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Supreme Court of Texas.
Christus Health Gulf Coast, Christus Health Southeast Texas, Gulf Coast Division, Inc., Memorial Hermann Hospital System and Baptist Hospitals of
Southeast Texas, Petitioners,
v.
Aetna, Inc. and Aetna Health, Inc., Respondents.
No. 05-0710.

December 6, 2006

Appearances:
Scott M. Clearman, McClanahan & Clearman, L.L.P., Houston, Texas, for petitioner.
Isaac J. Lidsky, United States Department of Justice, Washington, DC, for petitioner.
John B. Shely, Andrews Kurth LLP, Houston, Texas, for respondent.

Before:

Chief Justice Wallace B. Jefferson, Don R. Willett, Harriet O'Neill, David M. Medina, Paul W. Green, Nathan L. Hecht, Dale Wainwright, Phil Johnson, Scott A. Brister

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JUSTICE: 0710 Christus Health Gulf Coast versus AETNA, Inc..
COURT MARSHALL: May it please the Court. Mr. Clearman represent argument for the petitioner. Mr. Shely will present argument for the United States and its states Department of Health and Living Services. Petitioner has reserved four minutes for rebuttal. Mr. Clearman will open on the first eight minutes, will represent the matter ...

ORAL ARGUMENT OF SCOTT M. CLEARMAN ON BEHALF OF THE PETITIONER

MR. CLEARMAN: Chief Justice Jefferson and members of the Court. We are here to try to undo with decision below which found the brief do not have jurisdiction to sue a contract in statutory remedy. Statute given to us by the State of Texas. Our hospitals providing services and admitted into intra, an intermediate agreements with entities to provide Medicare. Those agreements are not subject to the Medicare Act and do not arise out of the Medicare Act, and the Court's conclusion that they do is aroused.
JUSTICE O'NEILL: Is there any possibility here that an "MkC", "M

might have to pose some of these claims?"

MR. CLEARMAN: Your Honor, the contracts by statute require us to waive the right of recovery from the plaintiff.

JUSTICE O'NEILL: But my understanding is that's unclear in this case, you know, help me with that.

MR. CLEARMAN: Well, It's not. It may be unclear because of the contract is not there but it's not unclear in the statute at 42 CFR 422504 G1. It provides that all contracts must have a waiver provision.

JUSTICE O'NEILL: So if, if there are no Medicare coverage by one of these hospital claims, there's no way about law that the hospital could then charged the legal way for that uncovered amount.

MR. CLEARMAN: If-- the answer to that is not for anything covered by the Medicare Act, is it have to go through this system? -

JUSTICE O'NEILL: But that act is -

MR. CLEARMAN: But if I did something totally different that was unrelated to Medicare then it would be a contract issue between that person in the hospital.

JUSTICE O'NEILL: - so coverage is an issue-- could be an issue for an enrollee.

MR. CLEARMAN: Not for anything that is covered by the Medicare Act. Let-

JUSTICE O'NEILL: But that -

MR. CLEARMAN: - let me -

JUSTICE O'NEILL: - certainly.

JUSTICE: But that, but that would have been covered if they stated business.

MR. CLEARMAN: Pardon?

JUSTICE: I mean that would have been covered if they -

MR. CLEARMAN: No. No. No. Anything that-- I mean, the way that's works is that the clean claims as we have alleged if I could just go back a little. We are obligated to prepare clean claims to present to the carriers, in this case it went to NAMM. Those are detailed explanations of what services have been provided that NAMM are meant to used for coverage to decide whether or not to pay it. It has only forty-five days to make that decision, because NAMM didn't have any money and went out of business, nobody ever looked at those points. Now, the statute says that we cannot hold an enrollee life and without at enrollee liability, there is no way for an administrative appeal to occur. And that is the essential answer here. Is it you%re looking at the scope of Medicare. There is no enrollee ability to engage in an appeal and I will point the Court specifically to Ren Care which explains us in Part B. That if the enrollees are not liable, then the enrollee has no appeal rights. That's expressly stated at 42 CFR 422-562(C). And in part B of that same provision, it says that the only person who can appeal is the enrollee. The MedicarekChoice part of the act. Now, furthermore -

JUSTICE: How, how do we know that-- what services were provided and whether they're covered by Medicare from this record?

MR. CLEARMAN: Well, the question is whether they're covered by our contract with NAMM; I would respectfully say -

JUSTICE: Okay.

MR. CLEARMAN: - if that's the issue

JUSTICE: And what is, and what is that contract show?

MR. CLEARMAN: - that contract has -

JUSTICE: Is that in the record?

