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February 18, 2021

The Honorable Tani Cantil-Sakauye
and Honorable Associate Justices
Supreme Court of California
350 McAllister Street
San Francisco, California 94102

Re: ***Hoag Memorial Hospital Presbyterian v. Superior Court* (*Sacks*)**
Case No. S266725
Amicus Curiae Letter in Support of Defendant's Petition for Review

Dear Chief Justice Cantil-Sakauye and Associate Justices:

Under rule 8.500(g) of the California Rules of Court, the California Hospital Association (CHA) respectfully submits this letter as amicus curiae urging this Court to grant review of the above-entitled case.[1]

Hoag Memorial Hospital Presbyterian's (Hoag) petition for review correctly explains why the trial court's denial of Hoag's motion for summary judgement must be reviewed and overturned either by this Court or by the Court of Appeal after a grant and transfer.

First, the trial court erred in finding that plaintiff-decedent Jerry Sacks's claim—that Hoag violated the Medicare Act's (42 U.S.C. § 1395 et seq.) (the Act or Medicare) notice requirement—was not a benefits claim under the Act. Here, it was determined that Hoag knew a drug it prescribed in the hospital for Sacks was not covered by Medicare but failed to notify him of the lack of coverage. When Sacks received his bill to cover the costs himself, he initiated an administrative review process under the Act. Sacks prevailed in that proceeding with a finding that Hoag

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[1] No party or counsel for a party in the pending appeal authored this proposed letter in whole or in part, and no person or entity other than amicus curiae, its members, or its counsel made any monetary contribution intended to fund the preparation or submission of this proposed letter. (See Cal. Rules of Court, rule 8.520(f)(4).)

was responsible for paying for the medical cost because it had failed to notify him that Medicare would not cover it. Since Sacks successfully petitioned for payment of benefits owed to him under the Act, this is clearly a claim for benefits.

Second, deciding whether a claim actually arises under the Act is a fact-intensive determination, but the case law highlighting the parameters of when a claim is subject to the Act's exhaustion requirement is sparse. Courts and practitioners alike would benefit from an additional opinion analyzing and making a determination based on the recurring facts presented here: a state law claim intertwined with a claim for Medicare benefits.

Finally, guidance is also needed on the recurring question of whether prior Supreme Court opinions and the Act allow a claimant to pursue administrative review of a benefits claim, receive a positive determination, and then proceed with an action on the same claim in state court as plaintiff has sought to do here, rather than filing an action in federal district court as the Act requires. *Roberts v. United Healthcare Services, Inc.* (2016) 2 Cal.App.5th 132 (*Roberts*) left open this question, but the better reasoned argument is that under those facts, a plaintiff must sue in federal court. This case presents a great vehicle for securing precedent on this important question.

INTEREST OF AMICUS CURIAE

CHA is a trade association representing over 400 hospitals and health care systems in California, comprising over 90 percent of the hospitals in the state. CHA is committed to establishing and maintaining a financial and regulatory environment within which hospitals, health care systems, and other health care providers can offer high quality patient care. CHA promotes its objectives, in part, by participating as amicus curiae in important cases like this one.

LEGAL ARGUMENT

I. This Court should grant review to provide clearer guidance on the complex and important issues at the intersection of this Court's holding in *McCall* and Medicare's requirement to exhaust administrative remedies.

A. The trial court erred in denying Hoag's motion for summary judgment because plaintiff's claims did arise under the Medicare Act.

The Act created a federally subsidized health insurance program administered by the Secretary of Health and Human Services (the Secretary). (*Heckler v. Ringer* (1984) 466 U.S. 602, 605 [104 S.Ct. 2013, 80 L.Ed.2d 622] (*Ringer*); *McCall v. PacifiCare of California, Inc.* (2001) 25 Cal.4th 412, 416 (*McCall*).) Claims that " 'aris[e] under' " the Act can be subject to judicial review only after the Secretary renders a " 'final decision' " on the claim. (*Ringer*, at p. 605.) The relevant term here is "arise under."

