THE UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF KENTUCKY
LOUISVILLE DIVISION

ELECTRONICALLY FILED

JOANNE BARROWS and SUSAN HAGOOD, individually and on behalf of all others similarly situated, Plaintiffs, v. HUMANA, INC., Defendant.	Civil Action No. 3:23-cv-00654-RGJ

DEFENDANT'S MOTION TO DISMISS PLAINTIFFS' CLASS ACTION COMPLAINT

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Defendant Humana Inc. ("Humana" or "Defendant") respectfully moves pursuant to Federal Rules of Civil Procedure 12(b)(1) and 12(b)(6) to dismiss the December 12, 2023 Class Action Complaint filed by Plaintiffs Joanne Barrows and Susan Hagood (collectively "Plaintiffs"). In short, Plaintiffs cannot forum-shop their way to a different Medicare coverage determination.

INTRODUCTION

Plaintiffs are Medicare Part C[1] enrollees. They each received Medicare Benefits under Part C of the Medicare Act through a Medicare Advantage ("MA") plan administered by Humana. Plaintiffs allege that Defendant wrongly denied Plaintiffs' requests for coverage of certain Medicare Benefits. Plaintiffs' putative class Complaint (R. 1)—which is heavily copied-and-pasted from a similar action filed by the same law firm against another Medicare Advantage Organization ("MAO")[2]—includes sensationalized allegations that Humana makes post-acute care coverage determinations based solely on the output of an Artificial Intelligence program. Plaintiffs' allegations are false.[3] But, even accepting Plaintiffs' allegations as true for purposes of this motion, Plaintiffs' Complaint must be dismissed for two reasons:

First, the Court lacks subject matter jurisdiction to adjudicate Plaintiffs' claims because Plaintiffs have failed to exhaust the exclusive administrative appeal process set by the Medicare

[1] Medicare Part C is also known as Medicare Advantage and was previously known as Medicare+Choice. *See* Medicare Program: Establishment of the Medicare Advantage Programs, 70 Fed. Reg. 4588, 4589 (Jan. 28, 2005).

[2] *Estate of Gene B. Lokken, et al. v. UnitedHealth Grp., Inc., et al.*, ECF 1, No. 0:23-cv-03514-JRT-DTS (D. Minn. Nov. 14, 2023).

[3] Humana acknowledges that the Court is required to "take as true all factual allegations in the complaint." *See Barret v. Harrington*, 130 F.3d 246, 251 (6th Cir. 1997). Humana notes, however, that if this case were to proceed past the motion to dismiss stage, the facts would unambiguously show that the Complaint's allegations that Humana uses the nH Predict tool to make adverse coverage determinations without human intervention have no merit. Further, the coverage determinations at issue in this case were reviewed and upheld at every level of administrative review that the Plaintiffs sought. *See infra* nn. 4–5.

Act for challenging a MAO's coverage determination. Under the Medicare Act and Centers for Medicare and Medicaid Services ("CMS") regulations, any Medicare beneficiary who disagrees with a benefit determination by her MAO must exhaust a four-step mandatory administrative review process that concludes with potential review by the Medicare Appeals Council, a federal agency authorized to issue final benefit determinations on behalf of the Secretary of Health and Human Services ("HHS"). *See* 42 C.F.R. § 405.920 *et seq.*; *Glob. Rescue Jets, LLC v. Kaiser Found. Health Plan, Inc.*, 30 F.4th 905, 911 (9th Cir. 2022). If a member disagrees with the Medicare Appeals Council's determination on behalf of the Secretary of HHS, she can seek relief in federal court by filing a lawsuit against the Secretary of HHS challenging the outcome of the agency's administrative determination. She cannot sue her MAO. *See* 42 U.S.C. § 405(g); 42 C.F.R. § 422.612(c); *id*. at § 405.1136(d)(1); *see also Ebert v. Anthem Health Plans of Ky, Inc*., 2022 WL 509117, at *2 (W.D. Ky. Feb. 18, 2022) (explaining that "in any civil action brought in federal court [disputing coverage of Medicare Benefits], the Secretary of HHS, in his or her official capacity, is the proper defendant." (internal quotations omitted)).

Plaintiffs seek to sidestep the exclusive administrative appeal process set by the Medicare Act. Indeed, both Plaintiffs have partially completed Medicare Part C's exclusive administrative appeal process: Plaintiff Susan Hagood received an adverse decision from a HHS Administrative Law Judge denying her appeal and upholding Humana's Medicare coverage determination (step three in the Medicare Part C administrative appeal process).[4] And Plaintiff Joanne Barrows

[4] *See* Exhibit 1 (the ALJ Decision for Ms. Hagood's appeal) at 1–2, 14. Although Plaintiffs avoid mention of the administrative record in their Complaint, the Court may take judicial notice of an ALJ decision and evaluate the administrative record without converting this motion into one for Summary Judgment. "[T]he decision of an ALJ is a proper subject of judicial notice." *United States v. An Undetermined Quantity of An Article of Drug Labeled As Benylin Cough Syrup*, 583 F.2d 942, 946 n.3 (7th Cir. 1978) (citing 10 Moore's Federal Practice § 201.02[1]). In general, this Court "has the power to 'judicially notice a fact that is not subject to reasonable dispute

similarly had her appeal denied by an independent Quality Improvement Organization ("QIO") appointed by CMS (step one in the Medicare Part C "fast-track" appeal process).[5] Unhappy with those decisions, Plaintiffs now attempt to pursue state-law causes of action in this Court. But, just as numerous other courts have held, those claims must be dismissed because this Court lacks subject matter jurisdiction to hear them.[6] *See, e.g.*, *Uhm v. Humana, Inc.*, 620 F.3d 1134 (9th Cir. 2010); *Trinity Home Dialysis, Inc. v. WellMed Networks, Inc.*, 2023 WL 2573914, at *5 (5th Cir. Mar. 20, 2023) (per curiam); *Giesse v. Sec. Dept. Health & Hum. Servs.*, 522 F.3d 697, 702–03 (6th Cir. 2008) ("[S]ection 405(h) clearly prohibits judicial review of plaintiff's claims

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because it...can be accurately and readily determined from sources whose accuracy cannot reasonably be questioned.'" *Robinson v. Woods*, 901 F.3d 710, 712 n.1 (6th Cir. 2018) (quoting Fed. R. Evid. 201(b), (d)). And as other courts in this circuit have uniformly held, the findings of an "ALJ decision cannot reasonably be questioned." *Powell v. Comm'r of Soc. Sec.*, 2019 WL 4686491, at *4 (E.D. Mich. Sept. 26, 2019) (taking judicial notice of ALJ decision); *Thumann v. Cochran*, 2021 WL 1222142, at *2 n.3 (S.D. Ohio Mar. 31, 2021) ("While ALJ Bruch's decision is not part of the certified administrative record, the Court finds it proper to take judicial notice of ALJ Bruch's decision"); *cf. Toth v. Grand Trunk R.R.*, 306 F.3d 335, 349 (6th Cir. 2002) ("[A] Court may take judicial notice of the rules, regulations and orders of administrative agencies issued pursuant to their delegated authority"). In this case, the ALJ decision outlines the procedural history, and explains Humana met its burden of proving that termination of Ms. Hagood's SNF services was correct.

[5] *See* Exhibit 2 (the QIO determination for Ms. Barrows' appeal). On December 11, 2021, Livanta, the CMS-appointed QIO responsible for reviewing Humana's denial of coverage, issued a determination letter upholding Humana's denial of coverage. The reviewer found that Ms. Barrows no longer met Medicare coverage requirements for SNF services. Because the Complaint alleges that "Ms. Barrows and her family vigorously appealed Humana's denial, but their efforts were unsuccessful," Compl., R. 1, PageID#: 13 (¶ 44), this Court is free to consider the referenced appeal determinations. *See Ashland, Inc. v. Oppenheimer & Co.*, 648 F.3d 461, 467 (6th Cir. 2011) (citation omitted); *Bassett v. Nat'l Collegiate Athletic Ass'n*, 528 F.3d 426, 430 (6th Cir. 2008). Moreover, because this issue goes to the Court's subject-matter jurisdiction, it would be free to consider documents bearing on administrative exhaustion even if they were not referenced in the Complaint. *See Humphrey v. U.S. Att'y Gen.'s Office*, 279 F. App'x 328, 331 (6th Cir. 2008).

[6] Plaintiffs fail to establish that the Court has subject matter jurisdiction because they did not adequately plead that they exhausted the four-step mandatory administrative review process required by the Medicare Act. The Complaint does not allege that either Plaintiff exhausted this process. And, if it had, the Secretary of HHS would be the proper defendant, not Humana.

[that medical benefits were allegedly arbitrarily and capriciously terminated] absent exhaustion of available administrative remedies."); *Cathedral Rock of N. College Hill, Inc. v. Shalala*, 223 F.3d 354 (6th Cir. 2000). Indeed, for precisely this reason, another federal district court within the Sixth Circuit dismissed a Medicare Part C enrollee's claims for similar post-acute care just last year. *See Harwood by Next Friend Adelson v. Aetna Health of Mich.*, 2023 WL 424715, at *2 (E.D. Mich. Jan. 26, 2023) (explaining that all of the plaintiff's claims arose under the Medicare Act because each was "inextricably intertwined with a Medicare benefits determination").

Second, the Court should dismiss this case because the Medicare Act expressly preempts all of the Plaintiffs' state law claims. Plaintiffs attempt to avoid the Medicare Act's requirements by pursuing state law causes of action through this lawsuit—however, they fail to state a claim for which relief can be granted because the Medicare Act preempts all of their claims. To ensure uniform administration of the Medicare Act's rules and regulations nationwide, Congress amended the Medicare Act to expressly preempt any state law or cause of action related to Medicare Act standards. *See* 42 U.S.C. § 1395w-26(b)(3); *see also* 42 C.F.R. § 422.402. Specifically, Congress intended to "supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to MA plans which are offered by MA organizations," *id.*, "including those established through case law," 70 Fed. Reg. at 4665—bringing not just state statutes and regulations within the scope of the Medicare Act's express preemption, but also state "common law claims," *Uhm*, 620 F.3d at 1156.

Courts have interpreted the preemption provision broadly, to mandate something "akin to field preemption." *See Pharm. Care Mgmt. Ass'n v. Mulready*, 78 F.4th 1183, 1206 (10th Cir. 2023); *Alston v. UnitedHealth Servs., Inc.*, 291 F. Supp. 3d 1170, 1173 (D. Mont. 2018). Plaintiffs raise a patchwork of state law causes of action scrutinizing Humana's review and denial

of their claims for skilled nursing facility ("SNF") care, but Humana's coverage determinations are not governed by state law. Instead, Humana is subject to "extensive regulations" by CMS, *e.g, Morrison v. Health Plan of Nev., Inc.*, 328 P.3d 1165 (Nev. 2014) (citing 42 U.S.C. § 1395w-26(b)(1) (2012)), which dictate the appropriate process for reviewing claims for Medicare Benefits and making coverage determinations for SNF benefits under the Medicare Act. *See* 42 C.F.R. § 422.101(a), § 409.30 (basic pre-admission and admission requirements), § 409.31 (level of care requirement), § 409.32 (criteria and need for skilled services), § 409.33 (examples of what qualifies as skilled nursing services), and § 424.20 (plan of treatment and certification requirements for post hospital SNF care). *See also* Compl., R. 1, PageID#: 7 (¶ 23), 11 (¶ 33). Allowing this case to continue would require the Court to apply twenty-three states' standards,[7] and risk outcomes that conflict with the federal government's Medicare rules. This is exactly why the Medicare Act has such a vast preemption provision. For these reasons, the Plaintiffs' claims are preempted, and the Complaint should be dismissed.