MR. CLEARMAN: We don't know what in the-- to be honest the 6,000 claims, they are in taxes bay and nobody has ever said any of this is

not covered or covered ...

JUSTICE: Which somebody could do that something.

MR. CLEARMAN: Well, the time to do that occurred way back when they were submitted to NAMM under the prompt pay statute. They should go through these claims many-- they were submitted electronically and if it doesn't hit the bells and whistles to be cover, it should be paid or it can audit it, they have the choice to say, "we can audit it." they didn't do that.

JUSTICE: But If Aetna could argue I supposed that, that time does not expired and they can still looked at the claims and say, "Okay if we're responsible to pay if we're-- if we state the name choose then we don't pay this one, we don't pay this, we pay this one."

MR. CLEARMAN: But that's an issue of the breach of the contract that only NAMM in the hospitals and that is for the state Court to decide. But it's not in issue of the Medicare Act and I'll show you just if I have made that in Ren Care, the two key decisions that there is no arising under Court claim and the reason is no horizon in the Medicare Act which is the whole talking instead arising under the Medicare Act. We don't have a remedy in state Court or federal Court for that matter because we have got through the administration process. That under that section cited by Ren Care is section 4058 NG and what is important about those is at that at the end of the Medicare reviewed process only can-- you could only sue the government for claim, Okay? In federal district Court. So the point is, there is government interest in this case and you can't just go sue the government for something it does not hear about. So there is no avenue for review which is what we care basically holds. There is no enrollee who cares about this claim anymore because they have received the services that they are entitled to it. They have waived their right to-- or had the right at the hospital claim when they signed it for. They're gone to take the 6,000 people going to show up and care about this issue, it's not going to happen.

JUSTICE O'NEILL: Well, but again minor standing is that the hospital can not always go against them if the claims are determined not to be covered. Two years, well, we made it-- the time is pass to contest coverage.

MR. CLEARMAN: Yes.

JUSTICE O'NEILL: So all the claims are covered and there's no right to go against the enrollee.

MR. CLEARMAN: It is our belief when the federal statute and under the Texas prompt payor that the failure of NAMM to do anything -

JUSTICE O'NEILL: Okay.

MR. CLEARMAN: - to response to those claims -

JUSTICE O'NEILL: But if you're wrong on that, and there were the ability to get that and contest coverage, did you agree that the Court of appeals got this right?

MR. CLEARMAN: It's the-- I'm sorry. That the, what?

JUSTICE O'NEILL: That the Court of appeals got this right -.

MR. CLEARMAN: Not this Court of appeals. No -

JUSTICE O'NEILL: The NAMM passed to those -

MR. CLEARMAN: - that the circuit got around. But if I may explain why, let's assumed we go against an individual for something that's not covered, okay. It's not part of the Medicare Act anymore, okay. If we did something that he would not done it is not part of the Medicare Act by definition we're stepping out of the Medicare Shoes and introduce the hospital shoes. Enrollee even says, "I think that they should have been covered." Okay? Next step, enrollee files petition with Aetna

saying I think you should have covered this point then it goes to the administrator process because what we have now is an enrollee has interested in the claim. Something we don't have within the Medicare issue.

JUSTICE O'NEILL: But I anticipate their argue that you have enrollees potentially interested in the claim and as long as they are potentially interested in the claim you have the results of the administrative revenues.

MR. CLEARMAN: You know, there-- there is no administrative remedy to exhaust for this claims. Aetna has done a wonderful job that the Fifth Circuit conclude and rejected that realizing that these claims don't arise under the Medicare Act and there's just-- there's nowhere for us to get? But in RenCare the contract itself said there would be no rise against enrollees and by statute every contract have that same statement in it. Our contract either has not in it or by law would be forced to have it in there we can't do this just without that provision in the contract. I am now going to sit down with Mr. Lidsky, speak.

