No. _____

IN THE

SUPREME COURT OF THE UNITED STATES

DARRELL E. WILLIAMS,

Petitioner,

v.

ALLEGHENY COUNTY, ET AL.,

Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Third Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether this Court should directly consider the issue of what constitutes "exhaustion of administrative remedies" according to the Medicare Act, because the statute is unclear whenever the Medicare Appeals Council ("MAC") does not render any decision.

LIST OF PARTIES

[X] All parties do not appear in the caption of the case on the cover page. A list of all parties under the caption ALLEGHENY COUNTY, ET AL., to the proceeding in the court whose judgment is the subject of this petition is as follows:

> Aetna Inc., Aetna Health Inc., and Aetna Life Insurance Company ("Aetna"), and ALLEGHENY COUNTY, as owner and operator of JOHN J. KANE REGIONAL CENTER-SC d/b/a KANE SCOTT CENTER ("Kane").

RELATED PROCCEEDING

• DARRELL E. WILLIAMS v. ALLEGHENY COUNTY ET AL., No. 23-2190 (3d Cir. 2024).

• DARRELL E. WILLIAMS v. ALLEGHENY COUNTY ET AL., W.D. Pa. No. 2:2021-cv-00656

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PETITION FOR WRIT OF CERTIORARI

Petitioner respectfully prays that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Third Circuit.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Third Circuit appears at Appendix A at pages 1a-9a to the petition and is unpublished. The opinion of the United States District Court for the Western District of Pennsylvania appears at Appendix B at pages 10a-36a to the petition and is unpublished.

JURISDICTION

The date on which the United States Court of Appeals decided my case was August 15, 2024. A timely petition for rehearing was denied by the United States Court of Appeals on the following date: September 11, 2024, and a copy of the order denying rehearing appears at Appendix C at pages 37a-38a. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The relevant provisions of the five (5) levels of administrative review of the Medicare Act is review by the Medicare Appeals Council ("MAC") at 42 C.F.R. § 405.1100(d) provides:

> "(d) When deciding an appeal that was escalated from the OMHA level to the Council, the Council will issue a final decision or dismissal order or remand the case to the OMHA Chief ALJ within 180 calendar days of receipt of the appellant's request for escalation, unless the 180 calendar day period is extended as provided in this subpart."

The relevant provision of 20 C.P.R. § 404.900a(5) provides:

> "(5) Federal court review. When you have completed the steps of the administrative review process listed in paragraphs (a)(1) through (a)(4) of this section, we will have made our final decision. If you are dissatisfied with our final decision, you may request judicial review by filing an action in a Federal district court."

The relevant provisions of the Exhaustion of Administrative Remedies of the Department of Health and Human Services, which oversees CMS and the Medicare Act at 45 C.F.R. § 90.50a(1) provides that a civil action may be filed when the administrative remedies are exhausted if:

> "(1) 180 days have elapsed since the complainant filed the complaint and the agency has made no finding with regard to the complaint."

STATEMENT OF THE CASE

Moneena Williams ("M.W."), deceased, was in Kane's skilled nursing facility (SNF) and receiving daily wound care until her services were terminated on May 18, 2019 by Aetna. While in Kane's SNF facility, M.W.'s wound was looking good according to the general progress notes ("GPN'). On May 19, 2023, M.W. was transferred to Kane's long-term care (LTC) facility (same building different floor) for ten (10) days. For the first five (5) days in the LTC (e.g., May 19-22), GPNs were generated stating among other things the assessment and treatment of M.W.'s wound. **However, the last five (5) days in the LTC (e.g., May 23-28), the GPNs were either not generated or missing for those five (5) days.** And on the morning of May 28, 2019, M.W. went to her follow-up vascular appointment; and from there was emergency transported to UPMC Presbyterian hospital for amputation. M.W.'s entire stay was at Kane, no other place.

The Third Circuit's reason for the five (5) day gap in the GPNs is as follow: "But Kane's policy only required documentation of a change in the wound,[14] so if it remained unchanged during that period, **no recordkeeping would have been required**." (Emphasis added; Appendix A at page 5a).

On May 18, 2021, Williams filed the present complaint along with exhibits showing the entire Medicare Appeal process. On June 28, 2023, the Court in an Order granted both Aetna's and Kane's Motions for Summary Judgment based upon, among other thing, that Williams or M.W. did not received a final decision from the MAC, and therefore failed to establish that he or M.W. exhausted each step of the administrative review process. (See App. B at page 33a). Williams appealed.

