IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF MISSOURI WESTERN DIVISION

MARTIN ZAKARIAN, and MARY JONES, on behalf of themselves and those similarly situated, Plaintiffs, v. THE RAWLINGS COMPANY LLC, RAWLINGS FINANCIAL SERVICES, LLC, and RAWLINGS & ASSOCIATES, PLLC, Defendants.	)	Case No. 24-cv-00229-SRB

ORDER

Before the Court is Defendant The Rawlings Company LLC, Rawlings Financial Services, LLC, and Rawlings & Associates, PLLC's (collectively, "Defendants") Motion for Judgment on the Pleadings. (Doc. #37.) For the reasons set forth below, the motion is DENIED.

I. FACTUAL BACKGROUND

The following allegations are taken from Plaintiff Martin Zakarian and Plaintiff Mary Jones's ("Plaintiffs") Class Action Complaint (Doc. #1), and from the Court's Order dated August 29, 2024, without further citation or attribution unless otherwise noted.[1] Only those allegations necessary to resolve the pending motion are discussed below. Additional allegations and facts relevant to the parties' arguments are discussed in Section III.

Plaintiffs are covered by and receive benefits through Medicare. Plaintiffs "entered into valid contracts with Medicare for the provision of healthcare insurance." (Doc. #1, ¶ 46.) Defendants are the nation's leading provider in Medicare recovery services and are authorized to

[1] The August 29, 2024 Order denied Defendants' motion to dismiss under Federal Rule of Civil Procedure 12(b)(6) and motion to strike class allegations under Rule 12(f). All page numbers refer to the pagination automatically generated by CM/ECF.

collect Medicare lien payments from proceeds of legal settlements or judgments. "Defendants are contracted by Medicare as Medicare's agent in the provision of healthcare insurance to Plaintiffs[.]" (Doc. #1, ¶ 47.)

Both Plaintiffs were injured in automobile accidents and resolved their claims against unidentified third parties. Defendants then "asserted a Medicare lien on the proceeds of [Plaintiffs'] settlement." (Doc. #1, ¶¶ 16, 22.) For both Medicare liens, Defendants "did not include an offset for the proportionate share of procurement costs." (Doc. #1, ¶¶ 17, 23.) Plaintiffs allegedly "paid, under protest, the Medicare lien as calculated and demanded by Defendants." (Doc. #1, ¶¶ 18, 24.) According to Plaintiffs, Defendants' alleged failure to "include an offset for the proportionate share of procurement costs" was in violation of the two methodologies for calculating the amount of recoverable Medicare payments under 42 C.F.R. § 411.37 (the "Procurement Cost Regulation"). (Doc. #1, ¶¶ 31-33.)

On March 29, 2024, Plaintiffs filed this lawsuit against Defendants. Plaintiffs assert two causes of action on behalf of themselves and on behalf of two putative classes: Count I– Negligence Per Se; and Count II—Breach of Contract.

Defendants now move for judgment on the pleadings under Federal Rule of Civil Procedure 12(c). Defendants argue the Court lacks jurisdiction because Plaintiffs' claims "arise under the Medicare Act and Plaintiffs failed to exhaust the mandatory administrative remedies before filing their Complaint." (Doc. #37, p. 7.) Defendants argue they are "also entitled to judgment on the pleadings because they are not proper defendants in this action. A Medicare enrollee may seek judicial review of a final decision only by bringing a claim against the Secretary of HHS." (Doc. #37, p. 8.) Plaintiffs oppose the motion, and the parties' arguments are addressed below.

II. LEGAL STANDARD

Rule 12(c) provides that a party may move for judgment on the pleadings. Fed. R. Civ. P. 12(c). The Court applies the same standard on a motion for judgment on the pleadings as it would on a Rule 12(b)(6) motion for failure to state a claim. *Westcott v. City of Omaha*, 901 F.2d 1486, 1488 (8th Cir.1990) ("[W]e review this 12(c) motion under the standard that governs 12(b)(6) motions."). Rule 12(b)(6) provides that a defendant may move to dismiss for "failure to state a claim upon which relief can be granted." Fed. R. Civ. P. 12(b)(6). "To survive a motion to dismiss [for failure to state a claim], a complaint must contain sufficient factual matter, accepted as true, to state a claim to relief that is plausible on its face." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (citations and quotations omitted). A motion for judgment on the pleadings may be granted if a plaintiff fails to exhaust administrative remedies, and materials outside the pleadings may be considered to determine this issue. *See Henson v. Union Pac. Railroad Co.*, 3 F.4th 1075, 1080 (8th Cir. 2021); *Saterdalen v. Spencer*, 725 F.3d 838, 841 (8th Cir. 2013).