MR. LIDSKY: Mr. Chief Justice. May it please the Court. I am Isaac Lidsky with the United States Department of Justice here in behalf of Amicus, U.S. Department of Health and Living Services. If I may I'd like to begin briefly with a few key points which I hope I help to clarify the issues before the Court. the first point, the Department of Health and Human Services administered a scheme at issue here, exist for one purpose to guarantee the rights of individual enrollees with, with respect to specific treatments at specific coverage issues. It's decided every step of the way with that purpose in mind and it can properly function to that end. Second point I'd like to stress, this case did not originate as a dispute over coverage. This, this case originated when an insurer or insurer entity went bankruptcy. So we have no money to make any on all claims. Not because these 6,000-- these 6,000 claims are only to find by records to then it will cover specific treatment and there is no contention that in the-- these 6,000 claims all for one treatment are uncovered there. They could-- the way that we we wrote-- we-- this 6,000 claims came for Court because the entity went bankrupt and couldn't pay. That was the third point, which is the critical point which really is sure about the Court of the Human Services position there. We still do not have before us a bona fide coverage dispute. We have this theoretical contention that somewhere in these 6,000 treatments, somewhere in these 6,000 claims there maybe the claim for service that is not covered on the Medicare. That maybe true but certainly not a reason to follow these 6,000 claims through Medicare administrative procedure. And in fact, they couldn't do so even if we thought that made any sense 'cause this was not design to do that and it is just as obviously bound by the congressional structure. I'm advised only Medicare administrative scheme. If the Court has no questions I also want to stress.

JUSTICE: Well, let, let me-- Does it matter that we don't have the contracts and evidence is that any way in fact that considered here.

MR. LIDSKY: Yes, your Honor. I think it does, I think it matters in a larger sense that in many ways I think this is an unfortunate case of certain putting the cart before the horse. There are many issues to be resolved the fundamental issues underlying this dispute are, where are those contracts? What did they say? Is there under Texas State Law contractual liability? How does it flow from that, that in the NAMM? These were all the great questions that we need to have answer. Only when those questions are answered, does there arise some potential liabilities upon such some potential liability on Aetna's part. And

only in that point would we have turned to these 6,000 treatments and someone in the first instance would have to look at then and they cover this issue. That's an important point is that someone it's not a mystery who that someone is and someone is that. There's no doubt, that Aetna been insurer has in the first instance the obligation to take the claims presented to it. Assess and adjust and looked at the nature of its contract, looked at the Medicare coverage and beside which claims that's going to, in good faith, pay a profit of which claims it's going to that for which claims is going to contest the coverage. In fact, that's why I'd exist that's why Aetna has a contractual relationship with United States government. It's part of the services that Aetna provides to the United States government as a part C provided.

JUSTICE: In the hospital position this is too late to do that -

MR. LIDSKY: The hospital's position as I understand, your Honor, is yes it's too late at this point. But that's the State Law, but that's the state's government and I believe their argument to be not on probably released qualified persons speak to it but I was-- will do so anyway. I believe their argument is under federal -

JUSTICE: Answer.

MR. LIDSKY: - under Texas prompt payment provisions. They had their chance, NAMM they had into-- had their chance to deny coverage. They missed, they missed that opportunity Aetna merits their liability so we don't even need to get into that process.

JUSTICE: And your position in the brief is that even if-- even the prompt pay statutory requirement or regulatory requirement has to be informed by one of the contract provision.

MR. LIDSKY: We don't take the position, your Honor, on the interaction between the Texas prompt payment provisions and the administrative scheme-- I can't tell you this much. Should the day come-- should this case go back to the lower Courts which we, we very much-- at good will? Should this case go back to the lower Courts and let's say just for the sake of argument, the prompt Texas prompt payment argument has rejected the standard that the Court deems as I should have enough judicial to process of this claims? At that point it's clear, again the obligation would lie with Aetna the first instance. To look at these claims, I looked unto it-- why do they exist to be business as an insurer? Is the process of these claims at the very risk and think that those claims. We don't refute, we don't take the position that-- we put that in the, in the positive. There may come a day, where all this interesting merely factual question are resolved where the prompt Texas-- Texas statutory prompt payment issues are resolved and at some point we, we have to turned to this not the 6,000 claims. There may come that day and there, there maybe some subset of the 6,000 claims where they are actual bona fide coverage issues. At that point, it maybe appropriate to turn DSHS and to invoke the administrative scheme.

JUSTICE O'NEILL: What, what, what would be wrong with starting with that process? We take all of these contracts through the administrative process, quantify which are covered or not covered then, then it ebstite our remedies.

MR. LIDSKY: Your Honor that-- proceeding in that manner. Well, first and foremost, we could have invoked the administrative machinery to do that if you want to. But the reason why the administrative machinery should and not to do that because that would turn the review system on its head. In, in the average case in the substandard case, you have an enrollee that some treatment submits a bail to in case of insurer asked her -

JUSTICE O'NEILL: So there would be more adviser with that an enrollee there?

MR. LIDSKY: Well, yeah. It would be more adviser with that an enrollee there and it would be frankly, your Honor and it would allow Aetna the insurance to be sure of its responsibility of processing these claims. That's what the -

JUSTICE: It should-- let's be there at 1:45 in that noon.

