No.

IN THE
SUPREME COURT OF THE UNITED STATES

**NEW VISION HOME HEALTH CARE, INC., et al.,**

**Petitioners,**

**- v. -**

**ANTHEM, INC., et al.,**

**Respondents.**

ON
PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

# PETITION FOR WRIT OF CERTIORARI

George F. Indest III
Counsel of Record
The Health Law Firm
1101 Douglas Avenue
Altamonte Springs, Florida 32714
Telephone: (407) 331-6620
E-mail: GIndest@TheHealthLawFirm.com

LEGAL PRINTERS LLC, Washington DC • 202-747-2400 • legalprinters.com

## QUESTIONS PRESENTED

1. Whether a circuit split exists between the Fifth and Sixth Circuits regarding whether federal courts have jurisdiction to issue mandamus relief to enforce a Medicare Administrative Law Judge's order.

2. Whether a circuit split exists between the Fifth and Sixth Circuits regarding whether federal courts have subject-matter jurisdiction over collateral claims against Medicare Administrative Contractors.

3. Whether subjecting collateral due process and tort claims against Medicare contractors to the channeling provisions of 42 U.S.C. 405(h) results in no meaningful review of said collateral tort and due process claims.

4. Whether the denial of oral argument by the Sixth Circuit Court of Appeals denied Petitioners their due process rights under the United States and Michigan Constitutions.

5. Whether the United States Attorney's appearance on behalf of Respondents without first filing with the District Court a statement of interest or formal request to intervene constituted reversible error.

## PARTIES TO THE PROCEEDING

The petitioners are New Vision Home Health Care, Inc., and Saleem Shakoor.

Respondents are Anthem, Inc., TrustSolutions, LLC, and National Government Services, Inc. Respondents were represented in this matter by the United States Attorney.

## CORPORATE DISCLOSURE STATEMENT

Petitioner New Vision Home Health Care, Inc., is a closely held, Michigan corporation and Medicare provider, and its owner, Mr. Saleem Shakoor, is a natural person and citizen of the United States. Petitioners certify that no Petitioner is a subsidiary or affiliate of a publicly owned corporation.

## TABLE OF CONTENTS

Page

QUESTIONS PRESENTED . . . . . . . . . . . . . . . . . . . . i

PARTIES TO THE PROCEEDING . . . . . . . . . . . . ii

CORPORATE DISCLOSURE STATEMENT . . . . iii

TABLE OF CONTENTS . . . . . . . . . . . . . . . . . . . . . iv

TABLE OF AUTHORITIES . . . . . . . . . . . . . . . . . vii

GLOSSARY . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . xi

OPINIONS BELOW . . . . . . . . . . . . . . . . . . . . . . . . 1

JURISDICTION . . . . . . . . . . . . . . . . . . . . . . . . . . 1

STATUTORY PROVISIONS INVOLVED . . . . . . . 2

STATEMENT . . . . . . . . . . . . . . . . . . . . . . . . . . . . 2

I. The Administration of Medicare and the Medicare Appeals Process . . . . . . 2

II. History of this Case . . . . . . . . . . . . . . 4

A. Petitioners Exhausted the Medicare Appeals Process . . . 4

B. Specific Findings of Respondents' Misconduct by the Medicare ALJ . . . . . . . . . . . . . 5

C. Procedural History/ Chronology . . . . . . . . . . . . . . . . 9

D. Summary of Grounds for Dismissal of the Second Amended Complaint by the U.S. District Court . . . . . 16

REASONS FOR GRANTING THIS PETITION . 18

I. The Decision below Creates a Circuit Split Between the Fifth and Sixth Circuits Regarding Whether Courts Have Mandamus Jurisdiction to Enforce a Medicare ALJ's Order . . . 19

II. The Decision below Creates a Circuit Split Between the Fifth and Sixth Circuits Regarding Jurisdiction over Collateral Claims under 42 U.S.C. § 405(g) . . . . . . . . . . . . . . . . . . . . . . . . 23

A. The Sixth Circuit's Failure to Identify Petitioners' Tort and Due Process Claims as Collateral Claims in the Present Case . . . . . . . . . . . . . 24

B. The Fifth Circuit's Analysis of Collateral Claims . . . . . . . . . 27

C. The Sixth Circuit's Reasoning in the Present Case is Contrary to Established Supreme Court Precedent and the Explicit Intent of the Applicable Statutory and Regulatory Provisions . . 33

III. This Case Presents an Issue of Great Public Importance as it will Ensure that Aggrieved Medicare Providers have Legal Recourse for the Misconduct of Private, For-Profit Medicare Contractors . . . . . . . . . . . 37

IV. The Sixth Circuit's Denial of Oral Argument Violated Petitioners' Constitutional Rights . . . . . . . . . . . 40

V. It was Improper for the United States Attorney to Appear on Behalf of Respondents . . . . . . . . . . . 41

CONCLUSION . . . . . . . . . . . . . . . . . . . . . . . . . . 42

## TABLE OF AUTHORITIES

<u>Cases</u>:

*Affiliated Prof'l Home Health Care Agency v. Shalala*, 164 F.3d 282 (5th Cir. 1999) . . . . . . . . . . . . . . . . . 28, 29, 36

*Bodimetric Health Servs., Inc. v. Aetna Life & Casualty*, 903 F.2d 480 (7th Cir. 1990) . . . . . . . . . . . . . . . . . . . . . . . 25

*Bowen v. City of New York*, 476 U.S. 467, 106 S. Ct. 2022, 90 L. Ed. 2d 462 (1986) . . . . . . . . . . . . . . . . 27

*Caring Hearts Pers. Servs. v. Burwell*, 824 F.3d 968 (10th Cir. 2016) . . . . . . . . . . 38

*Darby v. Cisneros* , 509 U.S. 137, 125 L. Ed. 2d 113, 113 S. Ct. 2539 (1993) . . . . . . . . . . . . . . . . 22

*Family Rehab, Inc. v. Azar*, 886 F.3d 496 (5th Cir. 2018) . . . . . . . . . 19-22, 28, 30, 31, 36

*Heckler v. Ringer*, 466 U.S. 602, 104 S. Ct. 2013, 80 L. Ed. 2d 622 (1984) . . . . . . . . . . . . . 29, 30

*Jones v. Alexander*, 609 F.2d 778 (5th Cir. 1980) . . . . . . . . . . . 22

*Kelsey Mem'l Hosp. v. Shalala*,
1998 U.S. Dist. LEXIS 10924
(W.D. Mich. June 26, 1998) . . . . . . . . . . . . 22

*Manakee Prof'l Med. Transfer Svc., Inc. v. Shalala*,
71 F.3d 574 (6th Cir. 1995) . . . . . . . . . . . . 22

*Mathews v. Eldridge*,
424 U.S. 319, 96 S. Ct. 893,
47 L. Ed. 2d 18 (1976) . . . . . . . . . . . . . . . 27-29

*New Vision Home Health Care, Inc. v. Anthem, Inc.*, 2018 U.S. App.
LEXIS 27993 (6th Cir. Oct. 3, 2018) . . . . . . 1

*Shalala v. Ill. Council on Long Term Care*,
529 U.S. 1, 120 S. Ct. 1084,
146 L. Ed. 2d 1 (2000) . . . . . . . . . . . 27, 33, 39

