No. 04-430

In the Supreme Court of the United States

LIFESTAR AMBULANCE SERVICE, INC., ET AL.,
PETITIONERS

v.

UNITED STATES OF AMERICA, ET AL.

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

BRIEF FOR THE FEDERAL RESPONDENTS IN OPPOSITION

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QUESTION PRESENTED

Whether the district court could properly exercise mandamus jurisdiction under 28 U.S.C. 1361 over petitioners' challenge to Medicare regulations governing the reimbursement of ambulance services.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-11a) is reported at 365 F.3d 1293. The opinion of the district court (Pet. App. 12a-43a) is reported at 211 F.R.D. 688.

JURISDICTION

The judgment of the court of appeals was entered on April 16, 2004. A petition for rehearing was denied on June 29, 2004 (Pet. App. 44a-45a). The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

Petitioners challenge regulations implementing a fee schedule governing the reimbursement of ambulance

services under Medicare. The court of appeals held that petitioners must raise their challenge under the specific review procedures of the Medicare Act, 42 U.S.C. 1395 *et seq.*, and could not circumvent those procedures by resorting to the general mandamus statute under 28 U.S.C. 1361.

1. The Medicare program, established in 1965 by Title XVIII of the Social Security Act, 42 U.S.C. 1395 *et seq.*, is a federally subsidized health insurance program for the elderly and certain disabled people. 42 U.S.C. 1395c, 1395d. Part A of the program provides insurance for covered inpatient hospital and related post-hospital services. 42 U.S.C. 1395x(m). Part B is a voluntary supplementary insurance program covering physicians' services and certain other medical and health services. 42 U.S.C. 1395k, 1395*l*, 1395x(s).

The Medicare statute provides that ambulance services are covered under Part B "where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations." 42 U.S.C. 1395x(s)(7). Medicare accordingly covers ambulance services, in both emergency and non-emergency situations, if the use of an ambulance is necessary in light of the beneficiary's medical condition at the time of transport, and if the ambulance service meets certain vehicle and crew requirements. 42 C.F.R. 410.40-410.41.

Medicare previously paid for ambulance services on a "reasonable cost" basis, if services were furnished by a hospital-based provider, or a "reasonable charge" basis, if services were furnished by a free-standing ambulance service supplier. 67 Fed. Reg. 9102 (2002). Those retrospective methodologies based payments on the costs or charges actually incurred. In the Balanced Budget Act of 1997, Congress directed the Secretary of

Health and Human Services (HHS) to establish a national fee schedule setting forth pre-determined amounts that Medicare would pay for ambulance services. Pub. L. No. 105-33, § 4531(b), 111 Stat. 451 (42 U.S.C. 1395m(*l*)).

The Balanced Budget Act of 1997 provides that in developing a fee schedule, the Secretary shall establish mechanisms to control increases in expenditures, establish definitions for ambulance services that link payments to the type of services furnished, consider appropriate regional and operational differences, and consider adjustments for inflation and other "relevant factors." 42 U.S.C. 1395m(*l*)(2)(A)-(D). The Act directs the Secretary to "phase in the application of the payment rates under the fee schedule in an efficient and fair manner." 42 U.S.C. 1395m(*l*)(2)(E). It mandates that the fee schedule be "budget neutral" by requiring that payments under the schedule in the year 2000 not exceed the inflation-adjusted expenditures that would have been made under prior law. 42 U.S.C. 1395m(*l*)(3). And it provides that "[t]he amendments made by this subsection shall apply to services furnished on or after January 1, 2000." Pub. L. No. 105-33, § 4531(b)(3), 111 Stat. 452 (42 U.S.C. 1395m(*l*) note).

On September 12, 2000, the Secretary promulgated a proposed ambulance fee schedule rule that, *inter alia*, included payments based on mileage covered by the ambulance. 65 Fed. Reg. 55,078. The rule proposed that the schedule take effect on January 1, 2001, and that the fee schedule be phased in over a four-year transition period during which some percentage of the payment would be based on the prior, cost or charge-based methodology, and an increasing percentage of the payment would be based on the new fee schedule. *Id.* at 55,085. The Secretary observed that the proposed

effective date for implementing the fee schedule did not meet the statutory deadline set out in the Balanced Budget Act of 1997. The Secretary explained, however, that the development of the fee schedule had been delayed by the burdens of ensuring that HHS's massive computer systems would be "Y2K" compliant and not disrupted by difficulties in accurately recognizing the calendar year 2000, and by obligations to implement other Medicare changes mandated by the Balanced Budget Act. *Id.* at 55,079.