MR. LIDSKY: Thank you, your Honor, that's what it insures what an insurance do. It's, you know, it's their business they barely risk in the engagement contractual relationships and they process the claims. And part of this Medicare Part C's insurance obligations with respect to their contractual relationships finance says is to process those claims. You can't come to the Department of Health and Living Services and then says, "Hey! Do us a favor, be our claims department because we have this they dispute and it's ..."

JUSTICE O'NEILL: It's not might the workers copies says that were -

MR. LIDSKY: - it's exactly it's not like the -

JUSTICE O'NEILL: - about the status of the bill. This is just to decide dispute not bill

MR. LIDSKY: That is exactly right and in particular is to decide specific issues and coverage with respect to specific enrollees at specific treatments. That sort of general contractual issues. I do just want to stress briefly one point, well two points for Aetna. The first is that, the Heckler versus Ringer analysis is that in many senses and unfortunes of RenCare and that's good in rejected to as dispute. Heckler versus Ringer is arising under task there's section 45H which governs suits against the United States, its agents or officers, agents, justice, secretary etc. Its provision was preempts in the action brought against the United States or its agents and that's the arising under task this augment that just to frustrate the efforts of people who have creatively plead around that provision. This dispute is not an action against the United States or its agents respond its country contention and frankly as with all due respect just an equivocally wrong. In the part A and B context, United States is the insured, there is the risk. If there is the risk, that provides insurance service it engages with two physical intermediaries agents which represent its interest, you know, to the actual contract into the actual running of these operations. But the risk of United States in the interest of the United States part C context is highly different.

JUSTICE: Your time has expired. Other any further questions? Thank you.

MR. LIDSKY: Thank you.

JUSTICE: The Court is now ready to hear argument from the respondents.

JUSTICE O'NEILL: May it please the Court. Mr. Shely will present arguments for the respondents.

ORAL ARGUMENT OF JOHN B. SHELY ON BEHALF OF THE RESPONDENT

MR. SHELY: May it please the Court. I'm John Shely for the Aetna, the respondents. The Court should affirmed this sue as for this case for alleged subject matter jurisdiction. Judge Hecht riding for the 14th Court of appeals from Janet Wilson of the Paris County. The

decision to say that the providers must exhaust their administrative remedies.

JUSTICE O'NEILL: Tell me what that exhaustion would look like?

MR. SHELY: Well, exactly whether it look like Judge and what's in this whole year is the Aetna with the trial Court. They started writing letters to us they try to exhaust, that's not in the record cause it happen in Aetna with the trial Court. Now let me tell you how it would normally work, Judge. The organization determination let's regard with that is that any determination made by MkC organization that's Aetna, with respect to any of the following the MkC organization refusal to provide or pay for services in whole or in part, including the type of level of services that the enrollee believed should be furnished or arranged by -

JUSTICE O'NEILL: It does not that contemplate an enrollee engaged in the administrative thought -

MR. SHELY: It set not-- it could not included the enrollee but this says we're including and we can just put your rush right now with notion that the regulations do not provide for the providers of Aetna organization determination never had. I'll cite to you 422566, excuse me, 4225665C which says, "Who can request an organization determination; the enrollee including his or her authorized representative and what is that cited by the Court of appeals, any provider that furnishes or intends to furnish services to the enrollee."

JUSTICE: But this time it seem like what you sense how that hospital is going to go to the federal agency that Penetrate Law Judge would say "this claim and this claim and this claim and this claim would all covered" and you're got to say "that's right well and then this claim and this claim and this claim."

MR. SHELY: That's left unbroken, let's remember what I have tried what the point-- what we have heard about what the contracts are in this case. Aetna has a contract with state law. It delegated that's the Medicare statute allows the risk to NAMM. NAMM contract is separated with the hospital now you have heard that supposing this contract has to keep the enrollees identified and say they pled that they did not have a contract that they had never agreements with NAMM and I have-- for you to go

JUSTICE: Prompt payment? Have you sought my question? My question is what is the agency going to decide, we wait to decide, we want you to decide of our claims covered or not.

MR. SHELY: Aetna is an agent and employed of the federal government for purposes of its role in this process. So the claims came into NAMM they say that there was no-- were some of the ...

JUSTICE: I'm going to ask you. I have versed the said question.

MR. SHELY: Yes, Judge.

JUSTICE: And the question is, what is the ALJ going to decide?

MR. SHELY: He has going to put you -

JUSTICE: What you got to say in his filings that could -

MR. SHELY: He is going to look at 6,000 claims to determine whether or not those were covered Medicare services.