III. DISCUSSION

As an initial matter, the parties' briefs provide background information on the Medicare Act and the Medicare Secondary Payer Law ("MSP") and regulations. To better frame Plaintiffs' claims and the pending motion, the following briefly summarizes that background. Medicare is a federally funded health insurance program and qualifying individuals may receive insurance benefits by enrolling in it. *See* 42 U.S.C. § 1395, *et seq.* "Under Medicare Part C, also known as 'Medicare Advantage,' the insurers that administer it are known as Medicare Advantage Organizations, or MAOs." (Doc. #37, p. 8.)

"Under the Medicare Advantage Program, a private insurance company, operating as an MAO, administers the provision of Medicare benefits pursuant to a contract with" the Centers

for Medicare and Medicaid Services ("CMS"). (Doc. #37, p. 8) (quoting *Humana Med. Plan, Inc. v. Western Heritage Ins. Co.*, 832 F.3d 1229, 1235 (11th Cir. 2016)). Each MAO "enters into a contract with the Secretary of the Department of Health and Human Services (the 'Secretary'), pursuant to which the MAO receives a fixed payment per enrollee in exchange for providing the same level of benefits available under traditional Medicare. 42 U.S.C. §§ 1395w-22, 1395w-27." (Doc. #37, p. 8.)

If "an MAO makes a payment for medical services that are the responsibility of a primary payer (e.g., other insurer or a tortfeasor), those payments are conditional, whether the primary payer's liability is established at the time of the conditional payment or later." (Doc. #37, p. 10.) "[U]nder the MSP Law, when a person (including an enrollee) receives payment for a benefit the MAO conditionally provided, the MAO can require that person to reimburse it for those conditional payments. MAOs often enforce these recovery rights through subrogation and recovery agents, such as" Defendants. (Doc. #37, p. 10.)

A. Exhaustion

When applicable, the Medicare Act contains a "nonwaivable and nonexcusable requirement that an individual present a claim to the [Department of Health and Human Services] before raising it in court." *Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 15 (2000). In particular, "'the sole avenue for judicial review for all claims arising under the Medicare Act' is through the exhaustion of administrative remedies before the Secretary." *Potts v. Rawlings Co.*, 897 F. Supp. 2d 185, 191 (S.D.N.Y. 2012) (quoting *Heckler v. Ringer*, 466 U.S. 602, 614–15 (1984)). "A claim 'arises under' the Medicare Act (1) if 'both the standing and substantive basis' for the claim is the Medicare Act, or (2) if the claim is 'inextricably intertwined' with a claim for benefits under the Medicare Act." *Id.* at 192 (quoting *Heckler*, 466 U.S. at 614-15). A federal court lacks subject matter jurisdiction if a plaintiff is

required—but failed—to exhaust a claim. *See Degnam v. Burwell*, 765 F.3d 805, 808 (8th Cir. 2014).

Here, Defendants argue Plaintiffs' claims arise under the Medicare Act. Defendants contend that the Medicare Act provides the standing and substantive basis for the claims. According to Defendants, "[w]hile pleaded as claims for negligence per se and breach of contract, the essence of Plaintiffs' claims is that Rawlings, in asserting Medicare recovery rights against Plaintiffs' settlement proceeds to recover conditional Medicare payments, violated the requirements of the Regulation." (Doc. #37, p. 15.) Defendants further contend that Plaintiffs' claims are inextricably intertwined with the Medicare Act because they "seek a determination of the amount of conditional Medicare payments that Medicare is entitled to recover. Resolving Plaintiffs' claims would therefore necessarily require the Court to determine Medicare's recovery rights under the MSP Law and the Medicare Act." (Doc. #37, p. 17.)

Defendants state that when a claim arises under the Medicare Act, "[t]here are four levels of administrative review that must be completed . . . [t]he first step of that process is called an 'organization determination.' 42 C.F.R. § 422.566(b)." (Doc. #37, p. 13.) However, "[t]here is no allegation that Plaintiffs submitted a Level 1 appeal by seeking reconsideration from the MAO (or [Defendants]) within 60 days of the organization determination. *See* 42 U.S.C. § 1395w-22(g)(1)-(2); 42 C.F.R. § 422.578-422.590." (Doc. #37, p. 19.) Based on the foregoing, Defendants argue this case must be dismissed for lack of subject matter jurisdiction.

Upon review, the Court rejects Defendants' arguments. As discussed above, Plaintiffs allege that Defendants asserted Medicare liens without an offset for the proportionate share of procurement costs, and that Plaintiffs paid Defendants under protest. Plaintiffs' claims for

negligence per se and breach of contract thus seek damages for procurement costs under 42 C.F.R. § 411.37.