*Southern Rehab. Group, P.L.L.C. v. Sec'y of HHS*, 732 F.3d 670
(6th Cir. 2013) . . . . . . . . . . . . . . . . . 24, 25, 33

*Wolcott v. Sebellius*,
635 F.3d 757 (5th Cir. 2011) . . . . . . . . . 19-22

Federal Statutes:

5 U.S.C. § 704 . . . . . . . . . . . . . . . . . . . . . . . . . . 22

28 U.S.C. § 517 . . . . . . . . . . . . . . . . . . . . . . . . . 42

28 U.S.C. § 1254(1) . . . . . . . . . . . . . . . . . . . . . . . . 1

28 U.S.C. § 1361 . . . . . . . . . . . . . . . . . . . . . 2, 19, 20

42 U.S.C. § 405 . . . . . . . . . . . . . . . . . . . . . 23, 24, 33

42 U.S.C. § 405(g) . . . . . . . . . . . . . . . . . . . . . 23, 32

42 U.S.C. § 405(h) . . . . . . . . . . . . . . . 2, 20, 27, 33, 39

42 U.S.C. § 1395ff . . . . . . . . . . . . . . . . . . . . . . . . . 2

Federal Regulations:

42 C.F.R. § 405.900(b) . . . . . . . . . . . . . . . . . . . 34, 35

42 C.F.R. § 405.904(a) . . . . . . . . . . . . . . . . . . . 35, 39

42 C.F.R. § 405.944 . . . . . . . . . . . . . . . . . . . . . . . 35

42 C.F.R. § 405.1048 . . . . . . . . . . . . . . . 4, 14, 19, 23

42 C.F.R. § 421.5(b) . . . . . . . . . . . . . . . . . . . . . . . . 2

Other Authorities

72 Fed. Reg. 48870 (Aug. 24, 2007) . . . . . . . . . . . 40

74 Fed. Reg. 65,296, 65,312 (Dec. 9, 2009) . . . . . . . 3

Fed. R. Civ. P. 11 . . . . . . . . . . . . . . . . . . . . . . . . 28

Fed. R. Civ. P. 24(b)(2) . . . . . . . . . . . . . . . . . . . . . 41

Fed. R. Civ. P. 24(c) . . . . . . . . . . . . . . . . . . . . . . . . 41

*New Vision Home Health Care, Inc.*,
ALJ Appeal No. 1-909 525621
(Dep't Health & Human Serv.,
Ofc. of Medicare App. Hearings,
Decision dated Sept. 4, 2013) . . . . . . . . . . . 14

## GLOSSARY

| | |
|---|---|
| ALJ - | Administrative Law Judge, in this case one appointed within the Office of Medicare Hearings and Appeals of the U.S. Department of Health and Human Services. An ALJ hearing is the third stage of the Medicare Appeals Process. |
| AQIC - | Administrative Qualified Independent Contractor. A private business entity contracted by CMS to provide administrative, training, and case management support to QICs. |
| CMS - | The Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services. |
| MAC - | Medicare Administrative Contractor. A private business entity contracting with CMS to provide administrative and claims processing services on a regional basis. (Note: this acronym is commonly used by the government to refer to the Medicare Appeals Council, as well. In this petition the designation "MAC2" or "Big MAC" is used to refer to the Medicare Appeals Council.) |
| MAC2 - | The Medicare Appeals Council (sometimes referred to below as the |

"Big MAC"). Review before the MAC2 is the fourth stage in the Medicare Appeals Process.

MAP - Medicare Appeals Process. A four stage process established by CMS for a Medicare provider to appeal denied claims.

NGS - National Government Services, Inc. A private contractor of CMS which was the original MAC for the state of Michigan in the underlying audit. It was a wholly owned subsidiary of Anthem, Inc.

MPIM - Medicare Program Integrity Manual. A manual adopted by CMS containing regulations and standards that apply to Medicare contractors such as MACs and ZPICs.

OMHA - Office of Medicare Hearings and Appeals, a division of the U.S. Department of Health and Human Services.

QIC - Qualified Independent Contractor. Review by a Qualified Independent Contractor is the second step in the Medicare Appeals Process.

Respondents- The Respondents in this matter are Anthem, Inc. ("Anthem"), National Government Services, Inc. ("NGS"), and TrustSolutions, LLC ("TrustSolutions"), private business entities contracting with CMS.

ZPIC - Zone Program Integrity Contractor. A private contractor which has as its primary purpose independently auditing Medicare providers for overpayments.

## PETITION FOR WRIT OF CERTIORARI

New Vision Home Health Care, Inc. ("New Vision"), and Mr. Saleem Shakoor ("Mr. Shakoor"), respectfully petition for a writ of certiorari to review the decision of the United States Court of Appeals for the Sixth Circuit in this case.

## OPINIONS BELOW

The decision of the Sixth Circuit Court of Appeals is *New Vision Home Health Care, Inc. v. Anthem, Inc.*, 2018 U.S. App. LEXIS 27993 (6th Cir. Oct. 3, 2018). A copy is attached as Appendix A (Pet. App. p.A-1). The Sixth Circuit Court of Appeals denied New Vision Home Health Care, Inc.'s petition for rehearing and rehearing *en banc* on December 6, 2018. That decision denying the petition for rehearing and rehearing *en banc* is attached as Appendix B (Pet. App. p.A-25).

## JURISDICTION

New Vision Home Health Care, Inc.'s petition for rehearing to the Sixth Circuit Court of Appeals was denied on December 6, 2018. New Vision Home Health Care, Inc., invokes this Court's jurisdiction under 28 U.S.C. § 1254(1), having timely filed this petition for a writ of certiorari within ninety (90) days of the Sixth Circuit Court of Appeals' judgment, given that the United States Attorney represents the

independent, for-profit contractor Respondents.

## STATUTORY PROVISIONS INVOLVED

Relevant portions of the Medicare and Social Security statutes, specifically 42 U.S.C. § 1395ff and 42 U.S.C. § 405(h), as well as 28 U.S.C. § 1361.

## STATEMENT

This case concerns the ability of federal judges to issue mandamus relief in order to enforce a Medicare ALJ's binding decision.

### I. The Administration of Medicare and the Medicare Appeals Process

The Department of Health and Human Services ("DHHS") administers the Medicare program through the Centers for Medicare and Medicaid Services ("CMS"). CMS, in turn, contracts with private entities known as Medicare Administrative Contractors ("MACs") that "act on behalf of CMS in carrying out certain administrative responsibilities." 42 C.F.R. § 421.5(b). As relevant here, CMS contracts with MACs to determine the first instance "the amount of the payments required pursuant to [the Medicare Act] to be made to providers of services. 42 U.S.C. § 1295kk-1(a)(4)(A). Such contractors, like CMS's own personnel, are "required to follow Federal laws,

regulations and [CMS] manual instructions when performing functions on behalf of CMS. 74 Fed. Reg. 65,296, 65,312 (Dec. 9, 2009).

