03-11-18

BEFORE THE COMMISSIONER OF
THE DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE

AMENDED NOTICE OF HEARING
on a
PETITION FOR DECLARATORY ORDER

(Pursuant to Tenn. Code Ann. §§ 4-5-223 – 224)

Petitioner: Chattanooga-Hamilton County Hospital Authority, d/b/a Erlanger Health System

Petitioner's Counsel:

Steven A. Riley
James N. Bowen
Greg Reynolds
Keane Barger
Riley Warnock & Jacobson, PLC
1906 West End Avenue
Nashville, TN 37203
(615)320-3700 (telephone)
(615)320-3737 (facsimile)
sriley@rwjplc.com
jimbowen@rwjplc.com
greynolds@rwjplc.com
kbarger@rwjplc.com

Case Number: 09.15-144571J

Background:

In 1986, Congress enacted the federal Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. § 1395dd. EMTALA requires that, when a person without the ability to pay for medical services presents with an emergency medical condition to a hospital's emergency room, the hospital must provide such treatment as is necessary to either stabilize the patient or transfer the patient to another facility.

Almost 20 years after Congress enacted EMTALA, Congress enacted the Deficit Reduction Act of 2005 ("DRA"). The DRA included a provision governing the payments for EMTALA-mandated emergency services provided to Medicaid beneficiaries who receive these services from a provider who does not have a contract with the beneficiary's Medicaid managed care entity:

> Any provider of emergency services that does not have in effect a contract with a Medicaid managed care entity that establishes payment amounts for services furnished to a beneficiary enrolled in the entity's Medicaid

> managed care plan must accept as payment in full no more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it could collect if the beneficiary received medical assistance under this subchapter other than through enrollment in such an entity. In a State where rates paid to hospitals under the State plan are negotiated by contract and not publicly released, the payment amount applicable under this subparagraph shall be the average contract rate that would apply under the State plan for general acute care hospitals or the average contract rate that would apply under such plan for tertiary hospitals.

42 U.S.C.A. § 1396u-2(b)(2)(D). In response to the DRA provision, the Tennessee General Assembly enacted Tennessee Code Annotated § 71-5-108, effective June 11, 2007. This statute provides:

> The TennCare bureau is directed to submit a state plan amendment to the centers for medicare and medicaid services that sets out a payment methodology for medicaid enrollees who are not also enrolled in medicare, consistent with provisions in § 6085 of the federal Deficit Reduction Act of 2005, regarding emergency services furnished by noncontract providers for managed care enrollees. The payment amount shall be the average contract rate that would apply under the state plan for general acute care hospitals. A tiered grouping of hospitals by size or services may be utilized to administer these payments. The payment methodology developed pursuant to this section shall be budget neutral for the state fiscal year 2007-2008 when compared to the actual experience for emergency services furnished by non-contract providers for medicaid managed care enrollees prior to January 1, 2007. It is the intent that this section only applies to the emergency services furnished by noncontract providers for medicaid managed care enrollees.

TennCare submitted to the Centers for Medicare and Medicaid Services ("CMS") two State Plan Amendments ("SPA") setting forth the rates at which non-contract hospitals should be reimbursed for outpatient emergency services ("SPA 08-003") and for inpatient hospital admissions required as the result of emergency outpatient services ("SPA 10-003") provided to TennCare enrollees. These SPAs were approved by CMS. Following approval of each SPA, TennCare promulgated Tenn. Comp. R. & Regs. 1200-13-13-.08(2)(b) and 1200-13-13-.08(2)(c) to implement the SPAs:

> (b) Covered medically necessary outpatient emergency services, when provided to Medicaid managed care enrollees by non-contract hospitals in accordance with Section 1932(b)(2)(D) of the Social Security Act (42 U.S.C.A. § 1396u-2(b)(2)(D)), shall be reimbursed at seventy-four percent (74%) of the 2006 Medicare rates for these services.

> (c) Covered medically necessary inpatient hospital admissions required as the result of emergency outpatient services, when provided to Medicaid managed care enrollees by non-contract hospitals in accordance with Section 1932(b)(2)(B) of the Social Security Act (42 U.S.C.A. § 1396u-2(b)(2)(B)), shall be reimbursed at 57 percent of the 2008 Medicare Diagnostic Related Groups (DRG) rates (excluding Medical Education and Disproportionate Share components) determined in accordance with 42 CFR § 412 for those services. For DRG codes that are adopted after 2008, 57 percent of the rate from the year of adoption will apply. Such an inpatient stay will continue until no longer medically necessary or until the patient can be safely transported to a contract hospital or to another contract service, whichever comes first.