On June 28, 2024, the Third Circuit panel affirmed the decision of the District Court. (Appendix A at pages 1a-9a). Appellant Williams respectfully requested a Rehearing En Banc, which was denied in an Order dated September 11, 2024. (Appendix C at pages 37a-38a).

Because 42 C.F.R.§ 405.1100(d) requires that the MAC issue a decision or dismissal within 180 days and before federal review (20 C.P.R. § 404.900a(5)), Williams and others similarly situated are without a remedy when the MAC fails to render any decision as in the present case. Therefore, Petitioner respectfully requests that this Court grant this petition for the reasons discussed below.

REASONS FOR GRANTING THE WRIT

I. Whether This Court Should Directly Consider The Issue Of What Constitutes "Exhaustion Of Administrative Remedies" According To The Medicare Act, Because The Statute Is Unclear Whenever The Medicare Appeals Council ("MAC") Does Not Render Any Decision.

As explained by the Third Circuit, upon receiving an initial determination on an application for benefits, a beneficiary must traverse four levels of administrative review before a district court has subject-matter jurisdiction to review a Medicare coverage decision: (1) a request for redetermination by a State Quality Improvement Organization contracted by the Centers for Medicare Studies (CMS); (2) a reconsideration request to a Qualified Independent Contractor contracted by CMS; (3) a hearing before an Administrative Law Judge for the Office of Health and Medicare Appeals; and (4) a review by the Medicare Appeals Council. (See App. A at page 8a).

Here, the court ruled that Williams exhausted only the first three levels of administrative review, and requested that the Medicare Appeals Council review his claim. Sometime in December of 2019 or January of 2020, M.W. received an Acknowledgment of Request for Review from the Departmental Appeals Board, stating that "it may be several months before the Medicare Appeals Council can act

on your request for review." Beyond this Acknowledgement of Request for Review, Williams has not received a decision or any other communications from the MAC. (See App. B at page 17a). Therefore, without an adverse final decision, Williams is not entitled to judicial review according 20 C.P.R. § 404.900 ("If you are dissatisfied with our final decision, you may request judicial review by filing an action in a Federal district court."). Hence, because of the MAC's failure to render a decision, no Federal Court would ever have subject-matter jurisdiction over any Medicare claim.

Furthermore, after some minimal research, the Medicare Appeals Board may have up to a one (1) to two (2) year backlog on rendering decisions. This type of delay in the MAC could render your case beyond the statute of limitation period, thereby preventing an aggrieved party from seeking judicial review. Only a ruling by this Court could prevent this type of nationwide injustice of Medicare claims by an aggrieved party; especially when the aggrieved party is not at fault and has followed all of the necessary steps in the Medicare appeals process.

In addition, the lower courts did not even consider 45 C.F.R. § 90.50 as a possible solution to the MAC's failure to render a decision in a case. 45 C.F.R. § 90.50a(1) states that a civil action may be filed when the administrative remedies are exhausted if: "(1) 180 days have elapsed since the complainant filed the complaint and the agency has made no finding with regard to the complaint." In

the present case, more than (180) days have passed before filing the original Complaint.

In light of the MAC's failure to render a finding on a claim and/or delay in rendering a decision, this Court should adopt some type of standard or precedent to prevent injustice caused by the MAC's delay or failure to render a decision.

For the reasons discussed above, this Court should grant the Petition.

CONCLUSION

In view of the foregoing, Petitioner Darrell E. Williams respectfully asks this Court to grant this Petition.

Dated: December 9, 2024

Respectfully submitted,

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APPENDIX A

NOT PRECEDENTIAL

UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

No. 23-2190

DARRELL E. WILLIAMS
Appellant,

v.

ALLEGHENY COUNTY, as owner and operator of John J. Kane Regional Center-SC, DBA Kane Scott Center; AETNA HEALTH INC; AETNA INC; AETNA LIFE INSURANCE CO

On Appeal from the United States District Court
for the Western District of Pennsylvania
(D.C. Civil No. 2-21-cv-00656)
District Judge: Honorable William S. Stickman, IV

Submitted under Third Circuit L.A.R. 34.1(a)
April 17, 2024

Before: HARDIMAN, SMITH and FISHER, *Circuit Judges*

(Filed: August 15, 2024)

OPINION*

FISHER, *Circuit Judge*.