BACKGROUND

I. THE MEDICARE ADVANTAGE PROGRAM

In 1997, Congress enacted Part C of Title XVII of the Social Security Act, known as the Medicare Act. The Medicare Act gives Medicare beneficiaries the option to receive benefits in one of two ways. An eligible party may participate in Medicare Parts A and B and have "CMS directly pay medical providers for [her] hospital and outpatient care." *Humana Med. Plan, Inc. v. W. Heritage Ins. Co.*, 832 F.3d 1229, 1233 (11th Cir. 2016). Alternatively, a Medicare enrollee may choose to participate in a Medicare Part C plan, known as a Medicare Advantage plan, and

[7] Ms. Barrows is a citizen of, and received care in, Minnesota. Compl. R. 1, PageID#: 6 (¶ 18). Ms. Hagood is a citizen of, and received care in, North Carolina. *Id.* (¶ 19). The Complaint does not allege that the named Plaintiffs have any connection to the remaining twenty states.

have a MAO—rather than CMS—provide her Medicare Benefits. *See id.* Ms. Barrows and Ms. Hagood both elected the latter and enrolled in a Medicare Part C Plan administered by Humana. Compl., R. 1, PageID#: 12 (¶ 39), 14 (¶ 50).

MAOs are heavily regulated entities whose activities are governed exclusively by the Medicare Act and CMS's implementing regulations. *See*, *e.g.*, 42 C.F.R. § 422.1 *et seq*. For instance, the Medicare Act and CMS regulations dictate *when* an MAO must cover medical services, *how* it can make those coverage determinations, and the exclusive process for a member to appeal if her coverage is denied. *See*, *e.g.*, 42 C.F.R. §§ 409.30–409.36 (CMS regulations for coverage of posthospital SNF care), § 422.137 (MAO's use of utilization management policies and procedures), § 422.566(b) (Medicare beneficiaries' right to appeal organizational determinations through the Medicare Act's exclusive administrative appeals process); *see also* CMS, Frequently Asked Questions Related to Coverage Criteria and Utilization Management Requirements in CMS Final Rule (CMS-4201-F) at 2 (Feb. 6, 2024) ("An algorithm or software tool may be used to assist MA plans in making coverage determinations, but it is the responsibility of the MA organization to ensure that the algorithm or artificial intelligence complies with all applicable rules for how coverage determinations by MA organizations are made."). Congress ensured uniform implementation of this nationwide program by expressly preempting any state law or cause of action that relates to, challenges, or regulates MAOs' compliance with Medicare standards. *See* 42 U.S.C. 1395w-26(b)(3). *See also* 42 C.F.R. § 422.402; 70 Fed. Reg. at 4665.

II. PLAINTIFFS' CLAIMS FOR SKILLED NURSING BENEFITS

This case concerns Humana's decision to end coverage for Ms. Barrows' and Ms. Hagood's post-acute care at a skilled nursing facility (SNF). Humana is an MAO that provides Medicare Benefits under Medicare Part C. Compl., R. 1, PageID#: 2 (¶ 4). As noted above, Ms. Barrows and Ms. Hagood are Medicare beneficiaries who elected to receive their Medicare Benefits through

an MAO, Humana. *Id.* at 12 (¶ 39), 14 (¶50). Ms. Barrows resides in Minnesota, and for all times relevant to this action, Ms. Hagood was a citizen of North Carolina. *Id.* at 6 (¶¶ 18–19). Both Plaintiffs allege that Humana wrongly ended coverage for their stays in skilled nursing facilities ("SNFs"). *Id.* at 13 (¶ 42), 15 (¶ 57).

The Plaintiffs allege Ms. Barrows was admitted to Good Samaritan Society Ambassador Rehabilitation Facility (a SNF) following her discharge from an inpatient hospital on November 26, 2021. *Id.* at 12 (¶ 41). After covering two weeks of SNF care, Humana informed Ms. Barrows that additional SNF care would no longer be covered. *Id.* at 13 (¶ 43). The Complaint alleges that "Ms. Barrows and her family vigorously appealed Humana's denial [of coverage], but their efforts were unsuccessful" and the appeals were denied. *Id.* (¶ 44). Similarly, on October 26, 2022, Ms. Hagood was admitted to a SNF. *Id.* at 14 (¶¶ 52–53). She was readmitted to Mission Hospital on November 28, 2022. *Id.* at 15 (¶ 56). On or around November 27, 2022, Humana notified Ms. Hagood that it had ended her coverage for SNF services on November 14, 2022 after determining that Ms. Hagood did not require the level of care provided by a SNF.[8] *Id.* (¶ 57).

The Complaint includes twenty-six causes of action that tie back to Humana's denial of coverage for Ms. Barrows' and Ms. Hagood's care, and its alleged improper investigation into Plaintiffs' claims for Medicare Benefits. Two breach of contract claims assume that Ms. Barrows and Ms. Hagood entered into a contract with Humana for the provision of insurance under the

[8] The Complaint misstates the timeline for Ms. Hagood's SNF care. *See* Compl. R. 1 PageID#: 15 (¶¶ 56–57). According to the ALJ's decision, Ms. Hagood was admitted to the SNF on October 26, 2022. *See* Exhibit 1 at 7. Humana covered her SNF care for 19 days. *See id.* at 7–8. On November 11, 2022, Humana issued a Notice of Medicare Non-Coverage informing Ms. Hagood and her family that her care would no longer be covered after November 13, 2022. *See id.* at 8–9. Her family opted to keep her in the facility until November 28, 2022, when she was readmitted to an inpatient facility. *See id.* at 18.

Medicare Advantage program. *Id.* at 19 (¶ 72), 21 (¶ 80). Humana's alleged breach, according to the Plaintiffs, was its "unreasonable denial to pay" for Plaintiffs' SNF claims without "adequate individualized investigation." *Id.* at 20–21 (¶¶ 74, 76–77, 84–85), and failure to provide a "thorough, fair, and objective investigation of each submitted claim prior to a claim denial." This, the Plaintiffs allege, resulted in an "unreasonable" denial of their claims for SNF benefits. *See id.* at 19–20 (¶¶ 71–78). The Plaintiffs' second cause of action alleges that Humana violated its implied covenant of good faith and fair dealing under the insurance agreement when it improperly delegated its claims review function and failed to require its agents to conduct a proper investigation of each submitted claim. *See id.* at 20–22 (¶¶ 79–88). Like the breach of contract claim, this, the Plaintiffs argue, "constitute[s] an unreasonable denial to pay benefits due to Plaintiffs." *See id.* And in their third cause of action, Plaintiffs allege that Humana unjustly enriched itself when it "knowingly received and retained wrongful benefits and funds from Plaintiffs" and "den[ied] its insureds medical payments owed to them." *Id.* at 22–23 (¶¶ 89–96).

The remaining causes of action are similarly rooted in Humana's denial of coverage and alleged improper investigation of their claims for benefits. Plaintiffs assert two North Carolina Unfair Claims Settlement Practices claims, and twenty-two additional state law causes of action under various state insurance bad faith statutes (as mentioned in footnote 7, twenty of these are in states where the Plaintiffs have no connection). *See*, *e.g.*, *id.* at 24 (¶¶ 97–104) (state Unfair Claims Settlement Practice claim alleging that Humana "refused to pay claims without conducting a reasonable investigation based upon all available information"), 30 (¶ 147) (alleging that Humana "had no reasonable basis for the denial of coverage" in violation of Colorado's Insurance Bad Faith statute), 32 (¶162) (same, Iowa), 33 (¶ 169) (same, Kentucky), 34 (¶ 176) (same, Nebraska), 36 (¶ 191) (same, Oklahoma), (¶ 194) (same, Rhode Island), 39 (¶ 208) (same, South Dakota),

33 (¶ 173) (alleging Humana's reason for denying Plaintiffs' claims "was unreasonable and without proper cause in violation of Massachusetts' Insurance Bad Faith law), ¶ 180 (same, North Dakota), 35 (¶ 185) (alleging Humana's denial of Plaintiffs' claims "constitutes refusal to pay claims in an arbitrary and capricious manner," Insurance Bad Faith in Ohio). All are premised on the same fact pattern: Humana's purported improper denial of coverage for Plaintiffs' SNF care. *See id*. at 20–21 (¶¶ 77, 85) 23–26 (¶¶ 94, 100–02, 109–10, 114), 29–36 (¶¶ 136, 140, 147, 153, 158, 162, 169, 173, 176, 180, 184, 189, 192), 38 (¶¶ 201–02), 40–43 (¶¶ 215, 220, 225, 228–30, 233–35).

STANDARD OF REVIEW

Under Rule 12(b)(6), the Court must dismiss a complaint if it "fail[s] to state a claim upon which relief can be granted." Fed. R. Civ. P. 12(b)(6). Rule 12(b)(6) motions weed out cases that do not warrant discovery because, based on the factual scenario on which the case rests, the plaintiff could never prevail. *See Ashcroft v. Iqbal*, 556 U.S. 662, 678–79 (2009). A court considering such a motion must disregard any conclusory allegations and judge the complaint on its well-pleaded factual allegations alone. *Id.* at 678; *see also Tackett v. M & G Polymers, USA, LLC*, 561 F.3d 478, 488 (6th Cir. 2009). If those factual allegations do not add up to a valid cause of action, the Court should grant the motion and dismiss the case. *See Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 561–64 (2007).

Because 12(b)(6) motions test only the sufficiency of the complaint, courts generally disregard evidence that does not appear on the face of the pleading. *Barrett*, 130 F.3d at 253. Nevertheless, a court "may also consider other materials that are integral to the complaint, are public records, or are otherwise appropriate for the taking of judicial notice" without converting the motion into one for summary judgment. *Ashland*, 648 F.3d at 467 (citation omitted). It may

also consider "exhibits attached to defendant's motion to dismiss so long as they are referred to in the Complaint and are central to the claims contained therein." *Bassett*, 528 F.3d at 430.

Motions to dismiss under Rule 12(b)(1) are a different story. The point of a 12(b)(1) motion is not to test the sufficiency of the complaint, but to remove from the Court's docket cases the Court cannot decide because it lacks subject-matter jurisdiction. When ruling on such a motion, courts are not confined to the allegations in the pleading. Rather, "it is well established that in considering a Rule 12(b)(1) motion to dismiss for lack of subject matter jurisdiction, the district court may look beyond the jurisdictional allegations in the complaint and consider whatever evidence is submitted." *Humphrey*, 279 F. App'x at 331. "The plaintiff bears the burden of establishing that jurisdiction exists." *Taylor v. Keycorp*, 680 F.3d 609, 612 (6th Cir. 2012). And if it cannot do so "by a preponderance of the evidence," the Court must dismiss the complaint. *Capitol Specialty Ins. Corp. v. IKO, Inc.*, 2013 WL 6196564, at *2 (W.D. Ky. Nov. 26, 2013).

ARGUMENT

I. THE MEDICARE ACT DEPRIVES THIS COURT OF SUBJECT MATTER JURISDICTION OVER PLAINTIFFS' CLAIMS, WHICH ARE SUBJECT TO A MANDATORY FEDERAL ADMINISTRATIVE EXHAUSTION PROCESS.

This case should be dismissed for lack of subject matter jurisdiction because neither named Plaintiff properly exhausted the Medicare Act's mandatory administrative review process. Ms. Hagood completed three of the required levels, but never submitted an appeal for a final determination by the Medicare Appeals Council (on behalf of the Secretary of HHS), and Ms. Barrows only completed the first level of review by a Quality Improvement Organization ("QIO"). When Congress passed the Medicare Act, it specified that all claims "arising under" Medicare must proceed through CMS's administrative review process and receive a final decision issued by the Secretary of HHS before they can be brought in federal court. 42 U.S.C. §§ 405(h), 1395w-22(g)(5); 42 C.F.R. § 422.566(b); *Harwood*, 2023 WL 424715, at 1–2 ("The Medicare

Act's grant of subject matter jurisdiction only permits judicial review of the final decision of the Secretary made after a hearing." (citing *Giesse*, 522 F.3d at 703–04; internal citations omitted; cleaned up)). This exhaustion requirement ensures national uniformity by allowing the federal government to set coverage criteria for Medicare Benefits and dictate how MAOs cover those Medicare Benefits and implement the Medicare program. Plaintiffs attempt to sidestep this mandatory administrative process by bringing their claims for Medicare Benefits under breach of contract, unjust enrichment, and state statutory claims to manufacture subject matter jurisdiction when none exists.

A. The Medicare Act Requires Plaintiffs To Exhaust A Four Step Administrative Review Process Before This Court Can Hear Their Claims.