In this case, Petitioner contends that the aforementioned regulations and SPAs violate Tenn. Code Ann. § 71-5-108 and are procedurally invalid. Petitioner additionally contends that promulgation of the aforementioned rules violated the Tennessee Constitution by usurping power reserved to the legislative branch.

Petitioner is a hospital that provided EMTALA-mandated services to TennCare enrollees who were enrolled with UnitedHealthCare Plan of the River Valley, d/b/a AmeriChoice ("AmeriChoice"), a TennCare Managed Care Organization ("MCO"). Through December 31, 2008, Petitioner and AmeriChoice had a contract for Petitioner to provide healthcare services to AmeriChoice enrollees. Between January 1, 2009 and February 28, 2015, Petitioner and AmeriChoice were not parties to such a contract. During that time period, Petitioner provided EMTALA-mandated services to AmeriChoice enrollees who presented to the hospital with an emergency medical condition.

In June 2009, Petitioner filed a complaint against AmeriChoice in Davidson County Chancery Court seeking a declaratory judgment that AmeriChoice is required to pay Petitioner at the average contract rate payable by TennCare MCOs for EMTALA-mandated services and at a reasonable rate of reimbursement for services provided to patients after stabilization. In January 2013, the trial court ruled that it was without subject matter jurisdiction to adjudicate Petitioner's claims because Petitioner failed to exhaust its administrative remedies. The Tennessee Court of Appeals reversed this decision, holding that Erlanger was not required to seek an administrative remedy prior to filing suit. *Chattanooga-Hamilton Cty. Hosp. Auth. v. UnitedHealthcare Plan of River Valley, Inc.,* No. M2013-00942-COA-R9-CV, 2014 WL 2568456 (Tenn. Ct. App. June 6, 2014). On November 5, 2015, the Tennessee Supreme Court affirmed the trial court's holding that it lacked jurisdiction to issue declaratory relief absent Petitioner's exhaustion of administrative remedies with TennCare. *Chattanooga-Hamilton Cty. Hosp. Auth. v. UnitedHealthcare Plan of River Valley, Inc.,* 475 S.W.3d 746 (Tenn. 2015)

Summary of Relief Requested:

Pursuant to the Tennessee Supreme Court's decision in *Chattanooga-Hamilton Cty. Hosp. Auth. v. UnitedHealthcare Plan of River Valley, Inc.,* 475 S.W.3d 746 (Tenn. 2015) and Tenn. Code Ann. §§ 4-5-223 and 4-5-225(b), Petitioner sought a declaration that Tenn. Comp. R. & Regs. 1200-13-13-.08(2)(b) and Tenn. Comp. R. & Regs. 1200-13-13-.08(2)(c) violate Tenn. Code Ann. § 71-5-108, to the extent these rules purport to establish the maximum compensation rate for out-of-network providers who provide services required by EMTALA to TennCare enrollees through the filing of a Petition for Declaratory Order on April 19, 2017. On January 9, 2018, Petitioner amended its Petition for Declaratory Order to additionally seek a declaration that SPA 08-003 and SPA 10-003 violate Tenn. Code Ann. § 71-5-108, to the extent they purport to establish the maximum compensation rate for out-of-network providers who provide services required by EMTALA to TennCare enrollee. Petitioner additionally alleged the rules are procedurally defective and invalid on the basis that TennCare violated the Tennessee Constitution by usurping power reserved to the legislative branch in promulgating the rules. Pursuant to these new allegations, Petitioner additionally seeks an order requiring TennCare to amend the state plan in conformity with the requirements of the Tenn. Code Ann. § 71-5-108 to establish rates that equal the average contract rates paid in Tennessee each year to in-network hospital providers that provide emergency care required under EMTALA. In accordance with Tenn. Code Ann. § 4-5-223, the Department of Finance and Administration will convene a contested case and issue a declaratory order as set forth herein.

Hearing:

The hearing will be held starting at 9 a.m. on June 25, 2018 and continue as necessary through June 29, 2018 at the Bureau of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243 in Room 4 East A. Persons attending the hearing should present appropriate identification at the guard desk on the first floor and ask that the guard contact Rob Bushong in order to be escorted to the hearing room.

The hearing will be held before Commissioner's Designee Will Cromer, sitting as the designee of Commissioner Larry Martin. Administrative Law Judge Steve Darnell from the Administrative Procedures Division of the Office of the Tennessee Secretary of State shall preside at the hearing. This matter will be conducted in accordance with Tenn. Code Ann. §§ 4-5-301 *et seq.*