These claims are not subject to the Medicare Act's exhaustion requirements. The Court agrees with Plaintiffs that:

> Where a conditional payment is made and the right to recoup becomes apparent by virtue of settlement, 42 C.F.R. Part 411 . . . provides the mechanism by which an MAO may subrogate a conditional payment. 42 C.F.R. § 411.22. In general Part 411 provides "a direct right of action to recover from any primary payer" or "any entity, including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a primary payment." 42 C.F.R. § 411.24(e)-(g). . . . 42 C.F.R. § 411.39(c) provides step-by-step instructions for obtaining a final conditional payment amount through the web portal in the event that settlement is imminent. 42 C.F.R. § 411.39(c). After giving notice of, *inter alia*, an impending settlement, a beneficiary plaintiff may obtain a list of conditional payments for which CMS is seeking recoupment. 42 C.F.R. § 411.39(c)(1)(iv)-(v). "The beneficiary . . . may then address discrepancies by disputing individual conditional payments, **once and only once** . . . ." 42 C.F.R. § 411.39(c)(1)(v) (emphasis added). **"The dispute process is not an appeals process, nor does it establish a right of appeal regarding that dispute."** 42 C.F.R. § 411.39(c)(1)(v) (emphasis added). **"There will be no administrative or judicial review related to this dispute process."** (Id.) (emphasis added). Crucially, after that dispute process is completed and payment received, "CMS [or an MAO] applies a pro rata reduction to the final conditional payment amount in accordance with § 411.37 and issues a final MSP recovery demand letter." 42 C.F.R. § 411.39(c)(1)(IX). There is no exception and no discretion related to this rule. . . . 42 C.F.R. Part 411 provides the process by which an entity such as [Defendants] may recover Medicare liens but does not provide for administrative review of particular conditional payments, and, most importantly, mandates—without exception or discretion—the application of procurement costs offset.

(Doc. #43, pp. 9-10) (emphasis in original).

Defendants' exhaustion arguments rely upon 42 C.F.R. § 422 and contend the "first step" is the "organizational determination" found at 42 C.F.R. § 422.566(b). However, these exhaustion requirements do not apply to the claims asserted by Plaintiffs. As explained by Plaintiffs, "Part 422 sets forth requirements that MAOs must follow with respect to grievance

procedures, organization determinations, and appeal procedures related to ***the provision of*** health care services. 42 C.F.R. §§ 422.560(b), 422.561, 422.564(a), 422.566." (Doc. #43, p. 11) (emphasis in original).

For example, 42 C.F.R. § 422.561 explains that:

> Appeal means any of the procedures that deal with the review of adverse organization determinations ***on the health care services the enrollee believes he or she is entitled to receive***, including delay in providing, arranging for, or approving the health care services (***such that a delay would adversely affect the health of the enrollee***), or on any amounts the enrollee must pay for a service, as defined under § 422.566(b).[2]

42 C.F.R. § 422.561 (emphasis added). Under these circumstances, the Court agrees with Plaintiff that "the 'administrative review' process [Defendants] rel[y] on relates to the provision of health care services" and does not apply to Defendants' "recoupment of conditional payments." (Doc. #43, p. 11.)

Finally, Defendants argue that "the weight of authority" supports their exhaustion arguments. (Doc. #51, p. 6.) However, Plaintiffs' opposition brief distinguishes many of those cases and the Court finds they do not support dismissal under the allegations in this case. For these reasons, and the additional reasons stated by Plaintiffs, the Court denies Defendants' motion to dismiss for failure to exhaust.

B. Proper Defendant

Defendants' secondary argument is "[e]ven if Plaintiffs' claims were properly before the Court . . . Plaintiffs have nevertheless sued the wrong party. Congress specified that Medicare beneficiaries could seek review of a final determinations only by suing the HHS Secretary—not

[2] On the current record, the Court cannot conclude that § 422.566(b) applies to recoupment costs under 42 C.F.R. 411.37.

the beneficiary's MAO or, as is the case here, the MAO's recovery vendor[.]" (Doc. #37, pp. 20-21.)

Upon review, this argument is rejected for two reasons. First, Defendants cite authority for the proposition that if a claim is exhausted, the aggrieved party must then sue the HHS Secretary. However, for the reasons discussed above, exhaustion is not required and Plaintiffs may pursue their claims directly against Defendants.

Second, Defendants' argument is contrary to applicable law and would create impermissible and unworkable hurdles to aggrieved parties. As explained by Plaintiffs, Defendants believe they have "a private cause of action against almost anyone when recovering a Medicare lien, but, if [Defendants] make[] a mistake while doing so, [Defendants] cannot be sued" or counter-sued. (Doc. #43, p. 18.) Instead, that individual must forego litigation against Defendant and proceed solely against the HHS Secretary via administrative proceedings. The Court rejects Defendants' arguments that they cannot and are not a proper party to this case.

For these reasons, and the additional reasons stated by Plaintiffs, the Court denies Defendants' motion to dismiss on the basis that they are not the proper party to this case.

IV. DISCUSSION

Accordingly, Defendants' Motion for Judgment on the Pleadings (Doc. #37) is DENIED.

IT IS SO ORDERED.

/s/ Stephen R. Bough
STEPHEN R. BOUGH
UNITED STATES DISTRICT JUDGE

Dated: December 2, 2024