Medicare has a highly structured appeals process for review of denied Medicare claims. The appeals process consists of four (4) steps:

1. **First Step.** If a claim submitted by a Medicare provider is denied (in whole or in part), the Medicare provider may appeal the denial to the MAC (in this case, for New Vision it was NGS). The first appeal is called a "request for redetermination." The request for redetermination is submitted to the MAC that originally denied the claim or demanded the refund of the alleged overpayment amount.

2. **Second Step.** If a claim is denied (in whole or in part) by the MAC upon its redetermination, the Medicare provider may then appeal the decision to a Qualified Independent Contractor ("QIC") (in this case, for New Vision it was Maximus), which is supposed to be a separate, independent entity contracted by CMS for that purpose. This second appeal is called "a request for reconsideration."

3. **Third Step.** If the claim is denied (in whole or in part) by the QIC upon the reconsideration, the Medicare provider may then appeal the decision further by requesting a formal administrative hearing before an ALJ of the DHHS' Office of Medicare Hearings and Appeals ("OMHA"). The ALJ's decision

is final unless any party requests further review by the Medicare Appeals Council within sixty (60) days. 42 C.F.R. § 405.1048.

4. **Fourth Step.** If any party to the ALJ hearing is dissatisfied with the decision of the ALJ that is issued after the hearing, then that party may appeal the case to the Medicare Appeals Council within sixty (60) days. After this period of time has passed with no appeal, the ALJ's decision becomes final. 42 C.F.R. § 405.1048. An organization called the Departmental Appeal Board manages and acts for the Medicare Appeals Council.

## II. History of this Case

### A. Petitioners Exhausted the Medicare Appeals Process

This case has been more than a decade in the making. A chronology of New Vision and Mr. Shakoor's long and complicated history within the Medicare appeals process, extending more than ten (10) years, is included in Section II.C., below.

Petitioners went through a complete ALJ hearing (the third level), then an appeal before the Medicare Appeals Council (the fourth level), and then another complete ALJ hearing (again, the third level).

The first ALJ hearing was in Petitioners' favor, but Respondents appealed it to the Medicare Appeals

Council. The Council remanded the case back for another ALJ hearing, which was, again, decided in Petitioners' favor. Pet. App. D; p.A-53. Following the second favorable ALJ decision, Respondents declined to appeal the case further. Respondents' declination of any further appeal rendered the second ALJ decision final agency action and binding on all parties. Petitioners, prevailing on more than 99% of the disputed claims, were satisfied with the result and also declined to appeal. After all, Petitioners had just successfully overturned $4 million dollars in an unlawful overpayment claim and had no logical or practical reason appeal further.

### B. Specific Findings of Respondents' Misconduct by the Medicare ALJ

The broadest picture of the case can be summarized as follows. Respondents subjected Petitioners to some of the most egregious bureaucratic misconduct, obfuscation, and due process deprivations possible. Claims were denied for knowingly illegitimate reasons. Crucial dispositive documents were withheld. Respondents knowingly committed Freedom of Information Act violations. Respondents engaged in intentionally false and misleading statistical extrapolation. Then, when Petitioners were finally successful, Respondents refused to abide by the ALJ's order and continued to recoup an overpayment that it knew was invalid. The disgust and disillusionment felt by Petitioners was shared by ALJ O'Leary, the final presiding Medicare judge. ALJ O'Leary's reduction of the more than $4 million

"overpayment" to nearly zero, a 99% reduction, was accompanied by scathing criticism of Respondents' conduct. See Pet. App. D; p.A-53. ALJ O'Leary's order contained numerous findings against the Respondents. The gist of these can be seen in the following headings; which were then explained in the order:

- "Problems both large and small, both technical and substantive";
- "Claim lines at issue not clearly defined . . . ";
- "Claim lines clearly omitted from QIC review . . .";
- "Substantive and evidentiary issues with the reconsideration decisions";
- "Citations to evidence not in the appeal record";
- "Citations to data files not in record and withheld from [Appellants] despite FOIA requests";
- "False or misleading characterizations in the Maximus [another government contractor] reconsideration decisions";
- "Intentional misrepresentations"; and
- "Fallacies of logic"

Pet. App. D; p.A-53.

Further, Judge O'Leary found that Respondents:

- failed to include mandatory elements;
- did not use due care;
- did not demonstrate even substantial compliance;
- the documents lack the legitimacy, integrity, and credibility to prove a sizable debt;
- failed to comply with CMS guidance in the MFMM and with the generally accepted government auditing standards;
- were far less than forthcoming;
- provided evasive FOIA [Freedom of Information Act] responses;
- failed to comply with the ethical guidelines and with generally accepted statistical practice and procedures;
- failed to faithfully execute their obligation to safeguard Petitioners' due process rights;

- undermined the integrity of the appellate process and violated the principles of fairness;

- knowingly committed breaches of the Medicare Program Integrity Manual (MPIM) rules;

- did not respond to FOIA requests;

- flagrantly disregarded MPIM guidance as well as generally accepted government auditing standards as well as statistical practice and procedures; and

- demonstrated a lack of adherence to CMS guidance and professional standards.

Pet. App. D; p.A-53.

Perhaps Judge O'Leary best summarized his findings with respect to Respondents' misconduct as follows:

> the lack of responsiveness of various Medicare entities documented herein paint a picture of bureaucratic delay and obstruction, which is prejudicial to providers with millions of dollars at stake who have to meet fixed deadlines for

filing appeals, despite being deprived of an accounting sufficient to show the accuracy of the calculated overpayment.

Pet. App. D; p.A-53.

### C. Procedural History/Chronology

| Date | Event |
|---|---|
| Jul. 31, 2007 | TrustSolutions, the Zone Program Integrity Contractor ("ZPIC"), issued an audit letter to New Vision (Petitioner/ Plaintiff) initiating a post-payment review (audit) requesting medical records, on Medicare claims reimbursed from January 1, 2004, to December 10, 2006, related to services New Vision provided to 186 Medicare beneficiaries regarding 228 episodes of home health care (dates of service or "DOS") from May 8, 2003, through October 3, 2006. |
| Sep. 2007 | Petitioner New Vision submitted the information and documents requested. |

| | |
|---|---|
| Aug. 14, 2008 | Respondent TrustSolutions denied approximately ninety percent (90%) of the claims previously paid. TrustSolutions then used a statistical extrapolation formula and issued a decision determining that an overpayment of more than $4,000,000 had been made to Petitioner New Vision. |
| Dec. 2009 | Although New Vision requested it, Respondents TrustSolutions and NGS failed to provide New Vision with any information regarding the statistical sampling and extrapolation methodologies or calculations used. |
| Dec. 30, 2009 | Petitioner New Vision received an audit demand letter from NGS to repay the purported $4,155,239.00 overpayment, as determined by TrustSolutions. |
| Jan. 24, 2010 | New Vision timely filed an administrative appeal with NGS of NGS's overpayment determination ("Redetermination Appeal"), the first step in the Medicare Appeals Process. |
| Mar. 2, 2010 | New Vision submitted a Freedom of Information Act ("FOIA") Request to TrustSolutions to obtain information regarding the statistical projection used to calculate the $4,155,239.00 overpayment. |