Darrell E. Williams sued the Kane Scott Center, as well as the Aetna Life Insurance Company and related entities, on behalf of the Estate of Ms. Moneena Williams. He brought a claim against Kane under 42 U.S.C. § 1983, alleging that Kane deprived Ms. Williams of her civil rights by violating the Nursing Home Reform Act (NHRA). He also brought state-law claims for breach of fiduciary duty, breach of contract, and breach of good faith and fair dealing against Aetna, alleging that it wrongfully terminated Ms. Williams' coverage for skilled nursing facility services. The parties filed cross-motions for summary judgment. The District Court denied Williams' motion and granted Kane's and Aetna's motions. We will affirm.[1]

I.

With respect to Williams' motion for summary judgment on his claims against Kane and Aetna, he bears "the initial responsibility of informing the district court of the basis for [his] motion, and identifying those portions of [the record] which [he] believes demonstrate the absence of a genuine issue

*This disposition is not an opinion of the full Court and pursuant to I.O.P. 5.7 does not constitute binding precedent.

of material fact."[2] Only then is he entitled to judgment as a matter of law.[3] The District Court held that Williams failed to meet that burden because his motion and supporting memorandum contained no citations to the record, did not distinguish between his claim against Kane and his claims against the Aetna Defendants, and failed to cite any "applicable law" or explain why he was "entitled to judgment as a matter of law" as required by the Western District of Pennsylvania's Local Rules of Court.[4] We agree.

On appeal, Williams argues (again without pointing to any supporting authority) that these infirmities can be forgiven because he filed a Concise Statement of Undisputed Facts along with his motion. But a district court "may not rely solely on the statement of undisputed facts" when ruling on summary judgment.[5] It is the movant's job to

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[1] The District Court had jurisdiction under 28 U.S.C. § 1331 (federal question). This Court has jurisdiction under 28 U.S.C. § 1291 (final decisions of district courts). We exercise plenary review over an order resolving cross-motions for summary judgment, and apply the same standard that the District Court was obligated to apply. *Auto-Owners Ins. Co. v. Stevens & Ricci Inc.*, 835 F.3d 388, 402 (3d Cir. 2016).

[2] *Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986).

[3] *Id.* at 322 (citing Fed. R. Civ. P. 56(c)).

[4] App. 11 (quoting LCvR 56(B)(2)). "App." citations are to the Appendix, provided by Williams. "Supp. App." citations are to the supplemental appendix, provided by Appellees.

[5] *Doeblers' Pa. Hybrids, Inc. v. Doebler*, 442 F.3d 812, 820 n.8 (3d Cir. 2006) (quoting *Vt. Teddy Bear Co. v. 1-800 Beargram Co.*, 373 F.3d 241, 244 (2d Cir. 2004)).

demonstrate why, under applicable law, the relevant facts entitle him to judgment as a matter of law. Williams failed to do that here. At most, he raised a "skeletal argument" which is "nothing more than an assertion" and does not preserve a claim on summary judgment.[6] The Court correctly denied Williams' summary judgment motion.[7]

II.

Williams next argues that the District Court erred in granting Kane's motion for summary judgment. Count I of Williams' complaint asserts a claim under § 1983 against Kane, alleging that Kane deprived Ms. Williams of her civil rights by violating the NHRA. As the non-moving party, Williams "must set forth specific facts showing that there is a genuine issue for trial."[8] Because he did not identify such facts, we agree with the District Court that summary judgment in Kane's favor was appropriate.

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[6] *United States v. Starnes*, 583 F.3d 196, 216 (3d Cir. 2009) (citation omitted).

[7] Kane correctly points out that the portion of the District Court's order denying Williams' motion for summary judgment was not included in his notice of appeal. But when from the "subsequent proceedings on appeal it appears that the appeal was intended to have been taken from an unspecified judgment order or part thereof," we may construe the notice as "bringing up the unspecified order for review." *Elfman Motors, Inc. v. Chrysler Corp.*, 567 F.2d 1252, 1254 (3d Cir. 1977).

[8] *Gans v. Mundy*, 762 F.2d 338, 341 (3d Cir. 1985) (quoting Fed. R. Civ. P. 56(e)).