The Medicare Act and associated federal regulations outline the only path for Medicare enrollees to challenge the denial of a request for coverage of Medicare Benefits. The question of whether an MAO must make payment for a service that the patient believes is covered by Medicare is an "organization determination" under the Medicare Act. 42 C.F.R. § 422.566(b)(2). So is any alleged "[r]eduction, or premature discontinuation, of a previously authorized ongoing course of treatment." *Id.* § 422.566(b)(4). Even an alleged failure to timely notify a member of an organization determination is itself treated as an organization determination, *id.* § 422.568(f), and therefore requires the member to follow the appeal process set forth below. Here, where both Plaintiffs allege harm due to Humana's review and denial of coverage for their continued SNF care, they plainly attempt to litigate the validity of an organization determination. *See Trinity Home Dialysis, Inc.*, 2023 WL 2573914, at *5 (claims for failure to reimburse challenged organization determinations and thus "clearly" arose under the Medicare Act).

Enrollees that wish to challenge an organization determination cannot go directly to court for relief. Instead, Congress required that all such disputes be presented to, and exhausted in, an

administrative appeal process. 42 U.S.C. §§ 405(g)-(h); *id*. §1395w-22(g).[9] MA plan members must complete four levels of administrative review prior to filing suit on any claim that arises under the Medicare Act. *See id*. § 1395w-22(g); 42 C.F.R. § 422.560 *et seq.* First, a member who is aggrieved by an MAO's decision to end coverage for SNF care may submit a request for an appeal to an Independent Review Entity ("IRE"), such as a QIO, contracted by CMS to review the MAO's decisions. *See* 42 C.F.R. § 422.626(a).[10] If the QIO upholds the MAO's termination of coverage, the member has 60 days to request it reconsider its' decision. *See id.* § 422.626(g). If still unsatisfied after this external review, the member has a right to a hearing by a HHS Administrative Law Judge ("ALJ"). *See id.* §§ 422.600–422.602. Finally, the member may seek review by the Medicare Appeals Council. *See id.* § 422.608. Only after the Medicare Appeals Council has issued its final determination on behalf of the Secretary of HHS can a beneficiary seek review in federal district court. 42 U.S.C. § 405(g)-(h); *id*. §1395w-22(g)(5); 42 C.F.R. § 422.612. If a member chooses to file suit, she can only sue the Secretary of HHS in the federal district court for the district where she resides. *See* 42 U.S.C. § 405(g).

[9] The Medicare Act's mandatory exhaustion requirement was created by cross references to the exhaustion and judicial review provisions of the Social Security Act, 42 U.S.C. §§ 405(g)-(h); *id*. § 1395ii.

[10] When the organization determination involves terminating coverage for SNF care, MA Plan members may use a process (as the named Plaintiffs did here) that "fast track[s]" their *initial* level one appeal, but they must still complete all four levels of review. *See* 42 C.F.R. § 422.626 (describing "fast-track" initiated appeals). Under the traditional process, a level one appeal requires members to seek reconsideration from their MAO within 60 days of the organization determination. *See* 42 C.F.R. §§ 422.578–422.590. If the MAO upholds the denial, the member may seek review by an IRE. *See id.* §§ 422.592–422.596. Steps 3 through 4 are the same as above. *See id*. §§ 422.600–422.608. If an enrollee misses the request window for a "fast track" appeal, the typical process outlined under §§ 422.592–422.596 applies. *Id.* § 422.626. Either way, plaintiffs must still complete all four levels of administrative review. Because the named Plaintiffs here utilized the "fast-track" appeal initiation, this motion focuses on that process as outlined in CMS Regulations.

Multiple federal courts have held that the administrative appeal process set forth in 42 U.S.C. §§ 405(g)-(h), §1395w-22(g), and 42 C.F.R. §§ 422.560–422.626 is the *exclusive* process for challenging a MAO's coverage determinations, and also that exhaustion of that process is a *jurisdictional prerequisite* that must be satisfied before a federal district court can hear the Plaintiffs' claims. *See*, *e.g.*, *Tenet Healthsystem GB, Inc., v. Care Improvement Plus S. Cent. Ins. Co.*, 875 F.3d 584, 587 (11th Cir. 2017) (quoting *Heckler v. Ringer*, 466 U.S. 602, 617 (1984)). As the Ninth Circuit explained in 2022:

> Congress intended to impose under the Medicare Advantage program the same administrative exhaustion requirement that applies to claims for benefits under original Medicare. Section 1395w-22(g), like its statutory counterpart under original Medicare, conditions judicial review on a "final decision" of the Secretary and channels judicial review through § 405(g), subject to the same jurisdictional limitations imposed by § 405(h). Congress imported these requirements into § 1395w-22(g) after the Supreme Court in *Ringer* had construed virtually identical language in § 1395ff(b)(1) to mandate administrative exhaustion as a prerequisite for obtaining judicial review of a claim for Medicare benefits.

Glob. Rescue Jets, 30 F.4th at 914. Thus, when plaintiffs—like the named Plaintiffs here—have failed to complete the administrative exhaustion process set by Congress for contesting Medicare Benefits, the Court lacks subject matter jurisdiction and the Plaintiffs' complaint must be dismissed. *See, e.g.*, *id.* at 914, 919–20; *Uhm*, 620 F.3d 1138; *Williams v. Allegheny Cnty.*, 2023 WL 4238892, at *7 (W.D. Pa. June 28, 2023); *Moses v. United Healthcare Corp.*, 2020 WL 2037115 (D. Ariz. Apr. 28, 2020); *Dicrescenzo v. UnitedHealth Grp. Inc.*, 2015 WL 5472926 (D. Haw. Sept. 16, 2015).

B. Plaintiffs' Claims Are Subject To The Medicare Act's Exhaustion Requirements Because They Are "Inextricably Intertwined" With The Denial Of Medicare Benefits.

Every cause of action here arises under the Medicare Act because they stem from Humana's termination of continued coverage for Plaintiffs' SNF benefits. As discussed above, Medicare beneficiaries must receive a final decision from the Secretary of HHS prior to seeking judicial

review of claims "arising under" the Medicare Act. *See* 42 U.S.C. § 405(h); *id*. § 1395ii; *Uhm*, 620 F.3d, at 1141. A claim "arises under" the Medicare Act if the "standing and the substantive basis for the presentation of the claims" is the Medicare Act, or if it is "inextricably intertwined with a claim for Medicare benefits." *Uhm*, 620 F.3d at 1141 (*citing Ringer,* 466 U.S. at 614–15); *see also Giesse*, 522 F.3d at 702 (Medicare Act was the "standing and substantive basis for" claim for monetary compensation for damages caused by the "arbitrary and capricious termination of [enrollee's] medical benefits"). Plaintiffs cannot circumvent the Medicare Act's exhaustion requirements by rebranding their claims for benefits under a different name. *See*, *e.g.*, *Ringer,* 466 U.S. at 614–16, 618, 621 ("supposed 'procedural' objections" and claims for "declaratory and injunctive relief" still sought "the payment of benefits" and a "right to future payments"); *United States v. Blue Cross & Blue Shield of Ala., Inc.*, 156 F.3d 1098, 1104 (11th Cir. 1998) (plaintiffs cannot "evad[e] administrative review by creatively styling their benefits and eligibility claims as constitutional or statutory challenges to Medicare statutes and regulations").

Further, a claim is "inextricably intertwined" with a claim for Medicare Benefits if it does not involve issues separate from a party's claim that it is entitled to benefits. *Uhm*, 620 F.3d at 1143 (breach of contract claim "premised on the fact that Humana 'failed to provide prescription drug benefits as promised'" and unjust enrichment claim alleging Humana "received monies as a result of payments made by [the plaintiffs] for prescription drug benefits that Humana failed to provide" arose under the Medicare Act because they were "at bottom" creatively disguised claims for benefits."); *Glob. Rescue Jets, LLC*, 30 F.4th at 919 (consumer protection claim rested "directly on the interpretation of benefits provided under Kaisers' Medicare Advantage plans" because, on plaintiffs' theory, Kaiser's failure to pay benefits would violate its Medicare Act obligations).

For example, in *Harwood by Next Friend Adelson v. Aetna Health of Michigan*, a Medicare Part C enrollee sued her MAO based on breach of contract, specific performance, and breach of good faith and fair dealing claims after it denied pre-approval for her transfer to an inpatient rehabilitation treatment center. 2023 WL 424715 at *2. The court explained that plaintiff's claims arose under the Medicare Act because each of the claims ultimately sought coverage for inpatient rehabilitation services. *Id.* Similarly, in *Hepstall v. Humana Health Plan, Inc.*, the court dismissed tort and contract claims against Humana because they had not been exhausted under the Medicare Act. 2018 WL 6588555 at *1 (S.D. Ala. Nov. 26, 2018). That plaintiff, the husband of a MA beneficiary, alleged that Humana wrongfully denied coverage for treatments, leading to economic harm and the death of his wife. The court concluded that the plaintiff sought "recovery for damages he suffered as a result of this refusal…[including] the costs he incurred for healthcare benefits that Humana refused to pay." *Id.* at *8. Even though the claim was restyled as a breach of contract and bad faith refusal to pay, the essence of the causes of action remained a "cleverly concealed claim for benefits under the Medicare Act." *Id.*

Here, despite Plaintiffs' creative attempts to disguise their claims for benefits as a novel legal theory, each cause of action arises under the Medicare Act because the Complaint asks the Court to judge Humana's process for reviewing claims and its eventual denial of SNF coverage. For example, Plaintiffs' breach of contract, breach of implied covenant of good faith and fair dealing, and unjust enrichment causes of action allege Humana's processes for reviewing and investigating claims led to a denial of benefits in breach of their insurance agreements.[11]

[11] These "breach of contract" claims fail for another reason too: MAOs do not issue "contracts" to Medicare Enrollees. Rather, Medicare Benefits are provided pursuant to federal law and regulations, and MAOs issue their beneficiaries an "Evidence of Coverage" document, which is largely written by CMS. *See, e.g.*, 42 C.F.R. §§ 422.111, 422.2261.

See Compl., R. 1, PageID#: 19–23 (¶¶ 71–78) (first cause of action alleging Humana entered into an insurance agreement with the Plaintiffs, under which it owed them fiduciary duties, which it purportedly breached by failing to provide a thorough, fair, and objective investigation of each submitted claim prior to claim denial, resulting in an unreasonable denial of their claims), (¶¶ 79–88) (second cause of action alleging Humana's improper delegation of its claims review function and failure to require its agents to conduct a proper investigation of each submitted claim "constitute an unreasonable denial to pay benefits due to Plaintiffs" in violation of the implied covenant of good faith and fair dealing), (¶¶ 89–96) (third cause of action alleging that Humana was unjustly enriched when it "knowingly received and retained wrongful benefits and funds from Plaintiffs" and "arbitrarily den[ied] its insureds medical payments owed to them"). These causes of action are similar to the breach of contract and unjust enrichment claims discussed in *Uhm*, which the court found were "merely creatively disguised claims for benefits" that ultimately sought to vindicate "the same alleged promises" and "secure a remedy for Humana's alleged failure to provide benefits." 620 F.3d at 1143. Thus, the Plaintiffs' causes of action each arise under the Medicare Act because they relate directly to Humana's denial of Medicare coverage.

Plaintiffs' twenty-three remaining state statutory causes of action similarly arise under the Medicare Act. Even though Plaintiffs avoid mentioning the type of remedy they seek under their state insurance bad faith claims, questions as to whether Humana's investigations into an enrollee's medical status were "adequate," Compl., R. 1, PageID#: 27 (¶117), relate directly to whether or not a benefit should have been covered. *See*, *e.g.*, 42 C.F.R. § 409.30–409.36 (CMS regulations for coverage of posthospital SNF care); *id*. § 422.137 (MAO's use of utilization management policies and procedures). Similarly, allegations that there was "no reasonable basis" for Humana to deny members' claims, *e.g.*, Compl., R. 1, PageID#: 29 (¶133), 30 (¶147), 32 (¶162), 33 (¶169),

34 (¶176), are inextricably intertwined with the Medicare Act regulations discussing when SNF coverage is proper. *See* 42 C.F.R. § 409.30–409.36 (CMS regulations for coverage of posthospital SNF care). Determining whether an MAO acted "without any reasonable justification" in denying benefits, Compl., R. 1, PageID#: 31 (¶153), is squarely within the role of each level of the Medicare Act's administrative review process. 42 C.F.R. § 422.566(b) (Medicare beneficiaries' right to appeal organization determinations through the Medicare Act's exclusive administrative appeals process). Thus, all of Plaintiffs' claims arise from the Medicare Act and must be properly exhausted before the Court can consider them.