A claim "arises under" the Act if (1) "both the standing and the substantive bases for the presentation of the claim is the Medicare Act"; or (2) "the claim is inextricably intertwined with a claim for Medicare benefits." (*McCall*, *supra*, 25 Cal.4th at p. 417, internal quotation marks omitted.) This Court has defined " 'inextricably intertwined' " as meaning those claims "that, 'at bottom,' seek reimbursement or payment for medical services, but not a claim *not* seeking such reimbursement or payment, which claim as pleaded incidentally refers to a denial of benefits under the Medicare Act." (*Id.* at p. 425.) In making this determination, courts look "not only to how the plaintiff has styled his claim, but also to its substance." (*Roberts*, *supra*, 2 Cal.App.5th at p. 150.)

Here, Sacks, a Medicare-eligible patient, received outpatient care at Hoag. (PWM, exh. 1, p. 7.) While at Hoag, Sacks received self-administrable drugs, medication that a patient can take for themselves. (PWM, exh. 1, pp. 7, 9; exh. 6, pp. 117–118.) Hoag then submitted all of Sacks's billing to Medicare for processing, but the amount corresponding to the billed amount for the drugs was not covered, meaning Sacks was responsible for the cost of the medication. (PWM, exh. 1, pp. 7, 9; exh. 5, p. 69.) Sacks paid a portion of the bill and sought redetermination of the initial decision denying coverage for the drugs. (See PWM, exh. 1, p. 9; exh. 5, p. 72.) He received an " 'unfavorable' " decision that the drugs were not covered

under Medicare and that he was responsible for payment. (PWM, exh. 5, p. 72; exh. 6, pp. 127–128.) Sacks then pursued the second level of administrative appeal. (See PWM, exh. 6, p. 148.) While the second level of review technically issued an " 'unfavorable' " decision on Medicare coverage, it also determined that *Hoag*, not Sacks, was responsible for the cost of the medicine, thus setting aside Sacks's obligation to pay anything for the drugs. (PWM, exh. 5, pp. 73–74; exh. 6, p. 150.)

After obtaining the relief he sought through the administrative review process, Sacks then brought suit in the California superior court. (PWM, exh. 1, pp. 6–7, 13–16.) Hoag filed a motion for summary judgment, which the trial court denied. (PWM, exh. 4, pp. 38–63; exh. 17, pp. 369–370.) The Court of Appeal summarily denied Hoag's writ petition. (See PFR 47.)

The issue in this case is whether Hoag's failure to provide notice to Sacks that the drugs given to him would not be covered by Medicare is inextricably intertwined with a Medicare benefits determination such that the exhaustion of administrative remedies requirement applies to this claim. (See PWM, exh. 17, p. 370.) Sacks argues, and the trial court agreed, that this claim is not inextricably intertwined with a benefits determination because there is no dispute that the particular drugs at issue are not a covered benefit under Medicare. (See PWM, exh. 9, pp. 248, 262–265; exh. 17, p. 370.) The trial court erred. The issue here does involve a benefits determination.

Under the Act, Hoag was required to give notice to a patient that particular drugs are not covered if Hoag "knew, or could be expected to know, that payment for [such drugs] could not be made under" the applicable Medicare sections. (42 U.S.C. § 1395pp(b); Medicare Claims Processing Manual (2019) Financial Liability Protections, §§ 30–30.2, 50.2.1, pp. 19–22, 37 <https://www.cms.gov/Regulations-

and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf> [as of Feb. 16, 2021].)[2] If Hoag had knowledge and failed to provide notice, it will be responsible for a cost that the beneficiary traditionally bears and is not covered by Medicare. (Medicare Claims Processing Manual, *supra*, Financial Liability Protections, §§ 30.2, 50.2.1, pp. 22, 37.) The administrative review process here determined that Hoag knew that the drugs were not covered and failed to give notice to Sacks. Thus, Hoag was required to pay for the drugs prescribed to Sacks.

Sacks's focus on the fact that the drugs he was prescribed are not a covered benefit under Medicare does not end the discussion of whether the decision arises under the Act. The Act's real benefit to Sacks is that he will not have to pay a cost he normally would have because Hoag failed to give the required notice under the Act. The Medicare statute thus protects beneficiaries like Sacks, as Sacks acknowledges (PWM, exh. 9, p. 247), because it gives "enough time for the beneficiary to make an informed decision on whether or not to receive the service or item in question and accept potential financial liability." (Medicare Claims Processing Manual, *supra,* Financial Liability Protections, § 50.1, p. 36.) Should Hoag fail to provide proper notice, then beneficiaries have the benefit of passing this cost, normally borne by them, onto Hoag. " '[A]t bottom,' [Sacks is] seek[ing] reimbursement or payment for medical services" (*McCall*, *supra*, 25 Cal.4th at p. 425), which he received here through a favorable administrative ruling.

