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Federal Court Sends Mixed Message on Hospital's Right to Payment for Out-of-Network Services

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Hospitals seeking reimbursement from a Medicaid managed care organization (MCO) for non-contracted services, and without the benefit of a single case agreement, need a legal basis to compel payment by the MCO. Hospitals have variously argued, for example, that by failing to pay, the plan has: been unjustly enriched; violated state statutes mandating payment for out-of-network emergency medical services or provisions of Title XIX of the Social Security Act (the Medicaid Statute); and/or breached its obligations under the contract with the state Medicaid agency pursuant to which the plan served as a Medicaid MCO. In a decision earlier this month that sent a mixed message to providers, a federal court refused to recognize a hospital's right to sue for reimbursement for out-of-network services either on a variant of the unjust enrichment theory or under the Medicaid Statute. The same court, however, allowed the hospital to maintain an action as a third-party beneficiary of the defendant Medicaid MCO's agreement with the state Medicaid agency.

Case Background

On June 6, 2012, the U.S. District Court in Washington D.C. denied in part and granted in part a motion by Advantage Health Plan Inc. (Advantage) to dismiss causes of action brought against it by Prince George's Hospital Center (P.G. Hospital). *Prince George's Hosp. Ctr. v. Advantage Health Plan Inc.*, No. 03-2392, 2012 U.S. Dist. LEXIS 78257 (D.D.C.) (Memorandum Opinion). Advantage operated a Medicaid MCO under contracts with the District of Columbia and had entered into network contracts with various health care providers in the D.C. area. P.G. Hospital, which is located in Maryland in the suburbs of D.C., was not a part of the Advantage network.

P.G. Hospital provided emergency services to five Advantage members on an out-of-network basis, and absent any single case contracts. The Emergency Medical Treatment and Active Labor Act obligated the hospital to provide these services, at least to the point of stabilizing the patients for transfer to a network provider. P.G. Hospital maintained that these individuals did not provide sufficient information for the hospital initially to identify their membership in the Advantage plan. As soon as that information became available, however, the hospital notified Advantage and sought payment from it for the emergency admissions and treatment. Advantage denied payment in each case, on the ground that the hospital did not provide timely notification of the admissions.

Causes of Action and Court Rulings

P.G. Hospital challenged the denials on three different legal grounds.

First, it claimed that it was lawfully and equitably subrogated to the patients' causes of action against Advantage for payment for the services rendered. In support of that theory, the hospital contended that public policy supports insuring indigent persons and paying for their hospital care. The hospital also claimed that Advantage would be unjustly enriched by the premiums paid to it by D.C. to cover the cost of necessary hospital services for plan members, if it were not required to pay for the services at issue. Unpersuaded by these arguments, the court noted that subrogation is the substitution of one party for another *whose debt the party pays*. P.G. Hospital's subrogation claim failed because the hospital sought to be subrogated to an alleged right of the patients to payment, but based only on *services* it rendered to them and not on its satisfaction of an actual debt. Accordingly, the court granted Advantage's motion to dismiss the subrogation claim.

Second, P.G. Hospital claimed that it had an implied private right of action to enforce the prompt payment provisions of the Medicaid Statute. Those provisions require that Medicaid

MCOs pay 90 percent of clean claims within 30 days of receipt from a provider and 99 percent within 90 days. See 42 U.S.C. §§ 1396a(a)(37)(A) & 1396u-2(f). The court rejected this claim as well. Initially, it discounted cases the hospital cited in which providers were able to bring similar actions against Medicaid payers, because all of the cases involved civil rights actions pursuant to 42 U.S.C. § 1983 against state agencies. The court concluded without analysis that P.G. Hospital could not bring a Section 1983 claim – for depriving a plaintiff of rights conferred by a federal statute under color of state law – because Advantage was a private company, and not a state actor. In so ruling, the court ignored the decisions of a number of other courts that have found Medicaid MCOs were in fact engaged in state action.

Because the court summarily rejected the possibility of a Section 1983 claim and because the Medicaid Statute does not expressly authorize a private cause of action, the court next considered whether P.G. Hospital had established an implied right of action under the four-pronged test in *Cort v. Ash*, 422 U.S. 66, 78 (1975). In finding that the hospital had not, the court concluded that: (i) Congress created the statutory provisions the hospital sought to invoke for the benefit of beneficiaries; (ii) the hospital failed to point to language in the statute or other guidance (such as letters from CMS to state Medicaid directors) indicating a legislative intent to create a private remedy; (iii) a private right of action was inconsistent with the underlying purposes of the legislative scheme, which left administration of the Medicaid program expressly to the discretion of state Medicaid agencies; and (iv) the hospital's main causes of action – for subrogation and breach of contract – were traditionally state law claims, which would be an inappropriate basis to infer a cause of action redressable by federal law. The court therefore dismissed P.G. Hospital's cause of action under the Medicaid Statute.

Third, and finally, P.G. Hospital argued that it had a viable cause of action against Advantage for non-payment for the out-of-network services as a third-party beneficiary of the contracts with D.C. pursuant to which Advantage served as an MCO (the MCO Contracts). The court noted at the outset that members of the public are rarely deemed to be intended beneficiaries empowered to enforce government contracts. Nonetheless, the court agreed that P.G. Hospital was just such a beneficiary in this case. Initially, the court noted that the MCO Contracts did not explicitly disclaim the creation of third-party beneficiary rights. Indeed, the contracts included specific promises to cover, and thus pay for, emergency services provided by out-of-network providers. As a result, the court concluded that the MCO Contracts created "an obligation in the MCO to pay those health care providers that render emergency treatments to the MCO's enrollees," and thus that "Advantage has a duty to make certain payments to providers, as third-party beneficiaries, which may be enforced by the providers against Advantage as the alleged breaching promisor." *Prince George's*, Mem. Op. at 23. The court therefore denied Advantage's motion to dismiss the cause of action for breach of contract.

Notably, in allowing the third-party beneficiary claim to go forward, the court also addressed a subsidiary contention that P.G. Hospital had failed to exhaust its administrative remedies. That was the case, Advantage argued, because the hospital had not timely requested a fair hearing through Advantage's internal appeals mechanism. The court rejected this argument as well, on the ground that the letters from Advantage to the hospital denying the reimbursement claims at issue failed to give notice of – or provide information regarding – the right to a fair hearing.

Conclusion

Providers that do not enter into single case agreements can face significant problems in obtaining appropriate reimbursement for out-of-network services rendered to members of Medicaid MCOs. The first hurdle in getting paid is establishing a legal basis for payment. The recent decision in *Prince George's* underscores the pitfalls in relying on the provisions of the Medicaid Statute or an unjust enrichment theory. At the same time, the decision reflects that more creative theories, such as relying as a third-party beneficiary on obligations in the MCO's contract with the state Medicaid agency, may succeed.

Please contact Sal Rotella (at 215.665.3729 or srotella@cozen.com) or any of the attorneys in the Cozen O'Connor Health Law Practice Group if you would like additional information or require assistance with out-of-network payment or any other Medicaid, Medicare, or commercial insurance payment issues.