C. Plaintiffs Did Not Fully Appeal Humana's Coverage Determinations Through Medicare's Mandatory Federal Appeals Process.

Even though all of the claims arise out of the Medicare Act, neither Ms. Barrows nor Ms. Hagood completed the four steps that the Medicare Act requires before a federal district court can hear their claims. Thus, this Court lacks subject matter jurisdiction and should dismiss Plaintiffs' Complaint.

As noted above, the MA appeal process is governed by federal statutes and regulations that require enrollees to complete four levels of administrative review *prior* to filing suit on any claim arising under the Medicare Act. *See* 42 U.S.C. § 1395w-22(g); 42 C.F.R. § 422.560 *et seq.*; *Uhm*, 620 F.3d at 1144 (federal courts could not assert jurisdiction over the claims when plaintiffs failed to allege that they appealed through the §405(g) process); *Harwood*, 2023 WL 424715 at *1 (complaint dismissed because plaintiff conceded she had not exhausted administrative remedies); *Haaland v. Presbyterian Health Plan, Inc.*, 292 F. Supp. 3d 1222, 1234 (D.N.M. 2018) (no subject matter jurisdiction because plaintiffs conceded MA member did not appeal a denial of a liver transplant evaluation); *Alston*, 291 F. Supp. 3d at 1175–76 (no jurisdiction when member made no contention that he complied with the exhaustion requirements). When a Medicare Advantage

enrollee's coverage of SNF benefits is terminated, she receives an initial determination from the MAO, which includes written notice of Medicare non coverage and outlines the Medicare appeals process. 42 C.F.R. § 422.568. Following notification of the denial of coverage, the enrollee may submit a request for a "fast track" appeal to an Independent Review Entity (in this case, a QIO) by noon the first day after the day of delivery of the termination notice. *Id.* § 422.626(a). If the QIO upholds the MAO's termination decision, the member has 60 days to request a Level 2 appeal, which asks the QIO to reconsider its determination. *Id.* § 422.626(g). An HHS ALJ reviews the record for Level 3 appeals that meet an amount in controversy requirement. *Id.* § 422.600. After the ALJ issues a decision, the enrollee has 60 days to appeal to the Medicare Appeals Council (MAC). *Id.* §§ 422.608, 405.1102(a)(1); Exhibit 1 at 16. The MAC's decision on a Level 4 appeal is considered a "final decision" by the Secretary of HHS. 42 C.F.R. § 422.612. It is only at this point—after the MAC issues its final decision—that the member may choose to sue the Secretary of HHS in federal court to challenge the determination. *See* 42 U.S.C. § 405(g); 42 C.F.R. § 422.612(c); *id*. § 405.1136(d)(1).

Here, the Plaintiffs have the burden of establishing subject matter jurisdiction exists. *Taylor*, 680 F.3d at 612. However, the Complaint fails to adequately allege that either of the Plaintiffs initiated the required administrative review process, much less received the required final decision by the Secretary of HHS. The Plaintiffs have failed to carry their burden. The only mention of *any* appeal in the entire Complaint is the threadbare allegation that Ms. Barrows and her family "vigorously appealed" Humana's denial of coverage. Compl., R. 1, PageID #: 13 (¶44). There is no mention of any appeals taken by Ms. Hagood. The Plaintiffs have not adequately shown that this Court has jurisdiction, and Plaintiffs case should be dismissed.

Going one step further, the administrative record reflects *neither* Plaintiff completed the administrative review process. On March 17, 2023, an ALJ issued a decision denying Ms. Hagood's Level 3 appeal and upholding Humana's coverage determination. Exhibit 1 at 14 (applying Medicare regulations and CMS guidance on SNF coverage to find that Humana "properly terminated coverage."). It appears Ms. Hagood did not appeal the ALJ's determination to the MAC for a final determination on behalf of the Secretary of HHS within the 60-day window. As the final level of review was never exhausted, the agency never issued a final decision. Further, the administrative record shows Ms. Barrows did not appeal Humana's coverage determination past the Level 1 expedited review, completed by the QIO. On December 11, 2021, Ms. Barrows received a Level 1 determination from the QIO, which indicated that it agreed with Humana's coverage determination because "[t]here [were] no medical issues to support the need for daily skilled nursing care" and Ms. Barrows "no longer me[]t the criteria for a Skilled Nursing Facility." Exhibit 2 at 3. The administrative record does not show that Ms. Barrows requested that the QIO reconsider its decision or tried to complete any of other levels required by the Medicare Act. Thus, the Court lacks subject matter jurisdiction over both Plaintiffs' claims. *Alston.*, 291 F. Supp. 3d at 1175–76. The Medicare Act is clear—the administrative appeal process is the proper forum for these complaints to be heard. *See* 42 U.S.C. § 1395w-22(g); 42 C.F.R. § 422.560 *et seq.* Plaintiffs cannot restyle their appeals to avoid that process and forum shop for relief in this Court instead.

D. Even If Plaintiffs Had Exhausted The Mandatory Appeals Process, The Secretary Of Health And Human Services—Not Humana—Would Be The Proper Defendant.

This case should be dismissed because, even if Plaintiffs had fully exhausted the exclusive administrative appeal process set by Congress, the Plaintiffs sued the wrong defendant. When Congress passed the Medicare Act, it specified beneficiaries could seek review of final determinations from the Secretary of HHS—not their MAO. *See* 42 U.S.C. § 405(g); 42 C.F.R.

§ 422.612(c); *id.* § 405.1136(d)(1); *see also Ebert*, 2022 WL 509117, at *2 ("Even though the insurer . . . is the opposing party during the administrative review proceedings at the agency level, once a dispute like this goes to court, the Secretary of HHS is the party responsible for defending the agency's decision below.") (collecting cases). Thus, the Plaintiffs in this case filed their Complaint against the wrong defendant. *See Madsen v. Kaiser Found. Health Plan, Inc.*, 2009 WL 1537878, at *4 (S.D. Cal. June 2, 2009) ("In any civil action seeking judicial review of a decision of the Medicare Appeals Council, the Secretary of HHS, in his or her official capacity, is the proper defendant.") (citing 42 C.F.R. § 405.1136(d)(1)). Therefore, the Complaint should be dismissed.

II. THIS COURT MUST DISMISS PLAINTIFFS' CLAIMS AGAINST HUMANA BECAUSE THEY ARE EXPRESSLY PREEMPTED BY THE MEDICARE ACT.

The Court must dismiss Plaintiffs' claims because they are preempted by the federal statutes and regulations that govern when MAOs must cover post-acute care, and how they make coverage determinations.

A. The Medicare Act Imposes A Sweeping Preemption Provision.

To preserve the federal government's ability to uniformly administer federal benefits and to avoid inconsistent application of the Medicare Program across the states, Congress expressly preempted any application of state statutes and causes of action that relate to Medicare coverage, rules, and regulations when it passed the Medicare Modernization Act in 2003. As the Ninth Circuit explained in *Uhm*:

> Prior to the 2003 amendments, the preemption clause provided that federal standards would supersede state law and regulations "with respect to" MA plans only "to the extent such law or regulation is inconsistent with such standards" and specified several "standards specifically superseded." 42 U.S.C. § 1395w-26(b)(3)(A)(2000). The 2003 amendments struck both that qualifying clause and the enumerated standards from the provision. *See* 42 U.S.C. § 1395w-26(b)(3)(A)(2003). The Conference Report accompanying the Act explains that, in striking the clause, Congress intended to broaden the preemptive effects of the Medicare Statutory regime[.]

Uhm, 620 F.3d at 1149 (citing H.R. Rep. No. 108-391, at 557 (2003) (Conf. Rep.) ("[T]he MA program is a federal program operated under Federal rules. State laws, do not, and should not apply[.]")). After the 2003 amendments, Medicare Part C's preemption provision now provides:

> The standards established under this part shall supersede *any State law or regulation* (other than State licensing laws or State laws relating to plan solvency) with respect to MA plans which are offered by MA organizations under this part.

42 U.S.C. § 1395w-26(b)(3) (emphasis added); *see also* 42 C.F.R. § 422.402. Multiple circuits have explained that the Medicare Act's amended preemption provision is "akin to field preemption." *See Mulready*, 78 F.4th at 1200, 1205 (describing Part D's preemption provision—which is identical to Part C's—as "unmistakably broad" and "expansive" such that field preemption is proper); *Medicaid & Medicare Advantage Prods. Ass'n of P.R., Inc. v. Hernández*, 58 F.4th 5, 12 (1st Cir. 2023) (explaining the 2003 amendment expanded the scope of preemption "beyond those laws that directly conflict with federal standards"); *Uhm*, 620 F.3d at 1150 ("Congress intended to expand the preemption provision beyond those state laws and regulations inconsistent with the enumerated standards").

Given the expansive language of the preemption provision, a conflicting state law standard, or "specific federal-state overlap" is not necessary for a state law to be preempted. *See Mulready*, 78 F.4th at 1208 (holding that an Oklahoma state statute, which purported to require pharmacy benefit managers to allow all Oklahoma pharmacies willing to accept the PBM's preferred-network terms, was preempted by the Medicare Act because the law "function[ed] as a regulation of a Part D plan itself." (cleaned up)). Instead, any state law-related cause of action and common law cause of action that relates to a Medicare standard is preempted. *See Rudek v. Presence Our Lady of Resurrection Med. Ctr.*, 2014 WL 5441845, at *4 (N. D. Ill. Oct. 27, 2014) (explaining the preemption provision applies to state common law because it would be "odd" for Congress to preempt state statutes and regulations but be "unconcerned about the greater risks of inconsistency

and variability posed by the application of state law"); 40 Fed. Reg. at 4665 ("all State standards, *including those established through case law*, are preempted to the extent they specifically would regulate MA plans") (emphasis added)).

When applying the broad field preemption provision, courts have explained "at the very least, any state law or regulation falling within the specified categories [from before the 2003 amendment] and 'inconsistent' with a standard established under the Act remains preempted." *See Uhm*, 620 F.3d at 1149–50 (common law fraud and state consumer protection claims were preempted when, "at bottom," they complained about marketing activities regulated under Medicare because a court's ruling on them had the potential to "directly undermine CMS's prior determination" and its "ability to create standards" that regulate Medicare entities); *Hernández,* 58 F.4th 5, at 12–14 (Puerto Rico statute that required MAOs to pay healthcare providers a minimum rate preempted due to conflict with federal Medicare standards); *Mulready*, 78 F.4th at 1208–09; *Williams*, 2023 WL 4238892, at *7 (breach of contract and breach of good faith and fair dealing claim against MAO preempted by Medicare Act); *Alston*, 291 F. Supp. 3d at 1173 (state-law claims alleging negligence, respondeat superior, intentional infliction of emotional distress, and breach of contract against MAO were preempted); *Potts v. Rawlings Co.,* 897 F. Supp. 2d 185, 199 (S.D.N.Y. 2012) (state anti-subrogation laws preempted by Medicare Act); *Phillips v. Kaiser Found. Health Plan, Inc.*, 953 F. Supp. 2d 1078, 1090 (N.D. Cal. 2011) (state-law unfair competition and consumer protection claims preempted by the Medicare Act); *Quishenberry v. UnitedHealthcare, Inc.*, 532 P.3d 239, 249 (Cal. 2023) (negligence claims based on MAO's alleged state law duty to ensure member received skilled nursing benefits preempted because the MAO's duty turned on a determination of whether the member qualified for SNF care and were therefore duplicative of MA standards); *Morrison v. Health Plan of Nev., Inc.*, 130 Nev. 517, 523 (Nev. 2014)

(state-law negligence claim against MAO concerning selection and supervision of participating providers was preempted by the Medicare Act).

