ARIZONA SUPREME COURT
ORAL ARGUMENT CASE SUMMARY

UNITED BEHAVIORAL HEALTH v. MARICOPA INTEGRATED HEALTH SYSTEM
CV-15-0239-PR

PARTIES:

Petitioners:	Maricopa Integrated Health System ("MIHS"), Aurora Behavioral Health Care-Tempe, LLC and Aurora Behavioral Health System, LLC (collectively, "Aurora")
Respondent:	United Behavioral Health, Inc. ("United")

FACTS:

Factual Background. In the late 1990s, Congress enacted Part C of the Medicare Act. Generally referred to as the "Medicare Advantage Program," it allows Medicare beneficiaries to obtain Medicare benefits through private managed health care organizations ("MA Organizations"). The federal government enters contracts with these organizations, paying them a fixed monthly capitation fee per enrollee for health care services. In exchange, the MA Organization agrees to provide Medicare beneficiaries belonging to its health care plan ("MA Plan") with all of the benefits they would be entitled to receive under traditional Medicare.

Upon payment from the federal government, a MA Organization "assume[s] full financial risk . . . for the provision of the health care services for which benefits are required to be provided." 42 U.S.C. § 1395w-25(b). As part of that obligation, it "must adopt and maintain arrangements satisfactory to [the federal administering agency] to protect its enrollees from incurring liability for payment of any fees that are the legal obligation of the [MA] [O]rganization." 42 C.F.R. § 422.504(g)(1). MA Organizations may contract with third-party providers to provide health care services to enrollees. There are few statutory or regulatory restrictions on those agreements' content, except that they must prohibit "providers from holding any beneficiary enrollee liable for payment of" fees that are the legal obligation of the MA Organization. *Id.* § 422.504(g)(1)(i).

United is an MA Organization that issues and administers various MA Plans. Petitioners operate acute inpatient psychiatric hospitals, and each entered a Facility Participation Agreement with United allowing them to participate in United's health care network to provide mental-health and substance-abuse health care services. MIHS provides services under member MA Plans; Aurora provides services not only under MA Plans but also under private employer benefit plans administered by United that are subject to ERISA.

MIHS's and Aurora's agreements with United are not identical, but their substantive provisions are generally the same. They state that the services that may be rendered are defined by the coverage provided in the "Member's Benefit Plan" or "Benefit Contract." All the agreements require pre-authorization before services may be provided. When a patient is about to

be admitted, the provider contacts United to determine if the patent is covered by a United member plan, and, if so, to obtain authorization for inpatient care. United pays Petitioners on a per diem basis. The agreements provide that in no event may the provider bill, charge, or have any recourse against any member for services eligible for reimbursement under the agreement.

The agreements do not mention the administrative review procedures set forth in the Medicare Part C regulations for challenging Medicare coverage decisions. 42 C.F.R. Subpart M. They do, however, contain arbitration provisions requiring the parties to submit to binding arbitration all disputes "arising out of their business relationship."

This dispute arises out of United's denial of coverage for: (1) continuing inpatient care for 20 MIHS patients who were covered by a MA plan and were admitted to MIHS on an inpatient basis for court-ordered involuntary mental health evaluation or treatment; and (2) inpatient care for 23 Aurora patients with mental health issues who either had coverage under a MA plan or were beneficiaries of a private employer benefit plan administered by United.

After United's coverage denial, Petitioners continued to provide inpatient care for these patients and filed separate demands for arbitration. United responded by filing separate lawsuits against MIHS and Aurora under A.R.S. §§ 12-3005(A) & -3007(B), seeking orders to stay arbitration on the ground that the disputes were not arbitrable. It argued that the Medicare Act preempted all state law remedies and instead required the providers to exhaust the Medicare Act's administrative appeal procedures. The superior court judges in the two cases resolved the issue by motion, but reached opposite results. In *MIHS*, the court rejected United's preemption argument and ruled that "the dispute is subject to arbitration under the agreement." In *Aurora*, the court agreed with United's argument, and granted its motion to stay arbitration. In each case, the losing party appealed, and the cases were consolidated on appeal.

The Court of Appeals' Opinion. Concluding that "Congress has enacted a specific procedure for resolving Medicare coverage disputes" that preempts and supersedes any claim involving Medicare coverage, the court affirmed the *Aurora* court's order staying arbitration of Medicare-related claims and reversed the *MIHS* order compelling arbitration. It found that the claims at issue were coverage disputes, and ruled that the Medicare Act's administrative appeals procedure was "the sole avenue for resolving coverage disputes." Under that procedure, it explained, judicial review is available, but only in federal court and only after all administrative remedies are exhausted. It also stated in a footnote that it did not need to reach whether Petitioners had "standing to file a Medicare administrative appeal based on 42 C.F.R. § 422.566(c)(1)" because that issue was "not before us in this case."

The court then turned to Aurora's contention that it was entitled to arbitrate the claims arising under some of its patients' private employer benefit plans. It ruled that Aurora's claims were subject to ERISA's "exclusive legal standards and remedies," and that an action "to recover benefits due" or to "enforce . . . rights under the terms of the plan" is a coverage claim subject to ERISA's civil remedy provision in ERISA § 502, 29 U.S.C. § 1132(a). It also ruled that this statutory remedy preempts any state-law cause of action. It held, however, that because the record was unclear "as to whether Aurora received a valid assignment of the members' [private employer plan] ERISA claims" to be able to assert an ERISA claim, it vacated the court's order staying

arbitration of those claims and remanded the case back to the trial court for further proceedings.

ISSUES PRESENTED FOR REVIEW:

(1) "The Federal Arbitration Act establishes a liberal policy favoring arbitration and mandates the rigorous enforcement of arbitration agreements. In light of that policy and mandate, did the Court of Appeals misapply the Act by holding that the Medicare administrative appeal process implicitly invalidates arbitration provisions in provider contracts (i) when the relevant federal agency and numerous courts have concluded that the administrative process is not available to providers with claims against entities such as United Behavioral Health, Inc., for services provided to Medicare Advantage patients, and (ii) when the United States Supreme Court has consistently upheld the rigorous enforcement mandate of the Act when the federal statutory or regulatory scheme at issue did not explicitly forbid arbitration[?]"

(2) "Under the Federal Arbitration Act, a court is limited to determining whether an enforceable arbitration agreement exists, and, if so, deciding whether the agreement covers the parties' dispute. The Act forbids courts from considering, in any way, the merits or validity of a party's claim. Did the Court of Appeals misapply the Act by concluding that a decision as to the arbitrability of Aurora's claims involving care provided to ERISA beneficiaries requires a preliminary determination 'whether Aurora has alleged a valid ERISA claim[?]' *Court of Appeals' Opinion* . . . ¶¶ 3, 36-38."