JUSTICE: - but it does not make any sense because it looks like that presumption has to be the other way their covered till somebody says they are not covered -

MR. SHELY: No. No, Judges. They have been-- to show course if there is uncovered service if they got to submit their claim with an assignment presumably from Medicare enrollee status is myth.

JUSTICE O'NEILL: And they have see the government and then Aetna's

going to further there's not a covered claim.

MR. SHELY: It is the claims have been approved that the claims they are submitting for payment.

JUSTICE O'NEILL: I guess what I'm saying now is prove to him because Aetna is being adjusted.

MR. SHELY: It comes through that. Thereafter, they are entitled to ask for reconsideration which after the trial Court they did to Aetna. Then Aetna sensed it and does the work, to scheme those and they have done it for review by an independent organization that contract with Medicare. That's Maximo's Chester. That's when the claims are.

JUSTICE: Sure. When the HMO pays claims for there without having a federal Curiae info whether they are covered. You'd used to agreed to pay.

MR. SHELY: On the other-- the fact that there's 6,000 here, it was the choice the hospital to form below what she gathered. But normally every claim comes in and in an instance NAMM who have had the risk paid claims for what covered claims.

JUSTICE: And they did not send them to the federal agency to-- for the termination coverage so you -

MR. SHEDLY: But we don't know whether there were any that one of their not-- if they were covered, they were paid. At some point as they say NAMM didn't respond to any of the claims that in itself is an organization determination under the rules. And I cite to you 5, excuse me, 422568F let's listen to it, effect of failure family to provide notice if the MkC organization failed to provide the enrollee with timely notice of an organization determination as first five in the section. This failure itself constitute in adverse organization determination and made the appeal. So they did not hear from NAMM as they have said that NAMM next step goes to-- go an appeal. They would appeal to Aetna, Aetna would look at it if would have paid it,they would have. If it is covered would have been paid if they don't like the determination. They, by Aetna then, they go to the next level which an outfit called Maximo's Chester. Not affiliated with Aetna which is contract with the HCFA. That's where the claims are looked at.

JUSTICE: Do you agree with Mr. Clearman Mc-- Christus does expressly waive it right to seek payment for the enrollee?

MR. SHELY: Absolutely not, your Honor. And I cite to you in the record 182 -

JUSTICE: Does the statute required that the contracts have that provision?

MR. SHELY: If they have had HCFA approved contract with the hospitals then the regulation requires at intending close to FIDA. They did not, they plead that they are referring under letter agreements.

JUSTICE: And I'm interrupted to your-- you're going to give me -

MR. SHELY: I want to give in cite, Judge. This is the letter H181 in the record at page 182 this is one the hospital throw HCFA. So we want you to ordered and pay this. But now three-- they have preserved their rights to reserve any of all claims They can snap here 65 as non-contract providers. And they say later in the letter that they hate-- they have to go after the enrollees but they are cheating that issue of solved that record. Absolutely does not support, it does not support that the hospital to not go after the individual enrollees. And the reason what we need to determine is aren't the claims covered. Once you know what the claims are covered through the administrative of procedure which the stat-- which the regulations and statute lay out in -

JUSTICE: - but ordinarily someone have to deny coverage before -

MR. SHELY: That?
JUSTICE: - that goes to you.
MR. SHELY: That's what is happening, your Honor. By the effect of their claim fails to provide an organization determination.
JUSTICE: - it just what brought. They did not say this are covered they just ...
MR. SHELY: Well, actually that's not correct either in the record and there's one proof. You can see that some of their complaints are for under paid claims. Under paid claims so there have had been an organization determination. That's what the record before is. And so that there is a group of 6,000 claims which they claim our covered they have presented it to NAMM that's NAMM didn't pay. NAMM in their words failure to response an organization determination. They had the right to appeal, they have said "if I lost your coverage" later-- but they had the right -
JUSTICE: Your position is even if NAMM did not pay the claim for a reason that have nothing to do with coverage they just [inaudible]. Even if that's the case it still had to go through the agency group.
MR. SHELY: Yes, it does and the reason for that is because you can spend a lot of time in the details or regulations this is Medicare money. Medicare is going to determine what is covered. Why is that enrollee -
JUSTICE O'NEILL: But what if what did they even-- contract with Aetna in the first place?
MR. SHELY: Well, in 1997 congress decided that when they passed Medicarek C that it make sense to be able to contract with HMO's or Manage Care Organizations. Statute of Medicare beneficiaries would have a wider range of choice in the part A and B.
JUSTICE O'NEILL: On addition to that but I mean it was also said that the insurer would be the governmental on town was that Aetna adjust claims so determine coverage if she -
MR. SHELY: Well, they specifically ...
JUSTICE O'NEILL: - and that Aetna is just sort of contract to that further then.
MR. SHELY: Well, now that the regulations specifically allow Aetna to delegate the risk to these idea.
JUSTICE O'NEILL: But that does not the question of the government is the allegation to Aetna to adjust this claims. But it seems to me that Aetna is trying to put the adjustment on those-- on the government appeals.
MR. SHELY: Aetna is in the first-- was in the chain it's in the first layer of enrollee overview, that's what happened. There was an adverse determination they since submitted the claim no left in their pleading they say that they submitted the claims to Aetna and Aetna refused to pay. We know this is about unpaid claims, they say that their damages are precisely the amount of this unpaid claims.
JUSTICE: But the question is, why are they -
MR. SHELY: Why?
JUSTICE: It seems to me make a difference, why they were unpaid? They are not paid because they're covered, not covered well they guess coverage has to be decided but if they are not paid because somebody will reject that's just a different way.
MR. SHELY: Well, in any contract does you need to prove that there's my claimants felt he has pay me they have not done that -
JUSTICE: Well, most of -
MR. SHELY: - they are correct.
JUSTICE: - most contract cases you have the contract as well.