At minimum, the Medicare Act preempts a state law or cause of action when "the conduct underlying the plaintiffs' allegations and state law claims [is] governed by federal regulatory standards." For instance, in *Hepstall v. Humana Health Plan, Inc.*, the court explained that it could not hear claims that sought to retroactively second-guess Medicare coverage determinations. 2018 WL 6588555, at *6–7. In that case, a member's husband sued Humana to recover "the value of his premiums paid in exchange for insurance that was not as represented, for the costs of healthcare which Defendant refused to pay, and for mental anguish or emotional suffering" as well as punitive damages for his wife's wrongful death. *Id.* at *4. The court explained that each of those claims was preempted because they all were "based on or ar[o]se from Defendant's refusal or failure to pay for certain medical services," an area substantially regulated by the Medicare Act, CMS regulations, and coverage guidelines. *Id.* at *7. Like in *Hepstall*, Plaintiffs' claims here relate to, and conflict with, existing Medicare standards, so the Medicare Act's preemption provision requires this Court dismiss them.

B. The Medicare Act Preempts Plaintiffs' Claims Because, "at Bottom" They Are About Coverage Determinations Addressed By Medicare's Vast Regulatory Scheme.

Plaintiffs' causes of action are preempted by the Medicare Act because each is, at bottom, about a coverage determination concerning Medicare Benefits: Each cause of action is based on the allegation that Humana improperly reviewed Ms. Hagood's and Ms. Barrows' claims for benefits, *see, e.g.*, Compl., R. 1, PageID#: 20–21 (¶¶ 74, 76, 82), 24 (¶¶ 99–102), leading to a denial of coverage for their post-acute care, *see id.* at 20–21 (¶¶ 77, 85) 23–26 (¶¶ 94, 100–02, 109–10, 114), 29–36 (¶¶ 136, 140, 147, 153, 158, 162, 169, 173, 176, 180, 184, 189, 192), 37–38 (¶¶ 201–02), 40–43 (¶¶ 215, 220, 225, 228-30, 233–35). As *Hepstall* explained, whether a benefit

is covered by a MA plan is the subject of federal standards, which compel MAOs to provide enrollees with "all services that are covered by Part A and Part B of Medicare", and to comply with "CMS's national coverage determinations" and its "general coverage guidelines." 2018 WL 6588555 at *7 (citing 42 C.F.R. §§ 422.101(a)–(b)); *see also* Compl., R. 1, PageID#: 8 (¶23).

Thus, claims that Humana wrongly denied coverage for post-acute care are preempted by the extensive Medicare rules, regulations, and guidance that govern each aspect of an MAO's authorization for post-acute care. *See*, *e.g.*, 42 C.F.R. § 409.30 (basic pre-admission and admission requirements); § 409.31 (level of care requirement); § 409.32 (criteria and need for skilled services); § 409.33 (examples of what qualifies as skilled nursing services); and § 424.20 (plan of treatment and certification requirements for post hospital SNF care). Plaintiff's claims that Humana improperly investigated whether coverage should have been required run headlong into CMS regulations that explain how MAOs can use utilization management policies and procedures to make coverage determinations. *See* 42 C.F.R. § 422.112(a)(6)(ii); § 422.137. Allegations that Humana wrongly delegated its responsibility to make coverage decisions are similarly "governed by standards set forth in regulations promulgated by CMS." *Hepstall*, 2018 WL 6588555, at *7; s*ee* 42 C.F.R. § 422.566(d) (requiring adverse coverage determinations to be reviewed by an "appropriate health care professional"); *Alston,* 291 F. Supp. 3d at 1174–75 (finding plaintiff's negligence cause of action, which alleged that an insurer breached its "duty to conduct a reasonable investigation based on all available information and affirm or deny coverage within a reasonable time" was preempted because a state-law based decision turning on reasonableness would be inconsistent with Medicare Part D standards). This Court cannot apply state causes of action to determine whether Humana properly evaluated the Plaintiffs' need for continued SNF care without second-guessing Humana's administration of federal Medicare standards.

For example, in *Snyder v. Prompt Medical Transportation, Inc.*, 131 N.E.3d 640, 653 (Ind. Ct. App. 2019), the Indiana Court of Appeals held that a state-law wrongful death claim against an MAO was preempted. There, as here, the plaintiff alleged that the MAO wrongfully denied Medicare Benefits (an air ambulance transport to another hospital). The trial court dismissed the MAO from the case, finding the claims preempted. Affirming that decision, the Court of Appeals noted that federal regulations govern the authorization of air ambulance transportation. *Id.* at 653. As the Court of Appeals further noted:

> [T]o resolve this argument, a court would have to apply a state law standard of care to a coverage determination governed by federal law. Indeed, if allowed to stand, the Estate's complaint could theoretically allow [the MAO] to be found negligent even if it fully complied with all federal laws and regulations. Under these circumstances, we can only conclude that the Estate's claims, which sound in state law that must be applied with respect to Medicare Part C, are preempted pursuant to Part C's express preemption provision.

Id. The Plaintiffs here should not be allowed to forum-shop their way to a different outcome by "creatively" cloaking their complaint over denial of Medicare Benefits as causes of action arising under state statutes or common law. *Uhm*, 620 F.3d at 1143; *Blue Cross & Blue Shield of Ala.*, 156 F.3d at 1104. These claims should be dismissed.

CONCLUSION

For the foregoing reasons, the Court should dismiss Plaintiffs' Complaint with prejudice.

Dated: March 20, 2024

Respectfully Submitted,

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CERTIFICATE OF SERVICE

I hereby certify that, on March 20, 2024, a copy of the foregoing was electronically filed with the Court of Clerk using the CM/ECF system, which will automatically send email notification of such filing to all counsel of record.

/s/ Michael P. Abate
Counsel for Defendant

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF KENTUCKY
LOUISVILLE DIVISION

ELECTRONICALLY FILED

JOANNE BARROWS and SUSAN HAGOOD, individually and on behalf of all others similarly situated, Plaintiffs, v. HUMANA, INC., Defendant.	Case No. 3:23-cv-00654-RGJ

DECLARATION OF KEVIN D. FEDER IN SUPPORT OF DEFENDANT'S MOTION TO DISMISS PLAINTIFFS' CLASS ACTION COMPLAINT

I, Kevin D. Feder, declare and state as follows:

1. I am an attorney licensed to practice in the State of California and the District of Columbia. I have been admitted *pro hac vice* in the above-captioned case.

2. I am a Partner at the law firm O'Melveny & Myers LLP, counsel for Defendant Humana Inc. ("Defendant" or "Humana"). I submit this declaration in support of Humana's Motion to Dismiss. I have personal knowledge of the following facts and, if called and sworn as a witness, I could and would testify to them.

3. Attached as Exhibit 1 is a true and correct redacted copy of the decision by James Satterwhite, Administrative Law Judge, dated March 17, 2023, which found that Humana properly terminated coverage of Plaintiff Susan Hagood's Skilled Nursing Facility ("SNF") services.

4. Attached as Exhibit 2 is a true and correct redacted copy of the December 11, 2021 determination letter issued by Livata, a CMS-contracted Quality Improvement Organization, which upheld Humana's decision to end coverage for Plaintiff Joanne Barrows' SNF services.

Respectfully submitted,

s/ Kevin D. Feder

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EXHIBIT
1

Department of Health and Human Services
OFFICE OF MEDICARE HEARINGS AND APPEALS
Atlanta, GA

Appeal of: S. HAGOOD	OMHA Appeal No.: 3-0000034493M
Enrollee: S. HAGOOD	Medicare Part: C
Medicare No.: *****[redacted]	Before: James Satterwhite Administrative Law Judge

DECISION

After considering the evidence of record and arguments presented during the hearing in this matter, I enter an **UNFAVORABLE** decision. Humana Gold Plus H6622-026 (HMO-POS) (the Plan) is not required to cover, under its skilled nursing facility (SNF) benefit, services provided to S. Hagood (Enrollee and Appellant) by The Oaks – Brevard (Provider) after the November 13, 2022 date of termination through her readmission to the hospital on November 28, 2022.

PROCEDURAL HISTORY

As of the termination date, the Appellant was a member of a Part C Medicare Advantage plan (MA Plan) or organization, Humana Gold Plus H6622-026 (HMO-POS), which was offered by Humana WI Health Organization Insurance Corporation. (Files 3 and 16).

On November 11, 2022, the Appellant was served with Notice of Medicare Non-Coverage (NOMNC) advising that her SNF coverage would end as of November 13, 2022 and that she would be responsible for coverage beginning November 14, 2022.[1] (File 6, pp. 2-3). A Detailed Explanation of Non-coverage followed, noting the Appellant was at a level where she could transition from daily skilled services to those provided intermittently. (File 18, pp. 2-3).

On appeal, Kepro, the applicable Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) issued a November 12, 2022 decision agreeing that the Appellant was properly discharged to long-term care. (File 17, pp. 2-3). On November 27, 2022, the BFCC-QIO issued a reconsideration decision upholding the decision to deny coverage and found the Appellant responsible for payment of services beginning on November 14, 2022. (File 11, pp. 2-3).

On January 26, 2023, the Office of Medicare Hearings and Appeals (OMHA) received the Appellant's timely Request for an Administrative Law Judge (ALJ) hearing, which was filed by the Appellant's Patient Advocate, Karen Sanders. (File 1). The amount in controversy meets the jurisdictional requirements for ALJ review. 42 C.F.R. §405.1006(b).

[1] The period at issue is limited to November 14, 2022 through the Enrollee's readmission to the hospital on November 28, 2022. (File 1, pp. 3-4).

Along with the hearing request, the Appellant and her representative submitted a brief statement indicating that the Appellant had been admitted to Mission Hospital from September 10, 2022 to October 26, 2022 [redacted PHI]. She was then admitted to The Oaks Brevard, [redacted PHI]. (File 1, p. 3). Ms. Sanders argued that the Appellant "has documented skilled services documented daily throughout her stay at the Oaks…". (*Id.* at 4).

A telephonic hearing was held on March 9, 2023 at the Office of Medicare Hearings and Appeals (OMHA) in Atlanta, Georgia. The Appellant was represented by Karen Sanders, MSN, RN, her Patient Advocate and Appointed Representative. Also present for the hearing were the Appellant's husband, Dan Hagood, her son, Chris Hagood, and her daughter, Lisa Hagood Moynihan. *Hearing Recording* (March 9, 2023), All witnesses were sworn in prior to offering testimony. (*Id.*). Both the BFCC-QIO and the MA Plan were notified of the hearing; however, no response was received from the MA Plan, and the BFCC-QIO waived participation. (File 20). No other parties or participants were present or testified during the hearing. *Hearing Recording* (March 9, 2023). During the hearing, I admitted all exhibited evidence, as reflected in the Exhibit Record portion of the Exhibit List, into the administrative record without objection. (*Id.*). Non-Exhibit Record items were excluded from the administrative record, also without objection. (*Id.*). The hearing recording has been added to the administrative record. The administrative record is now closed.

ISSUES

There are two key issues on appeal. 1) Whether coverage for skilled nursing facility (SNF) services was properly terminated as of November 13, 2022? 2) If not, should the MA Plan have been required to cover services, under its SNF benefit, for the Appellant from November 14, 2022 through the date she was readmitted to the hospital, November 28, 2022. Specifically, whether the Appellant continued to both require and receive skilled services on a daily basis after the date of termination.

APPLICABLE LAW AND POLICY

I. Principles of Law

A. Statutes and Regulations

Under Medicare Part C, coverage is provided through a Medicare Advantage Plan. A Plan provides coverage of, by furnishing, arranging for, or making payment for, all services that are covered by Part A and Part B of Medicare (if the enrollee is entitled to benefits under both parts) or by Medicare Part B (if entitled only under Part B) and that are available to beneficiaries residing in the plan's service area. *See* 42 C.F.R. § 422.101(a). The Plan's Evidence of Coverage states, "As a Medicare health plan, Humana Gold Plus H6622-026 (HMO-POS) must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules." (File 3, p. 43).