On December 21, 2000, before the proposed rule was finalized, Congress enacted legislation amending one component of the proposed fee schedule: the mileage payment to be made to certain ambulance service suppliers. The statute amended the phase-in provisions of the existing ambulance fee schedule statute to provide that the

> phase-in shall provide for full payment of any national mileage rate for ambulance services provided by suppliers that are paid by carriers in any of the 50 States where payment by a carrier for such services for all such suppliers in such State did not, prior to the implementation of the fee schedule, include a separate amount for all mileage within the county from which the beneficiary is transported.

Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. No. 106-554 (App. F —H.R. 5661), § 423(b), 114 Stat. 2763A-518. Congress specified that the amendment "shall apply to services furnished on or after July 1, 2001." § 423(b)(2), 114 Stat. 2763A-518.

On February 27, 2002, the Secretary promulgated the final fee schedule rule. 67 Fed. Reg. 9100. The final rule enlarged the transition period for phasing in the

new fee schedule to five years to accommodate ambulance provider requests for a longer adjustment period. *Id.* at 9118-9119. In addition, the final rule postponed the effective date until April 1, 2002. *Id.* at 9100. The Secretary explained that

> [i]n the September 12, 2000 proposed rule, we indicated our intention to implement the fee schedule beginning January 1, 2001. However, although the proposed rule was largely based on an agreement reached as part of the negotiated rulemaking process with representatives of the ambulance industry and other interests, we received over 340 public comments. We did not have sufficient time to carefully consider all comments and publish a final rule in time to implement the fee schedule by January 1, 2001.

Id. at 9104.

2. Petitioners are a class of ambulance service operators. They allege that the aforementioned Acts require the new fee schedule to be applied to services provided from January 1, 2000, forward, and that the Secretary therefore erred in establishing a later effective date. The district court found that it had mandamus jurisdiction under 28 U.S.C. 1361 over petitioners' claims and ordered the Secretary to adopt a fee schedule applicable to services rendered on or after the earlier effective dates specified by statute. Pet. App. 32a.

The district court held that the Medicare Act does not preclude mandamus jurisdiction, and that petitioners satisfied the criteria for invoking mandamus jurisdiction. Pet. App. 18a-19a, 20a-26a. The court reasoned that the Secretary had a nondiscretionary duty to establish the fee schedule and mileage provi-

sions by the statutorily-specified dates. *Id.* at 20a-22a. The court further reasoned that petitioners had no alternative means of securing review because the administrative review procedures established by Medicare were futile. *Id.* at 23a-26a. On the merits, the court granted summary judgment for petitioners. *Id.* at 20a-30a.

3. The court of appeals reversed, holding that the district court had erred in exercising subject matter jurisdiction under the mandamus statute. The court found it unnecessary to decide whether the Medicare Act forecloses mandamus jurisdiction, expressly stating that "[w]e assume, without deciding, that mandamus jurisdiction is not barred by 42 U.S.C. § 405(h) and, therefore, is available for a claim arising under the Medicare statute." Pet. App. 4a n.3. It held, however, that, even assuming mandamus jurisdiction is available, "[p]laintiffs cannot invoke the extraordinary remedy of mandamus because they have an 'alternative avenue of relief.'" *Id.* at 4a (quoting *Mallard* v. *United States Dist. Ct.*, 490 U.S. 296, 309 (1989)). The court explained that "[t]he Medicare Act establishes a comprehensive remedial scheme, providing both administrative hearing rights for aggrieved providers, such as [petitioners], and judicial review of the Secretary's final decisions." *Id.* at 4a-5a. The court further observed that "[i]t is undisputed that [petitioners] did not resort to these administrative remedies." *Id.* at 5a. The court of appeals accordingly vacated the district court's judgment and remanded with instructions to dismiss for want of subject matter jurisdiction. *Id.* at 11a.