Even if Sacks had not received direct monetary relief by having Hoag pay for the drugs (which he did), the notice that otherwise should have been given is, itself,

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[2] The Medicare Claims Processing Manual is an Internet-Only Manual (IOM) prepared by the Centers for Medicare and Medicaid Services (CMS). (See *Internet-Only Manuals*, Centers for Medicare and Medicaid Services <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs> [last visited Feb. 16, 2021].) It is a digital replica of CMS' official record copy, and it is CMS' "program issuances, day-to-day operating instructions, policies, and procedures that are based on statutes, regulations, guidelines, models, and directives." (*Ibid.*) "The CMS program components, providers, contractors, Medicare Advantage organizations and state survey agencies use the IOMs to administer CMS programs." (*Ibid.*) Additionally, the manual refers to section 1879 of the Social Security Act when discussing who is liable for payment. (See, e.g., Medicare Claims Processing Manual, *supra*, Financial Liability Protections, § 10, p. 12.) Section 1879 is codified at 42 U.S.C. § 1395pp. (See *Limitation On Liability of Beneficiary Where Medicare Claims Are Disallowed*, Social Security Administration <https://www.ssa.gov/OP_Home/ssact/title18/1879.htm> [as of Feb. 16, 2021].)

a "benefit" under the Act. The United States Supreme Court, in *Shalala v. Illinois Council on Long Term Care, Inc.* (2000) 529 U.S. 1, 13–14 [120 S.Ct. 1084, 146 L.Ed.2d 1], declined to construe 42 U.S.C. § 405(h) as being limited to only claims for direct *monetary* benefits. If Hoag had given Sacks notice that the drugs were not covered, a nonmonetary benefit required by the Act, then Sacks could have chosen to avoid, and declined to incur, a potential future cost, an indirect monetary benefit. The Court in *Shalala* explained that both monetary and nonmonetary benefits can arise under Medicare because they both may "involve the application, interpretation, or constitutionality of interrelated regulations or statutory provisions," which is why administrative review is required. (*Ibid.*) Here, Sacks received direct monetary relief in the administrative review process, which addressed his claim for a benefit under Medicare's interrelated statutes and regulations. (See PWM, exh. 6, p. 150.) This type of claim was deliberately decided as being within the purview of Medicare; the Medicare Claims Processing Manual specifically outlines both the steps providers must comply with and the steps beneficiaries can take to pursue an administrative appeal due to a violation of this statute. (Medicare Claims Processing Manual, *supra*, Financial Liability Protections, § 30, p. 20.) Therefore, even if Sacks had not received a monetary benefit (he did), his request for notice "arises under" Medicare because it is "inextricably intertwined" with a claim for a benefit under Medicare.

This Court's decision in *McCall* requires the same result. In *McCall*, this Court held that several state law claims arising out of a health maintenance organization's refusal to provide services under the patient's Medicare plan were not inextricably intertwined with a Medicare benefits claim, meaning they could be brought in state court. (See *McCall*, *supra*, 25 Cal.4th at pp. 415–416, 426.) The reason was that the plaintiffs might be able to prove elements of their claim without regard, or only incidentally, to Medicare coverage determinations because none of the causes of action seeks, " 'at bottom,' " payment or reimbursement for medical services or falls within the Act's administrative review process, and the harm plaintiffs suffered cannot be remedied by the review process. (*Id.* at pp. 425, 426.) None of these reasons are found here.

Sacks sought, and did receive, payment and reimbursement for medical services. The drugs Sacks was given were ultimately paid for by Hoag, and Sacks received a refund for the amount he initially paid. (See PWM, exh. 4, p. 52.) Sacks's claim did fall, and was clearly contemplated to fall, within the Act's administrative review process. The harm Sacks suffered can be and was remedied by the administrative review process. And Sacks's claim was not "incidental to" a Medicare coverage determination because if the inquiry as to whether notice was

required ultimately determined that Sacks *and* Hoag had no knowledge the prescribed drugs are not covered by Medicare, *then Medicare will be liable for the payment*. (Medicare Claims Processing Manual, *supra*, Financial Liability Protections, § 30.2, p. 22.) Therefore, Sacks's claim is "inextricably intertwined" with a claim for Medicare benefits and is subject to the Act's exhaustion of administrative remedies requirement.