According to § 1862(a)(1)(A) of the Social Security Act ("Act"), Medicare may not make a payment under part A or part B for anything which is not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. Furthermore, the provider is responsible for providing sufficient documentation to support that payment is due and the services were medically necessary and provided as billed. Act §§ 1833(e) and 1815(a).

Sections 1812 and 1813 of the Act establish the scope of benefits of the hospital insurance program under Medicare Part A. Section 1814 establishes conditions for and limitations on payment for services furnished by providers. Section 1814(a)(2)(B) of the Act provides that the post-hospital extended care services are such services that are or were required to be given because the individual needs or needed on a daily basis skilled nursing services (provided directly by or requiring the supervision of skilled rehabilitation personnel), which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis, for any of the conditions with respect to which he was receiving inpatient hospital services prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services.

In general, the implementing regulations for coverage include 42 C.F.R. § 409.30 (basic pre-admission and admission requirements); 42 C.F.R. § 409.31 (the level of care requirement); 42 C.F.R. § 409.32 (the criteria for skilled services and the need for skilled services); 42 C.F.R. § 409.33 (examples of skilled nursing and skilled rehabilitation services), and 42 C.F.R. § 424.20 (certification and plan of treatment requirements for post hospital SNF care).

Under 42 C.F.R. § 424.20, Medicare Part A pays for post hospital SNF care, only if the physician certifies the Beneficiary/Enrollee needs SNF care related to the medical condition for which they received inpatient care. The regulations require that the Beneficiary must have been hospitalized for at least three consecutive days, and must have been admitted to the SNF within 30 days of hospital discharge. 42 C.F.R. § 409.30(a) and (b).

Under 42 C.F.R. § 409.31(b), the following conditions must be met for SNF level of care requirements:

> (1) The beneficiary must require skilled nursing or skilled rehabilitation services, or both, on a daily basis.
>
> (2) Those services must be furnished for a condition —
>
> > (i) For which the beneficiary received inpatient hospital or inpatient CAH services; or
> >
> > (ii) Which arose while the beneficiary was receiving care in a SNF or swing-bed hospital for a condition for which he or she received inpatient hospital or inpatient CAH services; or
> >
> > (iii) For which, for an M+C Beneficiary described in § 409.20(c)(4), a physician has determined that a direct admission to a SNF without an inpatient hospital or inpatient CAH stay would be medically appropriate.
>
> (3) The daily skilled services must be ones that, as a practical matter, can only be provided in a SNF, on an inpatient basis.

To meet the daily basis requirement specified in 42 C.F.R. § 409.31(b)(1), the skilled rehabilitation services must be needed and provided seven days a week, or if skilled rehabilitation services are not available seven days a week those services must be needed and provided at least five days a week. 42 C.F.R. §§ 409.34(a)(1) and (2).

Under 42 C.F.R. § 409.32, the criteria required for skilled services and the need for skilled services:

> (a) To be considered a skilled service, the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel.
>
> (b) A condition that does not ordinarily require skilled services may require them because of special medical complications. Under those circumstances, a service that is usually nonskilled (such as those listed in § 409.33(d)) may be considered skilled because it must be performed or supervised by skilled nursing or rehabilitation personnel. For example, a plaster cast on a leg does not usually require skilled care. However, if the patient has a preexisting acute skin condition or needs traction, skilled personnel may be needed to adjust traction or watch for complications. In situations of this type, the complications, and the skilled services they require, must be documented by physicians' orders and nursing or therapy notes.
>
> (c) The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities. For example, a terminal cancer patient may need some of the skilled services described in § 409.33.

The following services, enumerated in 42 C.F.R. § 409.33(a), could qualify as either skilled nursing or skilled rehabilitation services:

> (1) *Overall management and evaluation of care plan*. (i) When overall management and evaluation of care plan constitute skilled services. The development, management, and evaluation of a patient care plan based on the physician's orders constitute skilled services when, because of the patient's physical or mental condition, those activities require the involvement of technical or professional personnel in order to meet the patient's needs, promote recovery, and ensure medical safety. Those activities include the management of a plan involving a variety of personal care services only when, in light of the patient's condition, the aggregate of those services requires the involvement of technical or professional personnel.
>
> (2) *Observation and assessment of the patient's changing condition* — (i) When observation and assessment constitute skilled services. Observation and assessment constitute skilled services when the skills of a technical or professional person are required to identify and evaluate the patient's need for modification of treatment or for additional medical procedures until his or her condition is stabilized.
>
> (3) *Patient education services* — (i) When patient education services constitute skilled services. Patient education services are skilled services if the use of technical or professional personnel is necessary to teach a patient self-maintenance.

Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities. 42 C.F.R. § 409.33(c).

42 C.F.R. § 409.35, sets forth the criteria required in making a "practical matter" determination, as required by 42 C.F.R. § 409.31(B)(3). The regulation states:

> (a) *General considerations.* In making a "practical matter" determination, as required by § 409.31(b)(3), consideration must be given to the patient's condition and to the availability and feasibility of using more economical alternative facilities and services. However, in making that determination, the availability of Medicare payment for those services may not be a factor. Example: The beneficiary can obtain daily physical therapy from a physical therapist in independent practice. However, Medicare pays only the appropriate portion (after deduction of applicable deductible and coinsurance amounts) of the first $500 of services furnished by such a practitioner in a year. This limitation on payment may not be a basis for finding that the needed care can only be provided in a SNF.
>
> (b) *Examples of circumstances that meet practical matter criteria* —
>
> (1) *Beneficiary's condition.* Inpatient care would be required "as a practical matter" if transporting the beneficiary to and from the nearest facility that furnishes the required daily skilled services would be an excessive physical hardship.
>
> (2) *Economy and efficiency.* Even if the beneficiary's condition does not preclude transportation, inpatient care might be more efficient and less costly if, for instance, the only alternative is daily transportation by ambulance.

When items or services are not covered because they are found to be not medically reasonable or necessary, a party's lack of knowledge of non-coverage may limit their liability. (§ 1879; 42 C.F.R. §§ 411.400 to 411.408; Medicare Claims Processing Manual ("MCPM"), Centers for Medicare and Medicaid Services ("CMS") Pub. 100-04, ch. 30; CMS Ruling 95-1).

The Plan has the burden of proving that the termination of services was the correct decision. 42 C.F.R. § 422.626(c). If the ALJ finds that termination of services was correct, the burden then shifts to the enrollee to prove that it needed and received a covered level of care for the post-termination dates of service. 5 U.S.C. 556(d)

B. Policy and Guidance

Section 1871(a)(2) of the Act states that unless promulgated as a regulation by Centers for Medicare and Medicaid Services ("CMS"), no rule, requirement, or statement of policy, other than an NCD, can establish or change a substantive legal standard governing the scope of benefits or payment for services under the Medicare program. See also 42 C.F.R. § 405.860. However, in lieu of binding regulations with the full force and effect of law, CMS and its contractors have issued policy guidance that establishes criteria for coverage of selected types of medical items and services in the form of manuals and local coverage determinations ("LCDs"). Administrative Law Judges are not bound by LCDs, but will give substantial deference to these policies when applicable. 42 C.F.R. § 405.1062. If an Administrative Law Judge does not follow a policy in a particular case, the Administrative Law Judge must explain why in the decision. 42 C.F.R. § 405.1062.

CMS issued the ***Medicare Benefit Policy Manual (MBPM)***, ch. 8, § 30 (2014), lists four factors, all of which must be met to establish coverage for care in a skilled nursing facility:

- The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel (see §§ 30.2 - 30.4); are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services;
- The patient requires these skilled services on a daily basis (see § 30.6); and
- As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF. (See § 30.7.)
- The services must be reasonable and necessary for the treatment of a patient's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

If any one of these four factors are not met, a stay in a SNF, even though it might include the delivery of some skilled services, is not covered. For example, payment for a SNF level of care could not be made if a patient needs an intermittent rather than daily skilled service.

MBPM, *supra*, ch. 8, § 30.4.1.2, states the following:

> Repetitious exercises to improve gait, or to maintain strength and endurance, and assistive walking are appropriately provided by supportive personnel, e.g., aides or nursing personnel, and do not require the skills of a physical therapist. Thus, such services are not inherently skilled. …

MBPM, *supra*, ch. 8, § 30.2.2 - Principles for Determining Whether a Service is Skilled, states:

> If the inherent complexity of a service prescribed for a patient is such that it can be performed safely and/or effectively only by or under the general supervision of skilled nursing or skilled rehabilitation personnel, the service is a skilled service; e.g., the administration of intravenous feedings and intramuscular injections; the insertion of suprapubic catheters; and ultrasound, shortwave, and microwave therapy treatments.

MBPM, *supra*, ch. 8, § 30.6 - Daily Skilled Services Defined, states:

> Skilled nursing services or skilled rehabilitation services (or a combination of these services) must be needed and provided on a "daily basis," i.e., on essentially a 7-days-a-week basis. A patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the "daily basis" requirement when they need and receive those services on at least 5 days a week. (If therapy services are provided less than 5 days a week, the "daily" requirement would not be met.)

This requirement should not be applied so strictly that it would not be met merely because there is an isolated break of a day or two during which no skilled rehabilitation services are furnished and discharge from the facility would not be practical.

FINDINGS OF FACT AND ANALYSIS

The [redacted]-year-old female Appellant was initially admitted to the Provider's SNF on [redacted], following a qualifying and lengthy hospital stay at Mission Hospital from [redacted]. (File 8, p. 2). Diagnoses at the time of SNF admission included [redacted]. (*Id.* at 2). [redacted] (*Id.* at 3).

According to the Orders, the Appellant [redacted] (*Id.* at 4). [redacted] (*Id.* at 5). [redacted] (*Id.*). It was noted that the Appellant [redacted]. (*Id.* at 5). In addition, the Appellant [redacted]. (*Id.* at 4). [redacted] (*Id.*).

During the Appellant's initial period of care, [redacted]. Notes run through November 11, 2022. (File 12, pp. 27-37; File 8, pp. 9-11).

[redacted] (*Id.* at 11). On November 4, 2022, it was noted that the Appellant's Plan coverage had been extended through November 10, 2022. The Provider noted [redacted] (*Id.* at 11). Notes indicate [redacted]. (*Id.*). Notes show [redacted] (*Id.* at 11).

Additionally, the Appellant was noted [redacted] (*Id.*). [redacted] (*Id.*).

[redacted], and it was noted the Appellant [redacted]

PHI (*Id.* at 10). PHI (*Id.* at 10). PHI

PHI (File 9, pp. 2-5). PHI (*Id.* at 2). In addition, the Appellant was indicated PHI. (*Id.* at 2). She was noted PHI. (*Id.*). PHI (*Id.*). PHI (*Id.*).

PHI (*Id.* at 4). PHI (*Id.* at 5).

The Appellant was indicated PHI *Id.* at 9). PHI (*Id.*).

In addition to the nursing notes running through November 11, 2022, PHI. (File 9, pp. 6-20). Notes specifically show PHI. (*Id.*). PHI (File 9, pp. 21-44). Notes show PHI (*Id.* at 7).

PHI (File 9, p. 22). PHI (*Id.* at 22). PHI (*Id.*).

On November 11, 2022, the Appellant was delivered a Notice of Medicare Non-Coverage (NONMC) indicating an intention to cease coverage of SNF services as of November 13, 2022. (File 8, p. 9; File 6; File 18). The Appellant's husband signed the NOMNC, indicating PHI. (File 6, p. 3). The corresponding Detailed Explanation of Non-coverage indicated that SNF services should end and that a transition to the

intermittent provision of services was warranted. (File 18, p. 2). The Plan found that, when admitted to the SNF, the Appellant required help to move around. As of the review, she was indicated to move around and perform most self-care skills with total help. The Plan cited to the Medicare guidelines, holding that in order to continue, a patient must have a need for daily skilled nursing or daily skilled rehabilitation. *Medicare Benefit Policy Manual (MBPM)*, chapter 8, Sections 30; 30.2.2; 30.3; 30.4.1.1; 30.6; 30.7.

The Appellant remained in the SNF facility following the NOMNC. She remained there until November 28, 2022, at which time she was readmitted to acute care.