| | |
|---|---|
| Mar. 17, 2010 | NGS upheld nearly all of TrustSolution's initial determinations on the redetermination appeal. |
| May 24, 2010 | Petitioner New Vision timely filed an administrative appeal with Maximus Federal Services ("Maximus") (the Qualified Independent Contractor or "QIC"), appealing NGS's redetermination findings (the "Reconsideration Appeal"), the second level of the Medicare Appeals Process ("MAP"). |
| July 23, 2010 | Maximus issued a "partially favorable" reconsideration decision which again upheld essentially all of Respondent NGS's redetermination findings in their entirety. |
| Aug. 19, 2010 | New Vision submitted its eleventh (11) FOIA Request to CMS and its contractors, including TrustSolutions, NGS, and Maximus, for information and documents regarding the statistical extrapolation. No response to this or prior requests was ever received. |

| | |
|---|---|
| Sep. 3, 2010 | Maximus supplied encrypted case file information to New Vision allegedly containing information responsive to New Vision's request for statistical information, however, said CDs were provided with inoperative passwords and, most importantly, missing the three (3) statistical data files relied upon by the QIC's statistician and Maximus as authority for upholding the statistical extrapolation at the reconsideration stage of the appeal. |
| Sep. 14, 2010 | Petitioner New Vision timely appealed the QIC's reconsideration decision, requesting a formal Administrative Law Judge ("ALJ") hearing before an Office of Medicare Hearings and Appeals ("OMHA"), the third stage of the Medicare Appeals Process. |
| Oct. 2010 | NGS began recoupment against New Vision on the alleged extrapolated overpayment, **approving** its claims made after 2007, but withholding the actual payments in order to offset the alleged $4,155,239.00 overpayment. (Note: This continued through New Vision's going out of business in 2016. |
| Nov. 16, 2010 | The ALJ issued an order of remand, remanding the case to the QIC (Maximus) for clarification as to its disposition on individual claims. |

| | |
|---|---|
| Nov. 24, 2010 | TrustSolutions supplied New Vision with the statistical sampling and extrapolation methodology which New Vision had never previously seen. |
| Dec. 30, 2010 | Maximus (the QIC) issued its second "partially favorable" reconsideration decision which again, upheld virtually all of NGS's redetermination findings in their entirety against New Vision. |
| Feb. 9, 2011 | New Vision filed its second request for a formal ALJ hearing (the third level of the Medicare Appeals Process), which was assigned to ALJ James S. O'Leary. |
| Oct. 18, 2011 | After a full hearing on this matter, ALJ O'Leary issued a fully favorable determination **in favor of** Petitioner New Vision, completely overturning both TrustSolutions's extrapolated overpayment determination of $4,155,239.00 and TrustSolutions's determination of actual overpayments of $672,493.57. |
| Dec. 14, 2011 | Q2A Administrators, LLC, the Administrative Qualified Independent Contractor (AQIC), appealed the ALJ's decision to the Departmental Appeals Board of the Medicare Appeals Council ("Big MAC"), the fourth step of the Medicare Appeals Process. |

| | |
|---|---|
| Feb. 8, 2012 | The Big MAC issued a decision finding that an error by the ALJ denied the government due process of law [sic] in the hearing, reversed the ALJ's decision and remanded the case to ALJ O'Leary for a new ALJ hearing. |
| Sep. 4, 2013 | In a decision issued after another formal ALJ hearing ALJ O'Leary again ruled **in favor of** Petitioner New Vision and overturned TrustSolutions's entire statistical sampling and overpayment determination, upholding the denial of only a small fraction of TrustSolutions's post-payment audit of 228 sampled claims. This decision, the third step in the Medicare Appeals Process, was favorable to New Vision and held valid over 99% of the Medicare claims submitted by New Vision. *New Vision Home Health Care, Inc.*, ALJ Appeal No. 1-909 525621 (Dep't Health & Human Serv., Ofc. of Medicare App. Hearings, Sept. 4, 2013); Pet. App. D; p.A-53. |
| Oct.-Nov. 2013 | No party appealed the ALJ's decision to the Medicare Appeals Council ("Big MAC"), thus making it "binding on all parties." 42 C.F.R. § 405.1048. |

| | |
|---|---|
| Sep. 2013-present | TrustSolutions and NGS continued to recoup Medicare reimbursements from New Vision to satisfy the audit findings reversed by the ALJ. Well over $200,000 has been withheld/recouped; none has been refunded to New Vision. |
| Sep. 1, 2016 | Petitioner New Vision filed suit in the U.S. District Court for the Eastern District of Michigan against Respondents, all private contractors, requesting mandamus relief, and collateral claims for negligence, gross negligence, tortious interference, deprivation of procedural due process, declaratory judgment, and injunction. |
| Aug. 28, 2017 | Judge Roberts reversed her earlier denial of Respondents' Motion to Dismiss for lack of jurisdiction following a request for reconsideration filed by the U.S. Attorney. |
| Sep. 27, 2017 | Petitioners filed an appeal with the United States Court of Appeals for the Sixth Circuit. |
| Oct. 3, 2018 | The United States Court of Appeals for the Sixth Circuit issues its decision affirming the District Court's dismissal of the case for lack of subject matter jurisdiction. Pet. App. A; p.A-1. |

| | |
|---|---|
| Nov. 16, 2018 | Petitioners filed a Petition for Rehearing En Banc, with an Amended Petition following on November 19, 2018. Pet. App. H; p.A-218. |
| Dec. 6, 2018 | The United States Court of Appeals for the Sixth Circuit entered an Order denying the Amended Petition for Rehearing. Pet. App. E; p.A-85. |

### D. Summary of Grounds for Dismissal of the Second Amended Complaint by the U.S. District Court

The chronology, and corresponding order by ALJ James S. O'Leary, show that New Vision and Mr. Shakoor successfully appealed their denied claims and were entitled to over $4 million in Medicare reimbursements. Pet. App. D. ALJ O'Leary's September 4, 2013, order constitutes final agency action on behalf of CMS since the order was not appealed to the Medicare Appeals Council. However, TrustSolutions and NGS continued to recoup payments from Petitioners to satisfy the overturned judgment. The recoupment continued until New Vision was forced to go out of business.

Petitioners suit requested mandamus enforcement of ALJ O'Leary's order in the United States District Court for the Eastern District of Michigan South Division before Judge Victoria A. Roberts. Pet. App. F; p.A-88. In addition to the counts for mandamus, Petitioners pleaded collateral claims

for common law torts like negligence, and violations of their constitutional due process rights.

Initially, District Judge Roberts denied Respondents' Motion to Dismiss the Second Amended Complaint. However, following Respondent's request for reconsideration, the District Court completely reversed its findings and, on August 28, 2017, Judge Roberts dismissed Petitioners' case for lack of jurisdiction stating:

> Because the Court finds New Vision did not fully exhaust administrative remedies for Counts I and II, it does not meet the first requirement for a writ of mandamus.

Pet. App. B; p.A-39. Additionally, the District Court found that Respondents did not owe Petitioners a "clear non-discretionary duty."

With respect to the collateral tort and due process claims, Judge Roberts reasoned that because Petitioners did not appeal ALJ O'Leary's order to the Medicare Appeals Council, Petitioners had not fully exhausted their administrative remedies. The District Court reached that decision even though all of the elements for each of those claims, and, in the case of the negligence and due process claims, the entire substantive claim, were expressly found by the ALJ O'Leary in his 300-plus page Order. Pet. App. D.