Section 1983 "does not create substantive rights, but provides a remedy for the violation of rights created by federal law."[9] So, to avoid summary judgment, Williams must establish that Ms. Williams was deprived of a federal right by someone acting under color of law.[10] Because a municipal government entity (Allegheny County) owns and operates Kane, Williams further needed to demonstrate that Kane violated Ms. Williams' rights pursuant to its own policy or custom,[11] and that such a policy or custom was the proximate cause of Ms. Williams' injuries.[12] Williams failed to do so.

The NHRA requires that nursing facilities maintain records, including the plans of care, for their residents.[13] Williams argues again on appeal that Kane staff violated Ms. Williams' NHRA rights—and Kane's own policy—by failing to sufficiently document the wound on Ms. Williams' leg between May 24, 2019 and May 28, 2019. But Kane's policy only required documentation of a change in the wound,[14] so if it remained unchanged during that period, no recordkeeping would have been required.

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[9] *Groman v. Twp. of Manalapan*, 47 F.3d 628, 633 (3d Cir. 1995).

[10] *Elmore v. Cleary*, 399 F.3d 279, 281 (3d Cir. 2005).

[11] *Bielevicz v. Dubinon*, 915 F.2d 845, 850 (3d Cir. 1990); *see also Monell v. Dep't of Soc. Servs. of N.Y.*, 436 U.S. 658, 694 (1978).

[12] *Id.*

[13] 42 U.S.C. § 1396r(b)(6)(C).

[14] Supp. App. 242.

It follows that, in order to prove that Kane staff violated the NHRA, Williams was required to show that her wound changed during the relevant period. He failed to do so. Williams relied on an expert who opined that Ms. Williams' wound worsened between May 24 and May 28.[15] But this expert was not in Ms. Williams' room during that time and did not talk to the wound care staff members. Williams did not file depositions, affidavits, or stipulations from Kane's wound care team or Ms. Williams' vascular surgeon. Because he was unable to point to any firsthand record evidence demonstrating that the wound worsened, there is no basis upon which a reasonable factfinder could conclude that: (1) Williams established that Kane violated Ms. Williams' rights under the NHRA; or (2) Kane's conduct was the proximate cause of Ms. Williams' injury. We thus affirm the District Court's grant of summary judgment to Kane.

III.

Finally, Williams argues that summary judgment should not have been granted to Aetna on Count II (breach of fiduciary duty), Count III (breach of contract) and Count IV (breach of duty of good faith and fair dealing). These contentions fare no better than his previous arguments.

Williams alleged that Aetna breached its fiduciary duty to Ms. Williams under the Employee

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[15] Supp. App. 171, 178.

Retirement Income Security Act ("ERISA").[16] ERISA imposes duties that apply only to employee benefit programs established or maintained by an employer.[17] Here, Ms. Williams was covered by a Medicare Advantage PPO plan—not a private plan maintained by an employer. Williams argues again on appeal that while Count II sought relief under ERISA provisions, viewing the complaint and exhibits holistically should have made clear to the District Court that he was advancing a Medicare claim. But Count II only makes an ERISA claim, so the District Court did not err in granting summary judgment to Aetna on that claim.

Williams further alleged that Aetna breached its contractual duty to Ms. Williams and breached the duty of good faith and fair dealing when it ordered her moved from a skilled nursing facility to long-term care. Because these claims "arise under" the Medicare Act, Williams was required to exhaust all administrative remedies available under the Medicare appeals process before bringing suit.[18] The District Court held that Williams failed to do so, and we agree.

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[16] Williams alleges violations of 29 U.S.C. §§ 1002, 1104, and 1132, all of which are part of ERISA. *See* App. 50–51.

[17] 29 U.S.C. §§ 1002(1), (2).

[18] 42 U.S.C. § 405(g); *Heckler v. Ringer*, 466 U.S. 602, 614–15 (1984).