B. The bench and the bar would benefit from additional authority discussing the parameters of what claims fall within the purview of the Medicare Act.

When California courts confront a claim involving Medicare, two important doctrines determine whether they have jurisdiction to hear the claim: federal preemption and the Act's exhaustion of administrative remedies requirement. (See generally *Roberts*, *supra*, 2 Cal.App.5th at pp. 142, 149.)

Since the *McCall* case, only two published California cases have discussed Medicare's exhaustion of administrative remedies requirement, *Roberts* and *Cotton v. StarCare Medical Group, Inc.* (2010) 183 Cal.App.4th 437. In *Roberts*, it was undisputed that the plaintiff had not even attempted to exhaust the available administrative remedies. (*Roberts*, *supra*, 2 Cal.App.5th at p. 151.) And in *Cotton*, the court's opinion primarily discussed the preemption doctrine and only addressed the exhaustion requirement in two paragraphs, citing *McCall* to find that the "plaintiffs [were] not disputing an adverse determination concerning Medicare benefits." (*Cotton*, at p. 456.) Neither case involved a thorough analysis of the facts within the context of the exhaustion requirement. This case presents the perfect opportunity to do so.

Deciding whether claims fall within the purview of the Act is a fact-intensive determination, but there is insufficient guidance from courts on how increasingly common fact patterns like this one should be resolved. As this Court pointed out, "some disagreement exists among state and federal courts on this question" of when a state law claim against Medicare providers falls within the Act's exclusive review process. (*McCall*, *supra*, 25 Cal.4th at pp. 415–416.) Judges and practitioners would benefit from having more opinions that analyze and apply the law to different sets of common fact patterns to better determine when judicial review is warranted. Doing so is in the best interest of all, since "[t]he exhaustion requirement affords the administrative agency an opportunity to correct any deficiency and avoid costly litigation or reduce the scope of litigation" while also "facilitat[ing] the development

of a complete factual record and allows the agency to apply its expertise, both of which can assist later judicial review." (*Syngenta Crop Protection, Inc. v. Helliker* (2006) 138 Cal.App.4th 1135, 1159–1160.) As a result, review here is warranted so that either this Court or the Court of Appeal can give much needed additional guidance.

II. Additional guidance is needed to answer when a plaintiff who obtained a favorable judgment by pursuing a claim through administrative remedies can then pursue a similar claim in state rather than federal court.

Regardless of whether Sacks's claim here arose under Medicare (it did), another important issue that warrants review is whether plaintiffs should be allowed to pursue their claim in state court after they obtained a favorable judgment on the same claim through the administrative process.

Here, after Sacks received and paid for a portion of his bill, he initiated his first level of appeal and sought redetermination. (PWM, exh. 1, p. 9; exh. 6, pp. 127–129; see Medicare Claims Processing Manual (2019) Appeals of Claims Decisions, § 220, p. 14 <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29pdf.pdf> [as of Feb. 16, 2021].) The reviewing Medicare contractor determined that the drugs were not covered by Medicare and Sacks was responsible for the cost of the medication. (PWM, exh. 6, p. 128.) Sacks then initiated the second level of appeal, which also determined the drugs are not covered by Medicare but ruled that Hoag was responsible for their cost. (PWM, exh. 6, p. 138.) The reviewing agent found that because Hoag "knew, or could reasonably have been expected to know, that Medicare payment for the [drugs] would be denied," it was responsible for the bill. (*Ibid.*) In making this determination, the reviewing agent cited to the Medicare Claims Processing Manual discussing how Hoag was required to provide notice to Sacks that the drugs would not be covered by Medicare. (*Ibid.*) Sacks was thus reimbursed the amount he paid and was not responsible for the remainder of the bill. (PWM, exh. 4, p. 52.) In short, Sacks was afforded all the relief he sought and to which he was reasonably entitled.

Despite his complete victory in the administrative process, Sacks sought to litigate the exact same claim in the state trial court: whether Hoag violated the Medicare statute by not providing notice to him that the prescribed drugs would not be covered by Medicare prior to giving the medication. (See PWM, exh. 17, p. 370.)