## REASONS FOR GRANTING THIS PETITION

Home healthcare is a multi-billion dollar industry largely driven by Medicare reimbursement. It is a matter of great public importance that providers are appropriately reimbursed by MACs, and that those MACs abide by the rules and regulations governing Medicare reimbursement. Without timely and fair reimbursement from Medicare, Medicaid, and Tricare, a vast majority of home healthcare providers will be forced out of business.

It is also a matter of great public importance that MACs adhere to orders from Medicare ALJs. The ALJs are the objective referees for an incredibly complicated and draconian system of appeals. If MACs are allowed to continue to audit in bad faith and to recoup payments made on valid claims despite having an order from an ALJ that directs them to do the exact opposite, then the four-step Medicare appeals process is entirely devoid of merit and only exists to insulate MACs from responsibility. Without the ability to take MACs and other contractors to task in the federal courts, there is no substantive process through which an aggrieved provider like Petitioners can challenge the MACs' unlawful behavior.

The Sixth Circuit's decision significantly impairs, if not entirely prevents, the ability of home healthcare providers to obtain judicial relief. The Sixth Circuit's decision leaves home healthcare providers without any means of enforcing their rights even with a favorable order from an ALJ. Just with

respect to the Medicare recoupments issue, the decision below affects billions of dollars in Medicare funding. This Court's review is therefore warranted.

## I. The Decision below Creates a Circuit Split Between the Fifth and Sixth Circuits Regarding Whether Courts Have Mandamus Jurisdiction to Enforce a Medicare ALJ's Order

The Sixth Circuit found that Petitioners did not exhaust their administrative remedies because Petitioners did not appeal a favorable ALJ order to the Medicare Appeals Council. Pet. App. A; p.A-1. This directly contradicts the Fifth Circuit's holding in *Wolcott v. Sebellius*, 635 F.3d 757 (5th Cir. 2011), and *Family Rehab, Inc. v. Azar*, 886 F.3d 496 (5th Cir. 2018) which held that an ALJ's order, which is not appealed by either party, is an appropriate basis upon which to issue mandamus relief. This is because the ALJ's order is considered binding on all parties, unless it is appealed to the Medicare Appeals Council. 42 C.F.R. § 405.1048.

In its Second Amended Complaint and on appeal, Petitioners argued that the Medicare ALJ issued an order directing Respondents to pay all claims that were previously denied. Petitioners further argued such a directive is fodder for mandamus relief should the government and its contractors fail to comply. Pet. App. F; p.A-88. After all, 28 U.S.C. § 1361 grants mandamus jurisdiction to the district courts. The federal appellate circuits have

further held that 28 U.S.C. § 1361 jurisdiction is not precluded by 42 U.S.C. § 405(h). *See Family Rehab., Inc.*, 886 F.3d at 505; *Wolcott v. Sebelius*, 635 F.3d 757, 764-65 (5th Cir. 2011).

Further, 28 U.S.C. § 1361 exists to grant review to "otherwise unreviewable procedural issues." *Family Rehab., Inc.*, 886 F.3 at 505. The Medicare appeals process, in contrast, exists to review claims adjudications rendered by Medicare and its private Medicare Administrative Contractors ("MACs"). The appeals process' purpose is to determine what claims should be paid and in what amounts. If the question presented by Petitioners does not relate to entitlement to Medicare payments or the amount of payment, it is "unreviewable" by the appeals process.

Petitioners asked the Sixth Circuit to find that Respondents' failure to pay claims that had been fully adjudicated through the appeals process was subject to mandamus relief. Instead, the Sixth Circuit inexplicably held that mandamus jurisdiction did not exist because Petitioners had not yet exhausted their administrative remedies. Pet. App. A; p.A-1. The reasoning for that conclusion being primarily that the ALJ decision was not the "Secretary's final decision" and was, instead, only "binding on the parties." Pet. App. A; p.A-1. It strains credulity to think that an ALJ, who is employed by the agency, can render a decision that is "binding" but not "final." Such a line of reasoning is akin to saying a District Court's (or a U.S. Circuit Court's) ruling is not final until the U.S. Supreme Court decides it.

The Sixth Circuit's decision on the merits is in direct conflict with the Fifth Circuit in *Family Rehab., Inc.*, which explicitly found that exhaustion is not a prerequisite for mandamus relief. The Fifth Circuit held: "To say that exhaustion is a jurisdictional requirement would only further conflate jurisdiction with the merits." *Family Rehab., Inc.*, 886 F.3d at 506. The law in the Fifth Circuit cleaves cleanly from the apparent law in the Sixth Circuit when the Fifth Circuit opined that "mandamus jurisdiction lies wherever a plaintiff seeks to 'compel an officer . . . to perform an allegedly non-discretionary duty owed to the plaintiff.'" *Id.* (quoting *Wolcott*, 635 F.3d at 763).

As such, the ALJ's order constitutes "final agency action" and should be considered to be the final decision of the Secretary of Health and Human Services. An ALJ's order demonstrates that plaintiff healthcare providers have a clear right to relief, the defendant MACs have a clear duty to act, and there is no adequate alternative remedy available. The Fifth Circuit in *Wolcott* determined that federal courts do, in fact, have mandamus jurisdiction when presiding over cases that deal with Medicare ALJ's orders. *Wolcott*, 635 F.3d at 763-766.

In departing from the holdings in *Wolcott* and *Family Rehab*, the Sixth Circuit fell prey to exactly what the Fifth Circuit warned against when it said:

> We have cautioned to "avoid tackling the merits under the ruse of assessing

> jurisdiction." *Wolcott*, 635 F. 3d at 763 (quoting *Jones v. Alexander*, 609 F.2d 778, 781 (5th Cir. 1980)). To say that exhaustion is a jurisdictional requirement would only further conflate jurisdiction with the merits. . . . For such requests, mandamus is plainly the "appropriate means of relief," and jurisdiction may obtain. *Jones*, 609 F.2d at 781.

*Family Rehab, Inc.*, 886 F.3d at 506.

If anything, Petitioners have a stronger argument for mandamus relief than those who sought it in *Family Rehab, Inc.*, or *Wolcott* because Petitioners actually did exhaust their administrative remedies and obtained a final order from the agency.

Where all administrative remedies have been exhausted, and an aggrieved party seeks the enforcement of final agency action, jurisdiction is mandatory under 5 U.S.C. § 704 and *Darby v. Cisneros*, 509 U.S. 137, 125 L. Ed. 2d 113, 113 S. Ct. 2539 (1993); *Kelsey Mem'l Hosp. v. Shalala*, 1998 U.S. Dist. LEXIS 10924, 3-7 (W.D. Mich. June 26, 1998)(citing *Manakee Prof'l Med. Transfer Svc., Inc. v. Shalala*, 71 F.3d 574, 580-82 (6th Cir. 1995)).

Petitioners sought to enforce the payment of claims that were already deemed improperly denied by the decision of the agency ALJ. The ALJ's order was final agency action pursuant to 42 C.F.R. § 405.1048 and Petitioners were entitled to mandamus relief for its enforcement.