Upon receiving an initial determination on an application for benefits, a beneficiary must traverse four levels of administrative review before a district court has subject-matter jurisdiction to review a Medicare coverage decision: (1) a request for redetermination by a State Quality Improvement Organization contracted by the Centers for Medicare Studies (CMS); (2) a reconsideration request to a Qualified Independent Contractor contracted by CMS; (3) a hearing before an Administrative Law Judge for the Office of Health and Medicare Appeals; and (4) a review by the Medicare Appeals Council.[19]

Williams exhausted only the first three levels of administrative review. Though he requested that the Medicare Appeals Council review his claim, Williams did not provide the District Court with any evidence that he received an adverse final decision. Because Williams failed to exhaust all administrative remedies during the appeals process, the District Court correctly held that it did not have subject-matter jurisdiction over his claims for breach of contract or breach of the duty of good faith and fair dealing.[20]

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[19] *See* 42 C.F.R. § 405.904(a)(1).

[20] The District Court concluded that even if Williams had properly exhausted these state-law claims, they would have been preempted by federal law. However, because we agree that the District Court did not have jurisdiction over these claims, we decline to reach the issue of preemption.

V.

For the foregoing reasons, we will affirm the District Court's ruling.

APPENDIX B

IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF PENNSYLVANIA

DARRELL EUGENE WILLIAMS,

Plaintiff,

v. Civil Action No. 21-cv-656

ALLEGHENY COUNTY as owner and operator of John J. Kane Regional Center-SC doing business as KANE SCOTT CENTER, et al,

Defendants.

MEMORANDUM OPINION

WILLIAM, STICKMAN IV, United States District Judge.

Plaintiff Darrell E. Williams ("Williams") initiated this action against Defendant Allegheny County ("Kane") as the owner and operator of John J. Kane Regional Center-SC, d/b/a Kane Scott Center and Defendants Aetna Life Insurance Company ("ALIC"), Aetna Inc., and Aetna Health, Inc., (collectively, "Aetna") individually and on behalf of the Estate of Moneena Williams ("M.W."). Williams brings a claim against Kane under 42 U.S.C. § 1983, alleging that Kane deprived the decedent of her civil rights by violating the Federal Nursing Home Reform Act ("FNHRA"),

42 U.S.C. 1396r *et. seq.,* and its implementing regulations 42 C.P.R. 483 *et. seq*. (Count I). Williams also brings claims for Breach of Fiduciary Duty (Count II), Breach of Contract (Count III), and Breach of Good Faith and Fair Dealing (Count IV) against M.W.'s insurance provider, Aetna, alleging that Aetna wrongfully denied M.W. coverage for skilled nursing care in May of 2019. Four motions are presently before the Court: Aetna's Motion to Strike Plaintiff's Appendix Exhibits B and C (ECF No. 74); Kane's Motion for Summary Judgment (ECF No. 54); Aetna's Motion for Summary Judgment (ECF No. 58); and Williams' Motion for Summary Judgment (ECF No. 63). For the reasons set forth below, Williams' Motion for Summary Judgment (ECF No. 63) will be denied; Kane's Motion for Summary Judgment (ECF No. 54) will be granted; and Aetna's Motion for Summary Judgment (ECF No. 58) will be granted. Aetna's Motion to Strike Plaintiffs Appendix Exhibits B and C (ECF No. 74) will be denied as moot.

I. FACTUAL AND PROCEDURAL BACKGROUND

A. Factual Background

Williams is the son and Personal Representative of the Estate of M.W., who died on May 11, 2020. (ECF No. 1, ¶ 3). The John J. Kane Regional Center is a skilled nursing facility in Pittsburgh, Pennsylvania that is owned and operated by Allegheny County. (*Id.* ¶¶ 4-6). At all

relevant times, M.W. was a member of Aetna Medicare Plan ("Plan"), a Medicare Advantage PPO Plan, offered by ALIC. (ECF No. 61-2). Under this Plan, M.W. was covered by Medicare and received covered Medicare health care through the Plan. (*Id.* at 3). The Plan covered "everything that Original Medicare cover[ed,]" but did not cover "[s]ervices considered not reasonable and necessary, according to the standards of Original Medicare." (*Id.* at 6, 7). The Plan required ALIC to "follow Original Medicare's coverage rules." (*Id.* at 4).

