th Cir. 2017) (holding that the out-of-network providers seeking to recover payment from a Medicare Advantage organization were required to exhaust administrative remedies before filing suit).

[7] 395 F.3d 555, 559-560 (5th Cir. 2004).

[8] 237 S.W.3d 338 (Tex. 2007).

[9] 2017 WL 4322385, at *5 (D. Hawai'i Sept. 28, 2017); see also Sarasota Cty Public Hosp. Bd. v. Blue Cross and Blue Shield of Fla., Inc., 511 F. Supp. 3d 1240 (M.D. Fla. Jan. 5, 2021) (denying a motion to dismiss because the contracted provider's claims against the Medicare Advantage plan did not arise under the Medicare Act, concluding that the provider did not have to exhaust administrative remedies to bring suit); cf. Tenet Healthsystem GB, Inc. v. Care Improvement Plus S. Central Ins. Co., 875 F.3d 584 (11th Cir. 2017) (citing RenCare and recognizing the distinction between contracted and noncontracted providers).

[10] 647 Fed. App'x 619, 625 (6th Cir. 2016),

[11] See CHRISTUS Health Gulf Coast v. Aetna, Inc., No. 05-0710, 2006 WL 985225, at *10-11 (Tex. filed Mar. 13, 2006) ("administrative exhaustion is not required when the "'enrollee has absolutely no interest'" in the dispute."); see also Ltr. Br. of United States 9, No. 15-3130, Ohio State Chiropractic Ass'n v. Humana Health Plan, Inc., (6th Cir. filed Mar. 14, 2016) (in a dispute involving a non-contracted provider, HHS stated 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.") (quoting RenCare, 395 F.3d at 558).

[12] See Global Rescue Jets, LLC, 2022 WL 1052671 at *7, n.4.