## II. The Decision below Creates a Circuit Split Between the Fifth and Sixth Circuits Regarding Jurisdiction over Collateral Claims under 42 U.S.C. § 405(g)

Petitioners in this matter filed multiple claims (Claims III - VIII of the Second Amended Complaint) that were specific to the misconduct of the Medicare contractors which misconduct was outside of the scope of the authority delegated to them by the agency and was unlawful. These claims included negligence, gross negligence, tortious interference with business relationships and expectations, procedural due process violations, and others. Pet. App. F; p.A-88. The Sixth Circuit affirmed the District Court's dismissal of Petitioners' collateral claims by claiming that Petitioners failed to satisfy the presentment and exhaustion requirements of 42 U.S.C. § 405. Specifically, the Sixth Circuit held the federal courts lacked subject-matter jurisdiction by finding that Petitioners had not exhausted their administrative remedies. 42 U.S.C. § 405(g). Such a holding necessarily meant the Sixth Circuit did not consider Counts III-VIII of the Second Amended Complaint to be "collateral claims." Pet. App. A; p.A-1.

### A. The Sixth Circuit's Failure to Identify Petitioners' Tort and Due Process Claims as Collateral Claims in the Present Case

The Sixth Circuit acknowledged 42 U.S.C. § 405 "prescribes a process for review of administrative decisions," but it failed to recognize Petitioners sought review of tortious conduct and due process violations committed by the Medicare contractors, not a review of any aspect of the final agency decision wrought by the four-step Medicare appeals process.

The Sixth Circuit based its holding exclusively on its earlier decision, *Southern Rehab. Group, P.L.L.C. v. Sec'y of HHS*, 732 F.3d 670 (6th Cir. 2013).

The basic holding was that Petitioners' claims for negligence, gross negligence, tortious interference with business relationships and expectancies, violation of right to procedural due process, declaratory judgment, and injunction should have been brought before the Medicare ALJ and carried forward until the bitter end of the Medicare appeals process. Specifically, the Sixth Circuit opined:

> Under *Southern Rehab.*, therefore, New Vision was required to exhaust its administrative remedies with regard to all of its claims in Counts III-VIII arising under the Medicare statute.

Pet. App. A; p.A-20. The Sixth Circuit continued its analysis of *Southern Rehab.* stating:

> we found that the state-law and federal constitutional claims were 'inextricably intertwined with the claim for review of the Secretary's decision' and must, like claims for review, 'be presented to the agency.'

*Id.* (quoting *Southern Rehab.*, 732 F.3d at 680.

It is undisputed that Petitioners could not obtain any relief for the unlawful conduct of Respondents during the appeals process other than as a contributing factor in determining whether or not to overturn Respondents' denial of their claims for reimbursement. *See Bodimetric Health Servs., Inc. v. Aetna Life & Casualty*, 903 F.2d 480, 486 (7th Cir. 1990). However, such consideration of Respondents' unlawful conduct is merely secondary to the ultimate issue and does not actually provide any substantive relief for Respondents' gross misconduct.

Where the Sixth Circuit's analysis failed, and where the circuit split arises, is in the court's refusal to address whether or not Counts III-VIII of the Second Amended Complaint were collateral. Surprisingly, the word "collateral" does not even appear in the Sixth Circuit's opinion. Nevertheless, the Sixth Circuit seems to have accidentally found the

claims to be collateral but failed to appreciate its own astute observations. In analyzing Petitioners' presentment arguments, the court stated:

> However, the district court found, and we agree, that whatever the ALJ may have determined about [Respondents'] actions, those determinations did not affect the substance of its order . . . The ALJ order simply found [Respondents] had made calculation mistakes and had overestimated the overpayments to [Petitioners]. **This conclusion would have been the same regardless of whether [Respondents] had acted from sterling motives or had been grossly negligent.**

Pet. App. A; p.A-22 (emphasis added).

Finding that whether or not Respondents had acted with mordancy or morality was of no consequence to the ALJs determination is the very essence of a collateral claim. If the conduct had nothing to do with whether or not the claims submitted by Petitioners were valid, then they cannot,

by definition, arise under the Medicare Act. *See Bowen v. City of New York*, 476 U.S. 467, 473-74, 106 S. Ct. 2022, 90 L. Ed. 2d 462 (1986). As Justice Breyer observed in *Shalala v. Ill. Council on Long Term Care*, 529 U.S. 1, 19 (2000), the channeling requirements of the Medicare Act do not require application of 42 U.S.C. § 405(h) where such a course "would not simply channel review through the agency, but would mean no review at all." *Id.* Forcing Petitioners to litigate tort and due process claims before an agency ALJ who is powerless to grant substantive relief thereon is just the kind of "no review at all" about which Justice Breyer warned.

### B. The Fifth Circuit's Analysis of Collateral Claims

The Fifth Circuit, in contrast, came to the opposite conclusion when assessing whether a claim is collateral. That circuit based its analysis on *Mathews v. Eldridge* and stated:

> There, the Court held that jurisdiction may lie over claims (a) that are "entirely collateral" to a substantive agency decision and (b) for which "full relief cannot be obtained at a post-deprivation hearing."

*Family Rehab, Inc.,* 886 F.3d at 501 (quoting *Mathews v. Eldridge*, 424 U.S. 319, at 330 (1976)). The Fifth

Circuit continued by stating:

> "when a plaintiff asserts a collateral challenge that cannot be remedied after the exhaustion of administrative review," courts shall deem exhaustion waived.

*Id.* (quoting *Affiliated Prof'l Home Health Care Agency v. Shalala*, 164 F.3d 282, 285 (5th Cir. 1999)). In the Fifth Circuit then, litigants are not going to be required to bring claims through the Medicare appeals process which are essentially dead on arrival for no other reason than to "check the box" of presentment and exhaustion. The Sixth Circuit, by contrast, would require those litigants to bring the same claims through the byzantine Medicare appeals process waiting years and spending untold resources fighting a battle that it knows it cannot win. It is also interesting to note that if an injured party is represented by counsel, the Sixth Circuit would have that attorney violate her oath as an officer of the court and bring a claim it knows is unremediable, in direct violation of the Federal Rules of Civil Procedure. *See* Fed. R. Civ. P. 11.

From the Fifth Circuit's perspective, collateral claims are those that do not require the reviewing court to "immerse itself" in the substance of the underlying claims for reimbursement from the Medicare program, nor do they portend a "factual

determination" related to the applicable provisions of the Medicare Act. *Affiliated Prof'l*, 164 F.3d at 285-86. In addition, the claim cannot request relief that would be "administrative," meaning it cannot be substantive, permanent relief that the plaintiff seeks or should seek through the agency appeals process. As determined in *Mathews*, the claim must seek some form of relief that would be unavailable through the administrative process. *Mathews v. Eldridge*, 424 U.S. at 330-32.

In this context, the Fifth Circuit analyzed *Heckler v. Ringer*, 466 U.S. 602, 104 S. Ct. 2013, 80 L. Ed. 2d 622 (1984) and found that in *Heckler* the plaintiffs:

> sought a declaration that HHS's policy was unlawful and that certain claims were reimbursable under the Medicare Act. That, the Court reasoned, was nothing more than "a claim that they should be paid" for certain procedures; as such, the claim was "inextricably intertwined" with [their] claims for benefits under the administrative process. Even though the plaintiffs had alleged certain procedural claims, the relief they sought from those

> claims was still substantive.