ARGUMENT

The court of appeals' decision is correct and consistent with this Court's precedents holding that man-

damus is an extraordinary remedy that is not available if the plaintiff has an adequate, alternative means of judicial review.

1. The Medicare Act generally makes federal jurisdiction over all claims arising under the Medicare Act contingent on presentment of a claim to the Secretary and exhaustion of statutorily-prescribed administrative remedies. With respect to ambulance services and other items paid under Part B, the Act, as in effect at the time the complaint was filed,* and subject to amount-in-controversy limitations not relevant here, provides that individuals and health care providers who are aggrieved by a reimbursement determination have a right to a hearing on their claim before the Secretary under 42 U.S.C. 405(b), and to judicial review of the Secretary's final decision under 42 U.S.C. 405(g). 42 U.S.C. 1395ff(b)(1)(A).

The Act provides that a party may obtain judicial review "after any final decision of the [Secretary] made after a hearing to which [the provider] was a party" by filing a civil action in district court within 60 days after notice of the decision. 42 U.S.C. 405(g). Finally, 42 U.S.C. 405(h), which is incorporated by reference into the Medicare Act, 42 U.S.C. 1395ii, makes the Act the

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* Congress amended 42 U.S.C. 1395ff to impose processing deadlines on certain administrative appeals and to require a claimant to exhaust an additional level of administrative reconsideration before seeking judicial review. Pub. L. No. 106-554 (App. F–- H.R. 5661), § 1(a)(6), 114 Stat. 2763; § 521, 114 Stat. 2763A-534. The amendments, however, do not apply to initial administrative determinations made before October 1, 2002, and do not otherwise alter the Act's requirements that condition judicial review on presentment of a claim to the Secretary and exhaustion of administrative remedies.

exclusive means of obtaining review of the Secretary's final decision. Section 405(h) provides:

> The findings and decisions of the [Secretary] after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the [Secretary] shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the [Secretary], or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28, [United States Code], to recover on any claim arising under this [title].

42 U.S.C. 405(h).

In short, the above provisions condition federal jurisdiction over Medicare claims on presentment of the claim to the Secretary and exhaustion of administrative remedies. They do so by establishing administrative hearing rights, by providing that final decisions made after a hearing are judicially reviewable *solely* under provisions of the Medicare statute, and by expressly foreclosing resort to the federal question jurisdiction provision of 28 U.S.C. 1331. *Shalala* v. *Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 7-14 (2000); *Heckler* v. *Ringer*, 466 U.S. 602, 614-619 (1984); *Weinberger* v. *Salfi*, 422 U.S. 749, 760-761 (1975).

This Court has not resolved whether Section 405(h) bars resort to mandamus jurisdiction pursuant to 28 U.S.C. 1361. *Your Home Visiting Nurse Servs., Inc.* v. *Shalala*, 525 U.S. 449, 457 n.3 (1999) (declining to address the Secretary's contention that the second sentence of Section 405(h) bars mandamus jurisdiction); *Ringer*, 466 U.S. at 616. Some courts have concluded, however, that, with respect to essentially procedural claims arising under Medicare or other pertinent titles

of the Social Security Act, Section 405(h) does not foreclose mandamus jurisdiction where the standards for mandamus relief are otherwise satisfied. See, *e.g.*, *Ellis* v. *Blum*, 643 F.2d 68, 82 (2d Cir. 1981) (Section 405(h) "does not preclude assertion of § 1361 jurisdiction over claims essentially procedural in nature."); *Belles* v. *Schweiker*, 720 F.2d 509, 512 (8th Cir. 1983) ("[I]n cases like the present one, which involve claims essentially procedural in nature, § 405(h) presents no obstacle to mandamus jurisdiction."); *Burnett* v. *Bowen*, 830 F.2d 731, 738 (7th Cir. 1987) ("Congress intended to preserve mandamus jurisdiction for claims that are procedural in nature."); *Monmouth Med. Ctr.* v. *Thompson*, 257 F.3d 807 (D.C. Cir. 2001) (mandamus jurisdiction available to compel Secretary to comply with regulations governing reopening of final reimbursement determination).