MR. SHELY: Again, they are burden to put amendment of reason that I did not submit this. They did not have the contract which they fraud you-- the indemned language is not there. They are pleading and establishes but had a variety of whole letter arrangement. Aetna paid every dime and ought to NAMM there's no when fault here for Aetna. They contracted HAR the hospitals with NAMM for three years as of their pleading says and they push and they push for higher rate. They are the ones who had the arrangement with NAMM and NAMM did have money left forgot run out of business. They're the parties who contracted this. Now Aetna, Aetna -

JUSTICE: And it may be true but I just don't see what it has to do with the federal agency coverage.

MR. SHELY: Aetna, your Honor, is the equivalent of the federal government in its will to the Medicare statute. I will cited to you the cases of the Marsaw case in our briefing, the Life Care case, the Folleycase. You practice long enough once in a while you have win a case. The Folley case this is actually recorded, I represented Aetna in the Folley case. NAMM was an intermediary, they admit below at 174 their record that of Life Care that the Life Care and Folley support the decision of the trial Court. So their only basis to try to get around that ruling and that admission here is to say that RenCare changed the world. And it did not, and the reason is that RenCare was what Judge refer to-- at most of pure payment dispute. There, the difference is there was a contract with the HMO, they have the contract with RenCare. They have contract we don't have that here, there was-- it was the coverage, was it me too? There was not dispute enormous how much, that's why RenCare is different. Now procedurally it's much different, because of was a complete preemption case. In this case, we were moved to federal Court. And the Court said "No it isn't, we're not going to find an exemption like we do for ERISA and the labor management relations act." Once we've decided that, that was the jurisdictional issue its comments, if you will are in the words of the Fifth Circuit, "Void them it could be ignore once there's no jurisdiction." But even getting beyond that the hospitals have no contract with that NAMM. Coverage is in dispute, we know that because the prompt phase statute that they claim to be suing under as Judge Yeiz has pointed out says that, "We're not liable under that four coverage services." We got a determined coverage, first even for them to proceed. Why does that make sense?

JUSTICE: Achievement. Let me just be sure, you said coverage is disputed but is it actually disputed about any particular claim?

MR. SHELY: Yes, Judge. Then the record will show where they claim that there were under payments of claims.

JUSTICE: What was the under payment because they run out of money or because they ...

MR. SHELY: It's not in the record as to why they have argued that NAMM just run out of money. That's not have been showing it all, It's not have been shown at all. For all we know NAMM have them all line that would degrade the issue in the process system. Did not get the checks so they run out but the day where the party with -

JUSTICE: Does it matter under your construction of the rules so where the-- where no, where no ruling is a default be a denial?

MR. SHELY: It does not mere, your Honor. No ruling means it's a denial issue.

JUSTICE: They don't get the money. It's a denial, as to rules.

MR. SHELY: Absolutely. May-- and under their theory at 45 days plus 14 on regular read they have the obligation to exhaust, start the

exhaustion process their administrative remedies.

JUSTICE: This matter say had a contract or not yet it's a default provision on the rule it should deny.

MR. SHELY: Not as an organization determination -

JUSTICE: They still have to-- they still had to go back -

MR. SHELY: Absolutely they have to go up and they don't have any cases to say they're going. We have cases let's say you do, the only thing they can say is when the Rencare case in the Fifth Circuit that's really when it comes down to all that they have. And in the end, in the end that case is easily essential. It-- with all due respect to Fifth Circuit, ignored the regulations which we have cited in our brief which shows that providers are a part of the exhaustion process. That they have the right to be.