*Family Rehab, Inc.,* 886 F.3d at 502 (quoting *Heckler v. Ringer*, 466 U.S. at 610). The Fifth Circuit summarized these findings further by saying:

> If the court must examine the merits of the underlying dispute, delve into the statute and regulations, or make independent judgments as to plaintiffs' eligibility under a statute, the claim is not collateral. [...] And if plaintiffs request relief that is proper under the organic statute—by requesting that benefits or a provider status be permanently reinstated—the claim is not collateral

*Family Rehab, Inc.,* 886 F.3d at 502.

Just like in *Family Rehab.*, Petitioners' procedural due process and *ultra vires* claims do not require a reviewing court "to wade into the Medicare Act or regulations." *Id.* at 11. But unlike in *Family Rehab.,* Petitioners have already been forced to cease their business operations which resulted in irreparable injury to themselves, employees, and patients. As the

Fifth Circuit has said, "[t]he combined threats of going out of business and disruption to Medicare patients are sufficient for irreparable injury." *Id.*

Due to the nature of Family Rehab's collateral claims and threat of irreparable injury, the Fifth Circuit determined that the court had jurisdiction to hear Family Rehab's collateral claims. Given that Petitioners' circumstances closely mirror Family Rehab's, it stands to reason that the Fifth Circuit would have granted Petitioners' the relief they sought where the Sixth Circuit did not.

Petitioners' Counts III-VIII are entirely collateral to their claims for payment. Medicare ALJs are not authorized to award damages or make constitutional determinations, they can only approve or deny claims for reimbursement. Consequently, Petitioners' claims in Counts III-VIII cannot be substantively satisfied through the authority of a Medicare ALJ. In addition, Petitioners' claims in Counts III-VIII have nothing to do with the merits of denial of a Medicare claim and are only concerned with the course of conduct taken by Respondents.

In *Family Rehab,* the Fifth Circuit found that, "because [Family Rehab] raises claims unrelated to the merits of the recoupment, its [due process] claims are collateral." *Family Rehab., Inc.,* 886 F.3d at 503. Similarly, Petitioners' claims in Counts III-VIII for negligence, gross negligence, tortious interference with business relationships and expectancies, violation of right to procedural due process, declaratory judgment,

and injunction are based in whole or in part on Petitioners' due process rights and, therefore, are collateral claims.

Petitioners' claims in Counts III-VIII are entirely separate from the adjudication of the Medicare claims in the underlying audit. Just as the Sixth Circuit held, Respondents' misconduct had no bearing on the substantive determinations vis-a-vis Petitioners' Medicare claims. Counts III-VIII only have to do with Appellee contractors' bad faith conduct during the process of the audit. Counts III-VIII do not arise out of the adjudication of the Medicare claims and would still be ripe for review even if the ALJ issued an adverse decision against Petitioners. These claims do not arise under the Medicare Act. Instead, they stand separately and apart from New Vision's claim for payment. As such, and according to the Fifth Circuit, New Vision's claims in Counts III-VIII are collateral claims, yet the very same constellation of facts, when presented to the Sixth Circuit, resulted in a finding that the claims are not collateral.

While 42 U.S.C. §405(g) creates an exception to the immunity of Medicare and its contractors, it is not the only exception to immunity with regard to Medicare contractors. Petitioners, in their pleadings, alleged that the contractors should lose immunity for acting outside of the course and scope of their duties as contractors and agents of the government. However, the court never reached the substantive issue of immunity because it incorrectly applied the jurisdictional requirements of 42 U.S.C. §405 to these

claims.

### C. The Sixth Circuit's Reasoning in the Present Case is Contrary to Established Supreme Court Precedent and the Explicit Intent of the Applicable Statutory and Regulatory Provisions

Both this case and the *Southern Rehab.* decision reflect an incorrect application by the Sixth Circuit of the Supreme Court's limitation of the "Michigan Academy" exception as set forth in *Illinois Council*, 529 U.S. at 15-20. In *Illinois Council*, the Supreme Court held that the "Michigan Academy" exception would apply only "where application of §405(h) . . . would mean no review at all." *Illinois Council*, 529 U.S. at 19. In the present case, the Sixth Circuit misapplied the limitation as it relates to Petitioners' tort claims which are not appealable and therefore, if forced to go through the Medicare appeals process, would result in "no review at all."

The Sixth Circuit's insistence that the state law claims could have been brought through the Medicare appeals process represents a fundamental misunderstanding of the Medicare appeals process and creates a dangerous precedent for health care providers who will have no recourse against gross negligence or intentional misconduct by Medicare administrative contractors, private, for-profit entities.

42 C.F.R. § 405.900(b) sets forth the scope of the Medicare appeals process and states

> Scope. This subpart establishes the requirements for appeals of initial determination for benefits under Part A or Part B of Medicare including the following:
>
> (1) The initial determination of whether an individual is entitled to benefits under Part A or Part B. (Regulations governing reconsideration of these initial determinations at 20 CFR part 404, subpart J).
>
> (2) The initial determination of the amount of benefits available to an individual under Part A or Part B.
>
> (3) Any other initial determination relating to a claim for benefits under Part A or Part B, including an initial determination made by a quality

> improvement organization under section 1154(a)(2) of the Act or by an entity under contract with the Secretary (other than a contract under section 1852 of the Act) to administer provisions of titles XVIII or XI of the Act.

42 C.F.R. § 405.900(b).

Initial determination is further defined in 42 C.F.R. § 405.904(a). Specifically, 42 C.F.R. § 405.904(a) limits "initial determinations" to two types of appeals: (1) entitlement appeals and (2) claims appeals. The misconduct of the Medicare contractors giving rise to the negligence, tortious interference, and due process claims in this matter is not limited to a specific Medicare claim, does not meet the definition of "an initial determination", and could not be remedied through the Medicare appeals process.

42 C.F.R. § 405.944 is the first level of appeal and sets forth the manner in which a redetermination may be requested. This level further demonstrates the inapplicability to the tort claims. A request for redetermination must include a specific beneficiary's name, the HICN number, the specific services or items at issue and the specific dates of service. *See* 42 C.F.R. § 405.944. Again, the conduct that gives rise to the tortious claims does not fall within this narrow scope. Petitioners were able to appeal the claims (which were

decided in their favor by the ALJ) but this process did not allow a determination related to Respondents' unlawful and tortious conduct. The overturning of claims does not always make a provider or beneficiary whole and the process does not allow providers to challenge the contractors' actions and immunity.

The Fifth Circuit, however, determined that courts do have subject-matter jurisdiction when assessing collateral claims after a plaintiff has brought the action to federal court after obtaining final agency action. "When a plaintiff asserts a collateral challenge that cannot be remedied after the exhaustion of administrative review," courts shall deem exhaustion waived. *Family Rehab., Inc. v. Azar*, 886 F.3d 501 (citing *Affiliated Prof'l Home Health Care Agency,* 164 F.3d at 285).