Analysis:

The Appellant is now seeking the continuation of coverage for skilled nursing facility (SNF) services, which were denied as of November 13, 2022, with the Appellant determined to be responsible from November 14, 2022 forward. Ultimately, the Appellant was readmitted to the hospital on November 28, 2022.

Care in a SNF is covered if all of the following four factors are met: (1) the patient requires skilled nursing services or skilled rehabilitation services that must be performed by or under the supervision of professional or technical personnel; (2) the patient requires these skilled services on a daily basis (*see* § 30.6); (3) as a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF (*see* § 30.7); and (4) the services must be reasonable and necessary for the treatment of a patient's illness or injury. *CMS, Medicare Benefit Policy Manual, MBPM, supra*, ch. 8, § 30.

Additionally, the skilled therapy and nursing services must be of a level of complexity and sophistication, or the condition of the patient must be of a nature that requires the judgment, knowledge, and skills of a qualified professional. 42 C.F.R. § 409.32; *MBPM, supra*, ch. 8, § 30.2.2.

According to Chapter 8 of the *Medicare Benefit Policy Manual*, an individual must have a need for daily skilled nursing or daily skilled rehabilitation in order to be eligible to receive coverage for skilled nursing facility services.

Here, upon initial appeal and upon reconsideration, the BFCC-QIO agreed that covered services should be suspended. (Files 17 and 11). Upon reconsideration, the BFCC-QIO stated:

> Based upon a complete review of the medical record, [redacted PHI]. It is possible that further improvements will take place over time; however, continued daily skilled nursing and therapy services in a skilled nursing facility are no longer reasonable and necessary. Additionally, continued stay in a skilled nursing facility is not required to maintain your current condition or to prevent or slow a further decline. (File 11, p. 2).

The BFCC-QIO further determined the Appellant to "have had adequate exposure to skilled therapy in this context to (*sic*) care. You [redacted PHI]. Your discharge plans are documented and appropriate including long-term care support." (*Id.*).

The Appellant's appointed representative, and patient advocate, Karen C. Sanders, provided arguments on the Appellant's behalf. *Hearing Recording* (March 9, 2023). Ms. Sanders provided a thorough and detailed assessment of the Appellant's initial hospitalization, transfer to the SNF, decline, and subsequent transfer back to acute care. (*Id.*). She provided additional evidence which she reviewed for the hearing record. (File 1 and File 24). In doing so, she noted that the Appellant continues to disagree with the position that she should be responsible for services from November 14, 2022 through November 28, 2022. *Hearing Recording* (March 9, 2023).

Ms. Sanders read portions of the BFCC-QIO reconsideration letter of November 27, 2022 and argued the Appellant's disagreement with the BFCC-QIO's determination. (*Id.*). Toward this, she addressed [redacted PHI]. *Hearing Recording* (March 9, 2023). She was then admitted to the SNF for rehabilitation services, requiring assistance with ambulation and self-care. Ms. Sanders pointed to the fact that, eighteen days after SNF admission, the Appellant was notified of her impending discharge. (*Id.*).

In addressing the issues at bar, Ms. Sanders cited to the *Medicare Benefit Policy Manual*, chapter 8, noting that the Plan denied services due to a lack of medical necessity. *Hearing Recording* (March 9, 2023). However, Ms. Sanders argued that the *MBPM* requirements were met, noting the Appellant received skilled services that were documented daily throughout her stay in the SNF. (*Id.*). She testified that the Appellant [redacted PHI] prior to her return to Mission Hospital on November 28, 2022. (*Id.*).

Pointing further to *MBPM*, chapter 8, Ms. Sanders cited to (provided) sections 10, 20, 30, 40, and 50, et. al. (File 1, pp. 47-102). She addressed the critical four factors required for SNF coverage, as set forth, above. *MBPM, supra*, ch. 8, § 30. Noting Section 30.2.2, Ms., Sanders highlighted that, "While a patient's particular medical condition is a valid factor in deciding if skilled services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is not skilled." She argued that the Plan was making a prognosis for the Appellant's need, or lack thereof, which they argue was inappropriate. *Hearing Recording* (March 9, 2023).

According to the testimony, [redacted PHI] (*Id.*). [redacted PHI] (*Id.*). Finally, over the last few days of her SNF stay, she was indicated [redacted PHI]. (*Id.*).

Detailing further the Appellant's admission to SNF care, Ms. Sanders noted the provision of a statement from [redacted PHI], indicating the Appellant [redacted PHI]. (*Id.*). [redacted PHI]

(*Id.*). Further provided, as summarized by Ms. Sanders, were the Provider's nursing notes PHI [redacted]. During this time, the SNF nurses also documented PHI [redacted]. (*Id.*). The nurses also noted PHI [redacted]. (See, File 24, pp. 14-18).

PHI [redacted] (File 24, pp. 21-22). PHI [redacted] (*Id.* at 22).

Ms. Sanders noted PHI [redacted] *Hearing Recording* (March 28, 2022). PHI [redacted] (*Id.*). PHI [redacted] (*Id.*). Ms. Sanders noted PHI [redacted]. (*Id.*). PHI [redacted] (*Id.*). PHI [redacted] (*Id.*). PHI [redacted] (*Id.*). PHI [redacted]

In addition to the Appellant's medical course, Ms. Sanders argued for a reduction in the total sum owed for this period. She argued that the bill for services should be reduced based upon the Appellant's deductible responsibility. (File 1, pp. 4-5, 31-33). Ms. Sanders noted an invoice amount of $6,993.60. (File 1, p. 31). She testified that this invoice should have included a deduction of $2,820.00 for the Appellant's copayment related to the fifteen-day period. At $188.00 (co-pay) per day, this is $2,820.00 in patient responsibility. (*Id.* at 31-33). She referred to File 1, Attachment C, the Patient Financial Responsibility Statement, and the notation that under the Appellant's benefits, days 1-20 are covered at 100%, and starting on day 21, the copay of $188.00 per day is owed. The agreement further indicates a $0 per day copay beginning on day 45. (*Id.* at 32). She therefore concluded that the bill should be adjusted to show $6,993.00 - $2,820.00 ($188.00 x 15 days) = $4,173.00. She held that the Appellant should be responsible for $2,820.00 covering the period November 14 through 28, 2022, and she sought a determination that the remainder of the bill was not the responsibility of the Appellant. (*Id.*).

The Appellant's family members then testified. *Hearing Recording* (March 9, 2022). The Appellant's daughter, Ms. Moynihan, recapped the Appellant's treatment, noting that, prior to the Appellant's initial admission to Mission Hospital PHI [redacted], her mother had largely been healthy. (*Id.*). She testified as to the Appellant's discharge from Mission Hospital to the Provider's facility PHI [redacted] despite the family's concern that she was not yet well-enough to leave acute in-patient care. (*Id.*). She indicted that the hospital physicians recommended PHI [redacted], but that this was denied by the Plan. They instead PHI [redacted]

[redacted] PHI [redacted]. (*Id.*). As noted previously, she remained in the Provider's care until late November. According to her daughter, on [redacted] PHI [redacted], the Appellant [redacted] PHI [redacted]. (*Id.*). [redacted] PHI [redacted] At that time, [redacted] PHI [redacted] Since this time, according to her daughter, the Appellant [redacted] PHI [redacted] *Hearing Recording* (March 9, 2023).

Ms. Moynihan testified that she was advised by others that the Plan would not approve any hospital stay of the duration needed and would not approve long-term acute care, no matter what the condition of the patient upon discharge. She testified as to statements made by various healthcare workers indicating the Plan provides for "consistent and constant denial." (*Id.*). She is of the belief that this is done as seniors are unaware how to properly file an appeal. (*Id.*).

The Appellant's son, Chris Hagood, also testified, reiterating his sister's feelings as to their mother's initial discharge from the hospital and subsequent decline. *Hearing Recording* (March 9, 2023). He too was concerned about the level of care she was receiving. He testified that PHI [redacted] (*Id.*). He found it ironic that the Appellant's decline coincided with the Plan's determination that she no longer required SNF care. (*Id.*).

Finally, the Appellant's husband, Dan Hagood, offered testimony. *Hearing Recording* (March 9, 2022). He noted his wife's suffering over the course of the past months and indicated he simply wants the Plan to cover the benefits outlined. (*Id.*). He noted the availability of SNF care for up to 100 days, and he summarized his understanding of the required copayment. (*Id.*). He testified that he is certain that the Appellant's condition was worsened by her transfer to the SNF. (*Id.*). The family has now switched the Appellant over to original or traditional Medicare, feeling the Plan would never offer the right level of care. (*Id.*). She can no longer get supplemental coverage as she has been hospitalized extensively. (*Id.*).

While very sympathetic to the position of the Appellant and her family, upon *de novo* review of the entire record, I am compelled by Medicare regulations and policy to find that the Plan properly terminated the Appellant's SNF coverage. Although the Appellant remained in the facility following the termination, services provided during that period are not covered under the Plan's SNF benefit.

Again, I am very sympathetic to the Appellant's situation in this matter, and I fully understand and have considered strongly the concerns of her family and the arguments of her representative. However, the issue precluding coverage for the period at issue is that the evidence submitted does not actually document daily skilled care. These records do support that the Appellant's condition did deteriorate substantially during the latter part of the period at issue, leading to her eventual re-admission to the hospital on November 28, 2022. However, I cannot rely solely on her decline after the termination date to find that coverage should have continued. Rather, I must look to the Appellant's condition upon the date of termination, November 13, 2022, to determine whether her medical condition had stabilized, and she had reached a point in therapy where services were no longer needed on a daily basis. After thoroughly considering the record, I find the termination of skilled nursing facility coverage as of November 13, 2022 was appropriate and is supported by records available from that time.

Further, there are no therapy records provided after the date of termination (November 14, 2022 forward) to support that the daily skilled therapy continued to be required by, or provided to, the Appellant. There is no confirmation in the medical record of ongoing therapeutic treatment, and it is evident from the therapy notes that, as of the date of termination, she [redacted]. Therapists on more than one occasion noted [redacted], and a determination in this matter does not turn on progress, or the lack thereof, the record does not document she required or received daily skilled therapy during the period remaining at issue.

Additionally, while the Appellant did continue to receive nursing services, the notes fail to show that the provided basic observation and assessment services were skilled in nature. Notably, the Appellant is allowed to submit evidence documenting the care the Appellant received following the issuance of the NOMNC, and here, the Appellant's representative submitted a good deal of information about her condition and subsequent hospitalization. However, the additional records, including the nursing treatment logs, did not provide the necessary information to determine non-custodial, skilled care was provided on a daily basis. (File 1 and File 24; *Hearing Recording*, March 9, 2023). The supplied records show the Appellant continued to have issues with [redacted]. However, the nursing notes document [redacted]. The documented services were not skilled in nature and did not require the presence or oversight of a skilled nurse. Rather, the documented services could have, as the BFCC-QIO opined, been provided at a lower level of care, with providers trained in custodial, rather than skilled care.

As for medications, the record indicates that the Appellant was receiving only oral and/or topical medications. As of the period at issue, she did not require injections, and IV antibiotics had ceased prior to the date of termination. I recognize the position of the family in that the Appellant eventually required greater assistance, and [redacted], but during her SNF stay, following the November 13, 2022 termination, this was not the case.

I further acknowledge that the Appellant [redacted]. This, however, also does not support a finding that the Appellant required and received daily skilled nursing services. Rather, during the period the services documented in the record were generally custodial in nature. Notably, Medicare does not cover custodial care unless daily skilled nursing and/or skilled therapy is provided.

The treatment provided and documented did not require the skills of professional health personnel (registered nurses, licensed practical (vocational) nurses, etc.) on a daily basis. 42 C.F.R. § 409.32; *MBPM*, *supra*, ch. 8, §§ 30, 30.2.1, 30.2.2; 30.6. Medicare considers such care that which is of an "inherent complexity" "such that it can be performed safely and/or effectively only by or under the general supervision of skilled nursing or skilled rehabilitation personnel…". As examples of the same, the *MBPM* provides treatment such as "intravenous feedings and intramuscular injections; the insertion of suprapubic catheters; and ultrasound, shortwave, and microwave therapy treatments." *MBPM*, supra, ch. 8, § 30.2.2. While the Enrollee did have a catheter, it was indwelling, and she required only changes to the urine collection bag. The catheter itself did not require replacement daily.