JUSTICE: I have just coming back to first series of questions. Say they have to go to get that all of them. You get the ALJ and -

MR. SHELY: Yes.

JUSTICE: What we hear of on and well, this is Sally Jones-Clay and -

MR. SHELY: One of 6,000 claims.

JUSTICE: One of 6,000 number one so get ready. And okay, if there's any dispute about Sally Jones-Clay and Aetna's as I have-- we know, we don't see that. Okay. Why we're here and what's the answer to that?

MR. SHELY: Well, if, if there was no dispute about the coverage claim, it did come through at I have been on-- would have that going up that it there they have not established coverage as to any of the 6,000 claims

JUSTICE: I know but if they know, they say we want the statute so here's our first claim Sally Jones. What you do -

MR. SHELY: Well, it, it'sn -

JUSTICE: - is it treatment? Is he covered or not? Well, what is that beside but we don't dispute to the -

MR. SHELY: Well, let's say that that happens, Judge and that means as one last claim to come back to and deal with in the Court System once the exhaustion process is completed, which of course, as one of the over-all arching reasons for having exhaustion of the administrative remedies. It will narrow the scope of the , of the claims that the Court needs to look at it. They don't have -

JUSTICE: But the agency we're not here to do that. We're not here to say -

MR. SHELY: Why?

JUSTICE: - as of huge the least to be dispute before you get there.

MR. SHELY: - to understand the instances they don't want to look at the 6,000 claims. That is much to understand but there's stuck with this. All right. Their stuck with the regulations and I have want just -

JUSTICE: So do it, do it with-- if I understand your theory. You're saying that hospitals present your claims to NAMM. And NAMM doesn't pay him, that's a denial. The hospitals should have filed the administrative procedure.

MR. SHELY: Should have asked Aetna to reconsider -

JUSTICE: Okay.

MR. SHELY: - in the time clears a lot by the regulation.

JUSTICE: And since those times had passed we can consider that denied to -

MR. SHELY: Yes.

JUSTICE: - and so they filed the claim in administrative Court saying "they should have paid it." And with that administrative Judge say "NAMM has to pay it or have not?"

MR. SHELY: What's a good question, Judge. I think, I think that suit, suit us we would be there but the only step before you get to ALJ is a request for a reconsideration and then it is sent to an independent agency contracted by HCFA. That's called Maximo's. That's where the claims when their lessor exhausting their administrative remedies after the trial Court. That's where the claims are. But with the ALJ would say, they would go and say Managed Care Organization, Aetna watched you do the coverage. Neither do, we don't and as long claim less to do or not. But it would be NAMM could be a party they can suit that in the state Court if they wanted to. They have just decide to go over they felt the money was. At the administrative process would be that MkC organization or Aetna would be the party if you will-- who is responding to the claims of the hospitals but they are providing services to Medicare enrollees and at submitting claims and support. And of it's one claim or 6,000 you need to show coverage that is their word. They had not done so they have not-- as to multiply where there an exhaustion because they certainly send them on the trial Court. You could make the argument that they were late. But Aetna did not do that and they send them on to Maximo's. So that's where they stand, Aetna has-- that's the way it's supposed to be that depending oof what Maximo's determine that the ALJ. It could eventually go to judicial review. Again, the overriding of this reason is we want Medicare recipients around the country be treated equally. That's why the Medicare administrative scheme make sense. So that people in Florida and Texas in main presumably -

JUSTICE: The U.S. Department is presumably has analysis that would applied all the state should is there any difference that we should apply to their assessment of this

MR. SHELY: Not in this instance with all due respect, your Honor. And the reason for that is they are not allowed under the Center of Labor versus Heins case United States Supreme Court to say that we actually have been doing a lot year from the regulations of law require. That is in our brief. In addition, they believe the case as established that the most of cooperative rule it's not what hit for HHS says they won today. So the commerce call them to do and that's what this regulation say. And they can not say below the only argument. The only argument the hospitals was only enrollees can use the administrative process. That's the defendant is wrong on the regulations. So that kind of morph that announce that well, we don't have to do that seems harassment to lot of claims. The fact to that matter is, there is a procedure in the place its occur here it's least part way through. It is designed to keep from this Courts having to looked at on with all due respect 6,000 claims when they get going. Once that happens once the process is exhausted coverage determine come back and did make their claim made up with their contracts in the record and any defenses can be assert of that. But the car before the horse is not knowing which you got to having from the-- in front of the Court as to claims and you need to determine coverage. That is-- and that links up in some ways that the prompt payment statute. Let's say this close up Mr. Gregoral insurance contract, they want to sue for prompt payment. Well, they have to prove that the claims that were submitted were in fact clean and there's no evidence if they say that there's no evidence of this were clean claim that were submitted. And then, they would have to show that it was covered because if it's not

covered, it's an absolute defense. I see my time is short for reasons pertained in our brief and the regulations passed that need to be filed the Aetna request of fee. Judgment of the Court of Appeals be affirmed in its entirety. Thank you.