This issue has already been resolved in Sacks's favor, and he has already obtained complete relief. His initial appeals addressed whether or not the drugs would be covered by Medicare, and because they were not, he received an "unfavorable" decision. (See PWM, exh. 6, pp. 127–128, 136–137.) This decision could have been appealed. (See PWM, exh. 6, p. 140.) However, the second level of review ultimately answered Sacks's presented question by finding Hoag was responsible for the cost because Hoag violated the notice requirement. (See PWM, exh. 6, p. 138; Medicare Claims Processing Manual, *supra*, Financial Liability Protections, §§ 30.2, 50.2.1, pp. 22, 37.) Therefore, Sacks's presented issue is moot.

The Court in *Ringer* emphasized that the exhaustion of administrative remedies is "the sole avenue for judicial review" for claims arising under Medicare. (*Ringer*, *supra*, 466 U.S. at pp. 614–615.) The Court further emphasized that *only after* a claimant has "pressed his claim through all designated levels of administrative review" can he seek judicial review *in federal district court*. (*Id.* at pp. 606–607.) Here, not only did Sacks fail to exhaust all four levels of administrative review (see Medicare Claims Processing Manual, *supra*, Appeals of Claims Decisions, § 220, p. 14.), but he also brought his claim in state court. Both actions violate the Supreme Court's express directions and the Act's language.

Only one published opinion in California has even come close to answering whether a plaintiff needs to pursue a claim through each level of review in order to be considered to have exhausted administrative remedies. In *Roberts*, a plaintiff did not attempt to exhaust any administrative remedy because his claim for benefits was only for $20, falling short of the threshold to obtain a hearing before the Secretary. (*Roberts*, *supra*, 2 Cal.App.5th at p. 151.) The court pointed out that a hearing before the Secretary is the *fourth* level of administrative review. (*Ibid.*) Therefore, because the plaintiff failed to pursue any of the preceding three tiers, he did not exhaust his administrative remedies. (*Ibid.*)

The court in *Roberts* left unanswered two important questions that can be addressed here: 1) for the purposes of Medicare's exhaustion requirement, is a claimant considered to have exhausted administrative review once he obtains a positive determination that might not warrant further appeal?; and 2) if so, can the claimant bring that same claim in a state trial court, federal district court, or neither? Allowing a claim that arises under Medicare to move forward in state court is against the express language of the Act and the United States Supreme Court's interpretation of it. This case affords the opportunity to provide guidance on these important questions.

CONCLUSION

For the foregoing reasons, the California Hospital Association respectfully requests that this Court grant the petition for review.

Respectfully Submitted,

HORVITZ & LEVY LLP
JEREMY B. ROSEN
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By: 
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Attorneys for Amicus Curiae
CALIFORNIA HOSPITAL ASSOCIATION

cc: See attached Proof of Service

PROOF OF SERVICE

Hoag Memorial Hospital Presbyterian v. Superior Court (Sacks)
Supreme Court Case No. S266725

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

At the time of service, I was over 18 years of age and not a party to this action. I am employed in the County of Los Angeles, State of California. My business address is 3601 West Olive Avenue, 8th Floor, Burbank, CA 91505-4681.

On February 18, 2021, I served true copies of the following document(s) described as **AMICUS CURIAE LETTER IN SUPPORT OF DEFENDANT'S PETITION FOR REVIEW** on the interested parties in this action as follows:

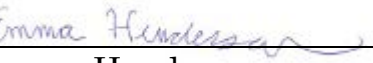
SEE ATTACHED SERVICE LIST

BY MAIL: I enclosed the document(s) in a sealed envelope or package addressed to the persons at the addresses listed in the Service List and placed the envelope for collection and mailing, following our ordinary business practices. I am readily familiar with Horvitz & Levy LLP's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the United States Postal Service, in a sealed envelope with postage fully prepaid.

BY E-MAIL OR ELECTRONIC TRANSMISSION: Based on a court order or an agreement of the parties to accept service by e-mail or electronic transmission via Court's Electronic Filing System (EFS) operated by ImageSoft TrueFiling (TrueFiling) as indicated on the attached service list:

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on February 18, 2021, at Burbank, California.



Emma Henderson

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Hoag Memorial Hospital Presbyterian v. Superior Court (Sacks)
Supreme Court Case No. S266725

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