Of note, the Appellant's family has expressed significant concerns about the care the Appellant received from the Provider, as well as the way the Enrollee has been treated by the Plan. They

also expressed concern about how other elderly individuals may be treated who are less able to advocate for themselves. These concerns can be reported through the Plan's grievance process or directly to the appropriate Beneficiary and Family Centered Care (BFCC)-Quality Improvement Organization.

While I certainly understand the frustrations of the family and sympathize with them given this complex situation involving their loved one, I am bound by Medicare regulations and cannot require the Plan to cover the services at issue where the documentation supplied for review fails to support that the Appellant received daily skilled nursing or therapy care during the period at issue. Further, I must find, based on the supplied medical records, that the Appellant had reached a level, as of the date of termination, where discharge to a lower level of care was appropriate. Therefore, I cannot require the Plan to provide SNF coverage for the period at issue.

CONCLUSIONS OF LAW

I find that the Plan properly terminated coverage of the Appellant's SNF services, and the record does not establish that she required and received daily skilled therapy or nursing after the date of termination. Therefore, the Plan is not required to cover SNF services provided to the Appellant during the period remaining at issue, from November 14, 2022 (date of termination November 13, 2022) through her readmission to the hospital on November 28, 2022. However, the Plan may be required to cover some of the services provided during that period under its Part B benefit, but that issue is not before me.

ORDER

The decision in this matter is **UNFAVORABLE**. The Medicare Advantage Plan is **DIRECTED** to process the claim in accordance with this decision.

SO ORDERED

James Satterwhite
Administrative Law Judge

DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) / DEPARTMENTAL APPEALS BOARD Form DAB-101 (12/19)

REQUEST FOR REVIEW OF ADMINISTRATIVE LAW JUDGE (ALJ) MEDICARE DECISION / DISMISSAL

1. APPELLANT (the party requesting review)	2. ALJ APPEAL NUMBER (on the decision or dismissal)
3. BENEFICIARY*	4. MEDICARE NUMBER (Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI))*

*If the request involves multiple claims or multiple beneficiaries, attach a list of beneficiaries, Medicare numbers, and any other information to identify all claims being appealed.

5. PROVIDER, PRACTITIONER, OR SUPPLIER	6. SPECIFIC ITEM(S) OR SERVICE(S)

7. Medicare claim type: ☐ Part A ☐ Part B ☐ Part C - Medicare Advantage
☐ Part D - Medicare Prescription Drug Plan ☐ Entitlement/enrollment for Part A or Part B

8. Does this request involve authorization for an item or service that has not yet been furnished?
☐ Yes If Yes, skip to Block 9.
☐ No If No, Specific Dates of Service:

9. If the request involves authorization for a prescription drug under Medicare Part D, would application of the standard appellate timeframe seriously jeopardize the beneficiary's life, health, or ability to regain maximum function (as documented by a physician) such that expedited review is appropriate? ☐ Yes ☐ No

I request that the Medicare Appeals Council review the ALJ's ☐ decision or ☐ dismissal order [check one] dated _____. I disagree with the ALJ's action because (specify the parts of the ALJ's decision or dismissal you disagree with and why you think the ALJ was wrong):

(Attach additional sheets if you need more space)

PLEASE ATTACH A COPY OF THE ALJ DECISION OR DISMISSAL ORDER YOU ARE APPEALING.

DATE			DATE		
APPELLANT'S NAME (the party requesting review)			REPRESENTATIVE'S NAME (include signed appointment of representative if not already submitted)		
ADDRESS			ADDRESS		
CITY, STATE, ZIP CODE			CITY, STATE, ZIP CODE		
TELEPHONE NUMBER	FAX NUMBER	E-MAIL	TELEPHONE NUMBER	FAX NUMBER	E-MAIL

(SEE FURTHER INSTRUCTIONS ON PAGE 2)

Form DAB-101 (12/19)

If you have additional evidence, submit it with this request for review. If you need more time, you must request an extension of time in writing now, explaining why you are unable to submit the evidence or legal argument now.

If you are a provider, supplier, or a beneficiary represented by a provider or supplier, and your case was reconsidered by a Qualified Independent Contractor (QIC), the Medicare Appeals Council will not consider new evidence related to issues the QIC has already considered unless you show that you have a good reason for submitting it for the first time to the Medicare Appeals Council.

IMPORTANT: Include the HICN or MBI and ALJ Appeal Number on any letter or other material you submit.

This request must be received within 60 calendar days after you receive the ALJ's decision or dismissal, unless we extend the time limit for good cause. We assume you received the decision or dismissal 5 calendar days after it was issued, unless you show you received it later. If this request will not be received within 65 calendar days from the date on the decision or dismissal order, please explain why on a separate sheet.

You must file your request for review in writing with the Medicare Appeals Council at:

Department of Health and Human Services
Departmental Appeals Board
Medicare Appeals Council, MS 6127
Cohen Building Room G-644
330 Independence Ave., S.W.
Washington, D.C. 20201

You may send the request for review by U.S. Mail, a common carrier such as FedEx, or by fax to (202) 565-0227. If you send a fax, please do not also mail a copy. ***You must send a copy of your appeal to the other parties and indicate that all parties, to include all beneficiaries, have been copied on the request for review. For claims involving multiple beneficiaries, you may submit a copy of the cover letters issued or a spreadsheet of the beneficiaries and addresses who received a copy of the request for review.***

If you have any questions about your request for review or wish to request expedited review of a claim involving authorization of your prescription drug under Medicare Part D, you may call the Medicare Appeals Council's staff in the Medicare Operations Division of the Departmental Appeals Board at (202) 565-0100. You may also visit our web site at www.hhs.gov/dab for additional information on how to file your request for review.

PRIVACY ACT STATEMENT

The collection of information on this form is authorized by the Social Security Act (section 205(a) of title II, section 702 of title VII, section 1155 of Title XI, and sections 1852(g)(5), 1869(b)(1), 1871, 1872, and 1876(c)(5)(B) of title XVIII, as appropriate). The information provided will be used to further document your claim. Information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your claim. Information you furnish on this form may be disclosed by the Department of Health and Human Services or the Social Security Administration to another person or governmental agency only with respect to programs under the Social Security Act and to comply with Federal laws requiring the disclosure of information or the exchange of information between the Department of Health and Human Services, the Social Security Administration, or other agencies.

Department of Health and Human Services
OFFICE OF MEDICARE HEARINGS AND APPEALS
Atlanta, GA

Appeal of: **S. HAGOOD**	OMHA Appeal No.: **3-0000034493M**
Enrollee: **S. HAGOOD**	Medicare Part: **C**
Medicare No.: [redacted]	Before: **James Satterwhite** Administrative Law Judge

Index of the Administrative Record and Exhibit List

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OMHA-156
Dated: 2023-03-09

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Non-Exhibit Record	Administrative File Reference		
	File Name	Page Range	
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EXHIBIT
2

Livanta

10820 Guilford Road
Ste 202
Annapolis Junction, MD. 20701
See Next Page

Fax Cover Sheet

Date: 12/13/2021

To: HUMANA INSURANCE COMPANY

From: Livanta **Phone:**See Next Page

Fax: See Next Page

RE: Control ID #: MN-956332-AP

Message:

Immediate Attention Required

Please include this Control ID #: MN-956332-AP with all correspondence.

CONFIDENTIALITY NOTICE: The document(s) accompanying this fax contains confidential information that is legally privileged. This information is intended only for the use of the intended recipient named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this faxed information except its direct delivery to the intended recipient named above is strictly prohibited. If you have received this Fax in error, please notify us immediately by telephone to arrange for return of the original documents to us.

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Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

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BFCC-QIO DETERMINATION LETTER

December 13, 2021

HUMANA INSURANCE COMPANY
550 W. Adams St
5th Floor
Chicago, IL 60661

Enclosed with this cover letter is a copy of the BFCC-QIO Determination Letter that was sent to the beneficiary.

Please include this Case Control ID#: **MN-956332-AP** with all correspondence.

Livanta LLC
10820 Guilford Road
Suite 202
Annapolis Junction, MD 20701

(877) 588-1123

CONFIDENTIALITY NOTICE: The document(s) accompanying this letter contains confidential information that is legally privileged. This information is intended only for the use of the intended recipient named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of the enclosed document(s) except its direct delivery to the intended recipient named above is strictly prohibited. If you have received this letter in error, please notify us immediately by telephone to arrange for return of the original documents to us.

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BFCC-QIO DETERMINATION LETTER

December 11, 2021

Leslie Kramer
3372 Creekview Terrace
Minnetonka, MN 55305

Case: MN-956332-AP
Patient Name: Joanne Barrows
Patient Date of Birth: [redacted]
Provider: Good Samaritan Society - Ambassador
Service Date: [redacted] **Medicare(HIC)#:** [redacted]
[redacted]

Dear Joanne Barrows:

Thank you for your patience while we completed a thorough review of your provider's decision to end services. We understand the appeal process can be stressful. We hope your experience with Livanta has been a positive one.

Livanta LLC is authorized by Medicare to review medical care and services to decide if medical services meet professionally recognized standards of health care, are medically necessary, and are delivered in the most appropriate setting. Livanta LLC is also mandated to conduct an expedited review when a beneficiary appeals a provider's decision to end Medicare covered services.

An independent, certified, licensed, practicing peer reviewer reviewed the provider's decision to end coverage for the medical services from Good Samaritan Society - Ambassador. Based on a review of the available medical documentation, and the information you provided. the peer reviewer found that you no longer meet the Medicare coverage requirements for skilled nursing facility services. The peer reviewer offered the following comments:

A review of medical records received shows that the patient has multiple medical conditions including [redacted]. *The patient has no skilled nursing needs that require this level of care. Skilled services are no longer needed daily to maintain function or prevent decline. There are no medical issues to support the need for daily skilled nursing care. The patient no longer meets criteria for a Skilled Nursing Facility and further management can be provided at a lower level of care.*

You or your representative were notified by telephone on December 11, 2021 at 3:16 PM Eastern time that the decision to end these services was upheld. These services will no longer be paid for by the Medicare program beginning on December 12, 2021.

You will be responsible for the cost of all services continued at Good Samaritan Society - Ambassador beginning on December 12, 2021, except for those that are covered (when applicable) by Medicare Part B. If medical services were stopped before December 12, 2021, you will be responsible only for applicable deductible or coinsurance amounts and convenience services and items not normally covered by Medicare.

Good Samaritan Society - Ambassador and Medicare have been informed of this decision. We encourage you or your representative to discuss arrangements for further health care with your physician or case manager. Please be aware that this decision should not affect your Medicare coverage for medically necessary and appropriate services that you may require in the future.

If you disagree with our decision, you may request that Livanta LLC reconsider its decision to uphold Good Samaritan Society - Ambassador's end of Medicare covered services. Your request must be made by telephone or in writing no later than **sixty (60) calendar days** from the date of this notice to:

Livanta LLC
Attention: Expedited Determinations
6830 W. Oquendo Rd Suite 202
Las Vegas, NV 89118
888-524-9900

If you or your representative have any questions regarding this action please call Livanta LLC at 888-524-9900.

Sincerely,

Steven H. Stein MD FACEP

Steven H. Stein, MD FACEP
Medical Director

The Livanta Medical Director signs all letters to maintain physician reviewer anonymity.

cc: Good Samaritan Society - Ambassador
HUMANA INSURANCE COMPANY

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF KENTUCKY
LOUISVILLE DIVISION

ELECTRONICALLY FILED

JOANNE BARROWS and SUSAN HAGOOD, individually and on behalf of all others similarly situated, Plaintiffs, v. HUMANA INC., Defendant.	Case No. 3:23-cv-00654-RGJ

ORDER DISMISSING

Having considered the Motion to Dismiss filed by Defendant Humana Inc., and all responses thereto, and being otherwise sufficiently advised, the Court hereby ORDERS that Humana's motion is GRANTED. Plaintiff's Complaint is DISMISSED WITH PREJUDICE.

SO ORDERED this _____ day of _____ 2024.

_____
United States District Judge