JUSTICE: Thank you.

REBUTTAL ARGUMENT OF SCOTT M. CLEARMAN ON BEHALF OF PETITIONER

MR. CLEARMAN: You know, If I may just a second, you've hit-- probably the key point of common sense in this entire claim. And the Court below covered was not even alleged to be an issue. That was an issue that was created by the Court of Appeals. If you go back and looked at the record not brief, we point that out. Below, Aetna said that it, it fully complied with its obligation to find NAMM and it said NAMM breach the contract by failing to pay the hospital for covered claims. Now, 6,000 claims that are submitted by computer included things like coffin, hurt fingers, and they asked you just assumed that they have to go to 6,000. This, this is just the best gained known to man to avoid paying.

JUSTICE: What is your best response to the argument that no ruling is tantamount through the denial approach?

MR. CLEARMAN: Well, the first thing is that there it-- in the instance of an enrollees' interest then you go back to the law and they always says, an enrollees, we should be paid. It is a case that if it, if it did not respond to the enrollees' request that can be deemed that it did not. But the entire statute looks to the enrollee, now there are times when the doctor can do it on behalf of the patient who he believed his immediate care or something like that-

JUSTICE: But-

MR. CLEARMAN: - that it always occurs on.

JUSTICE: Hospitals did used to take the assignment from the enrollees so your submission is only half of our sooner in the shoes of the enrollee.

MR. CLEARMAN: - Well, as the, as the, as the Court points out in Ren Care, the assignment exist. All hospitals get assignments. But that's not what we're suing on, our suit is against -

JUSTICE: No. But we're talking about submission to-- for payment, the NAMM. I thought that-- don't you have-- when you submit, don't you have to undersign an enrollee in order to submit on their behalf?

MR. CLEARMAN: No.

JUSTICE: Do you have one?

MR. CLEARMAN: I'm sure we do. That the ...

JUSTICE: And so it was your submission pursuant to the enrollees right?

MR. CLEARMAN: No. Our submission was pursuant to our contractual obligation with NAMM to provide Medicare enrollees services. That is our contract, that is why the federal government won't have anything to do. And I point out it, it at the, at the really important point-

JUSTICE: Let me stop you just a minute. Do you have a contract?

MR. CLEARMAN: Yes. We've got -

JUSTICE: Not just depending on the letter agreement.

MR. CLEARMAN: What we have contracts that are extended by letter agreements and that is pled in the record.

JUSTICE: Okay.

MR. CLEARMAN: But let me tell you why at the jurisdictional issue we are at right now. We pled we have a contract, should it put in the record, you're, you're right you would have put the issue to rest but we pled that we also had clean claims which means that we submitted claims that were to be paid. And we pled that they just refuse to pay because they did not have the money. Under Texas statute, Aetna under the prompt payment remains liable to us until it pays.

JUSTICE: And what is your position in response to the Counsel's statement that the regulations, in fact, allow to provide to appeal a refusal to pay?

MR. CLEARMAN: Well, if you looked at-- my response would be the looked at the decision in Ren Care and the statutes that apply which talked about an enrollee interests.

JUSTICE: If that -

MR. CLEARMAN: It has to be -

JUSTICE: What is the language, let me ask you this: what, what is your position on that? What is the language in the regulation? Does it include providers?

MR. CLEARMAN: It-- in certain instances but not one that applies here, okay. The Aetna's-- let me get to this last point which is very important. Aetna has to be the federal government in this case to win this case and that's why they say it in their brief. Contrary to the silly fact that the federal government's action sitting over here. The reason is that this case only those down to four or five GNH which were the only provisions in statute to say, "you have to have this suit, go through the administrative process and then in federal Court. That's why they say Texas Courts don't have jurisdiction. That statute requires the federal government to be the defendant. Aetna is the defendant here, it's the risk bearing entity in part C not A or B and all of the cases that they're trying to say that they are the government or in A and B.

JUSTICE: Any further questions? Thank you, Mr. Clearman. The case is submitted and the Court will take another brief recess.