Petitioners argue that the court of appeals' decision, in denying mandamus relief in this particular case, conflicts with the above appellate authority. Pet. 14-15. Petitioners reason that the court of appeals' decision, by recognizing the availability of alternative remedies established by the Medicare Act, effectively renders mandamus jurisdiction unavailable in all instances. Pet. 22-25. That is not correct. The decision below "assume[d], without deciding, that mandamus jurisdiction is *not* barred by 42 U.S.C. § 405(h) and, therefore *is* available for a claim arising under the Medicare statute." Pet. App. 4a n.3 (emphasis added). The court of appeals' decision thus expressly did not decide whether mandamus jurisdiction is available for claims arising under Medicare.

The court of appeals correctly found such consideration unnecessary because petitioners' undisputed failure to follow the administrative and judicial review

procedures specified in the Act, 42 U.S.C. 405(b) and (g), precluded their ability to meet the traditional standards for mandamus relief, thereby obviating the need to address whether mandamus relief might be appropriate in other circumstances. Pet. App. 4a-5a. That holding is fully consistent with this Court's similar refusal to decide whether mandamus relief would ever be available for Medicare and Social Security claims because the plaintiff otherwise could not meet the standards for mandamus relief, *i.e.*, a clear non-discretionary duty and unavailability of alternative avenues of relief. *Heckler*, 466 U.S. at 616 ("We have on numerous occasions declined to decide whether the third sentence of § 405(h) bars mandamus jurisdiction * * * because we have determined that jurisdiction was otherwise available under § 405(g)."); accord *Your Home Visiting Nurse Servs.*, 525 U.S. at 457 & n.3 (plaintiff failed to show existence of a clear nondiscretionary duty).

Nothing in the court of appeals' decision suggests or purports to hold that Medicare's administrative remedies will be adequate in each and every instance, without regard to the nature and circumstances of the claim. It thus does not, as petitioners maintain, foreclose mandamus jurisdiction in an appropriate case. For instance, the court of appeals did not confront a circumstance where the Act itself provides no administrative or judicial review of a final decision of the Secretary. Cf. *Your Home Visiting Nurse Servs.*, 525 U.S. at 453-454 (holding an intermediary's refusal to reopen a reimbursement decision is not subject to review under the Act).

2. The court of appeals decision is also consistent with the standards for mandamus relief set forth in this Court's precedents. The mandamus jurisdiction con-

ferred by 28 U.S.C. 1361 "is intended to provide a remedy for a plaintiff only if he has exhausted all other avenues of relief and only if the defendant owes him a clear nondiscretionary duty." *Ringer*, 466 U.S. 602, 616 (1984). It is a narrow remedy reserved for extraordinary circumstances and, as such, ordinarily "may not be resorted to as a mode of review where a statutory method of appeal has been prescribed." *Roche* v. *Evaporated Milk Ass'n*, 319 U.S. 21, 27-28 (1943).

The court of appeals correctly applied those standards in holding that mandamus jurisdiction could not be asserted over petitioners' claims. The court noted that Medicare's remedial scheme provides for administrative review followed by plenary judicial review of all claims arising under the Medicare statue, and concluded that, "[i]n the face of this comprehensive statutory scheme, it cannot be said that the second requirement for mandamus review—that there be no alternative avenues of relief—is met." Pet. App. 10a.

Petitioners argue that the remedy available under Medicare's jurisdictional scheme is not adequate. Petitioners thus assert that because they "can only obtain the relief they seek through an order directing a federal official to comply with the law, no 'other remedy' besides mandamus can possibly exist." Pet. 25-26. That contention lacks merit. Medicare's judicial review provisions afford the reviewing court plenary power to direct a federal official to comply with the law, and the court is fully empowered to enter any other injunctive or declaratory relief that the court deems appropriate. Cf. *Illinois Council*, 529 U.S. at 23 ("[A] court reviewing an agency determination under § 405(g) has adequate authority to resolve any statutory or constitutional contention that the agency does not, or cannot, decide."). Petitioners thus err in asserting that the

assumption of mandamus jurisdiction pursuant to 28 U.S.C. 1361 affords the only avenue of relief on their claims. Medicare's jurisdictional scheme provides a fully adequate remedy, and the court of appeals therefore correctly held that mandamus relief was inappropriate in this case.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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