Petitioners' collateral claims did not require the court to examine the merits of the underlying dispute, delve into the statutes and regulations, or make independent judgments as to Petitioners' eligibility under a statute. Therefore, the claims were plainly and "entirely collateral" as in the case *Family Rehab., Inc.,* 886 F.3d at 503. Additionally, Petitioners could not and cannot obtain any relief from a postdeprivation hearing since there are no administrative remedies or reviews available to evaluate their claims.

### III. This Case Presents an Issue of Great Public Importance as it will Ensure that Aggrieved Medicare Providers have Legal Recourse for the Misconduct of Private, For-Profit Medicare Contractors

By allowing the Sixth Circuit's unduly narrow and erroneous definition of a collateral claim to stand, it effectively deprives Medicare providers of the right to seek recourse for the misdeeds of federal contractors which are private, for-profit entities.

Justice (then Judge) Gorsuch, in an opinion he authored while on the Tenth Circuit Court of Appeals said:

> Medicare is, to say the least, a complicated program. The Centers for Medicare & Medicaid Services (CMS) estimates that it issues literally thousands of new or revised guidance documents (not pages) every single year, guidance providers must follow exactingly if they wish to provide health care services to the elderly and disabled under Medicare's umbrella. Currently, about 37,000 separate guidance documents can be found on

> CMS's website-and even that doesn't purport to be a complete inventory.

*Caring Hearts Pers. Servs. v. Burwell*, 824 F.3d 968, 970 (10th Cir. 2016).

Following Justice Gorsuch's line of reasoning, it is wholly unfair to hold providers like Petitioner to strict compliance with an absurd morass of rules and regulations that the promulgating agency cannot keep track of itself. Then, adding insult to the proverbial injury, the Sixth Circuit's holding essentially immunizes federal contractors from adhering to simple principles of fundamental fairness and due process.

That immunity can be demonstrated no more clearly than in Respondents' case. The Medicare ALJ, an employee of the agency, expressly found that Respondents committed, at a minimum, gross derelictions of duty and intentional violations of Petitioners' procedural due process rights. Then, when Petitioners fought their way through the appeals process and were vindicated to the tune of a near complete reversal of a $4 million overpayment demand, the contractors refused to abide by the order and continued to recover the invalid overpayment.

Petitioners then, as they are permitted to do, looked to their last resort, the federal courts. But, instead of finding relief, the courts slammed the door and declined to even exercise jurisdiction. In justifying its action, the District Court, and the Court of Appeals

by affirmation, adopted a position that is the height of bureaucratic absurdity. Petitioners were told they did not present their tort and due process claims to the agency that is, by statute, powerless to resolve them. Respondents intentional acts of misconduct shut down a thriving business and put hundreds of hard working citizens out of work.

The lesson of the District Court and the Sixth Circuit is that providers are required to present claims through an appeals process that is, by design, not authorized to resolve them. Then, if they win on the underlying claim denials, Medicare providers are required to appeal their "win" further up the ladder knowing that the tort and due process claims are unresolvable.

The purpose of the Medicare appeals process is to appeal denials of payment for claims or benefits. *See* 42 C.F.R. § 405.904(a). The process is not designed to resolve common law tort or constitutional claims. The entire purpose of the *Michigan Academy* exception is to allow collateral claims to be resolved outside the agency channeling regulations when forcing the case through the channel would result in no review at all. *See Illinois Council*, 529 U.S. at 19.

The decisions rendered in this case thus far are demonstrably contrary to this Court's interpretation of the purpose of 42 U.S.C. § 405(h). Allowing Respondents to force Petitioners' collateral claims through the agency channeling process means no review at all.

Finally, the decision to require Petitioners' collateral tort, due process, and *ultra vires* claims to run through agency channels is contrary to the intent of 42 U.S.C. § 1320c-6(b). That section intended to hold Medicare contractors liable for acts of ordinary negligence, gross negligence, and intentional misconduct. *Id.* Allowing contractors to hide behind the Medicare appeals process' inability to award damages or substantive relief to persons aggrieved by agency contractors renders the due care requirement of 42 U.S.C. § 1320c-6(b) effectively moot. *See also* 72 Fed. Reg. 48870, 48877-78 (Aug. 24, 2007)(declining to expand contractor immunity to a gross negligence standard as doing so would be contrary to the Social Security Act).

## IV. The Sixth Circuit's Denial of Oral Argument Violated Petitioners' Constitutional Rights

The Fifth Amendment of the U.S. Constitution and Article I, Section 17 of the Michigan State Constitution guarantee a fair trial and due process of law.

Petitioners filed two requests for oral argument with the Sixth Circuit. Both attempts were denied.

Oral argument is intended to offer the litigants a chance to educate the court on complicated issues of law and/or fact. A case like this which involved the Medicare appeals process, Medicare regulations, and

an incredibly complicated factual and procedural history begged for oral argument. Denying Petitioners' request for oral argument deprived it of the opportunity to put its case fully before the court.

### V. It was Improper for the United States Attorney to Appear on Behalf of Respondents

The action filed by Petitioners was one between and among private parties. Neither the United States nor any of its constituent agencies were named as defendants in the suit. Despite the fact that the United States was not a party to the suit, the United States Attorney appeared on behalf of Respondents, private, for-profit entities.

Petitioners contend representation by the United States Attorney was improper and a violation of its due process rights and Fed. R. Civ. P. 24(b)(2).

Fed. R. Civ. P. 24(b)(2) permits the court to allow a government officer or agency to intervene in a case provided the officer or agency files a timely motion. *Id.* The rule further requires the intervention motion to be served on the parties, state the grounds for intervention, and be accompanied by a pleading that sets out the claim or defense for which intervention is sought. Fed. R. Civ. P. 24(c).

The government failed to file a statement of interest, a motion, or a pleading of any kind

identifying the grounds upon which it was permitted to intervene. Without such filing, Petitioners were deprived of the opportunity to challenge the United States Attorney's appearance in the case on behalf of the Respondents.

Petitioners filed a Motion to Disqualify the United States Attorney, but it was denied as moot when the District Court granted Respondents' Motion to Dismiss.

Additionally, 28 U.S.C. § 517 requires the United States Attorney to, at a minimum, make its interests in a case known, a burden which it failed to carry.

Respondents are for-profit entities that acted outside the scope of their engagement by the United States and were not entitled to a free defense by the government. Permitting Respondents the benefit of a legal defense funded by the United States Treasury was unlawful and prejudicial to Petitioners who had to pay their own legal fees.

## CONCLUSION

For the foregoing reasons, Petitioners New Vision Home Health Care and Mr. Saleem Shakoor respectfully request that this Court grant their petition for a writ of certiorari.

______________________________________
**GEORGE F. INDEST III, J.D., M.P.A., LL.M.**
Florida Bar No.: 382426
Lead Counsel
Primary e-mail:
GIndest@TheHealthLawFirm.com
Secondary e-mail:
CourtFilings@TheHealthLawFirm.com
**THE HEALTH LAW FIRM**
1101 Douglas Avenue
Altamonte Springs, Florida 32714
Telephone: (407) 331-6620
Telefax: (407) 331-3030
**ATTORNEY FOR RESPONDENT**
**THE HEALTH LAW FIRM, P.A.**