On April 24, 2019, Dr. Michael Madigan ("Dr. Madigan") diagnosed M.W. with a ruptured popliteal aneurysm in her right leg. (ECF No. 55, ¶¶ 1-2); (ECF No. 56-2). At that appointment, Dr. Madigan discussed his treatment recommendations and "the possibility of right [a]bove the knee amputation given that amputation is a high risk for ruptured aneurysms." (ECF No. 56-2, p. 2). Shortly after M.W. received that diagnosis, Kane requested that M.W. be admitted to its Skilled Nursing Facility ("SNF") and, the next day, Aetna approved six days of coverage for M.W.'s stay at Kane's SNF. (ECF No. 60, ¶¶ 21-22). *See also* (ECF Nos. 61-5, 61-6). M.W. was admitted to Kane's SNF on May 2, 2019, for rehabilitation of her ruptured popliteal aneurysm. (ECF No. 55, ¶ 5). M.W.'s wound was examined by Kane staff on the day she was admitted, and was measured at 18 centimeters long, 6.5 centimeters wide, and 5

centimeters deep. (ECF No. 56-4, p.2). On May 3, 2019, M.W. was seen by her attending physician, Dr. Mario Fatigati ("Dr. Fatigati"), who noted that "[t]he vascular aspects of [M.W.'s] leg are tenuous[,]" and ordered changes to the treatment of M.W.'s wound. (ECF No. 56-3, p. 3). See also (ECF No. 55, ¶ 10).

On May 7, 2019, the day coverage for M.W.'s stay in the SNF was set to expire, ALIC received a request from M.W. for continued stay at Kane's SNF, which it approved through May 14, 2019. (ECF No. 61-8, p. 2). On that same day, M.W.'s wound was examined again and measured at 18 centimeters long, 7 centimeters wide, and 8 centimeters deep. (ECF No. 55, ¶ 12); (ECF No. 56-5). Certified Registered Nurse Practitioner ("CRNP") Karen Zagrocki ("Zagrocki") "issued an order to discontinue previous treatment to popliteal area, and to apply Silvadene cream to the wound after cleaning. The wound vac was to remain in place." (ECF No. 55, ¶ 11). The next day, M.W. had a follow up appointment with Zagrocki, who noted that the wound vac was in place, that the wound had cellulitis with a possible pseudomonas infection, and that there was "yellowish, greenish, tannish drainage to the posterior right thigh wound." (*Id.* 13); (ECF No. 56-5, p. 4). Dr. Fatigati also conducted an examination of M.W.'s wound on May 8, 2019, during which he noted the presence of a foul-smelling drainage, indicated that the wound

would be treated with antibiotics, and expressed concern for the "viability of the leg." (*Id.* ¶ 14); (ECF No. 56-5, p. 5). M.W.'s wound was examined again on May 9, May 10, and May 13, 2019, and large amounts of discharge was noted. (*Id.* ¶¶ 15-16); (ECF Nos. 56-4, 56-5). On May 14, M.W.'s wound was measured at 8 centimeters long, 9 centimeters wide, and 0.5 centimeters deep and Zagrocki issued a series of orders regarding the treatment of M.W.'s wound, including one discontinuing the use of Silvadene in favor of Santyl. (*Id.* ¶¶ 18-19); (ECF Nos. 56-4, 56-5). Zagrocki followed up the next day and noted that M.W. had been fully treated with antibiotics and that her wound had improved. (*Id.* 20); (ECF No. 56-5).

On May 16, 2019, M.W. had an appointment at the office of her vascular surgeon, after which, CRNP Megan Laughlin ("Laughlin") sent a letter stating that M.W.'s wounds were "overall looking good" and providing instructions for M.W.'s continued treatment. (ECF No. 64, ¶ 8). The letter instructed M.W.'s caretakers to: continue applying santyl and prysma to M.W.'s wounds; "[c]ontinue white foam to all tunneling wounds to anterior knee and calf wound, covered by black foam@125mm hg continuous suction[;]" change the wound vac three times per week; and to continue prysma to left groin. (*Id.*). The letter also indicated that M.W. was scheduled for a follow-up appointment in two weeks

for "likely suture removal." *(Id.*). Williams attended the May 16 appointment with M.W. and was told by Laughlin that M.W. "is not out of the woods" and that she "could still lose her leg." (ECF No. 56-6, p. 15). Laughlin also told Williams that she was impressed with how well the Kane SNF nurses were taking care of M.W.'s wound. (*Id.*)*;* (ECF No. 69, p. 7). ALIC approved coverage for SNF services through May 18, 2019, but also issued a Notice of Medicare Non-Coverage ("NOMNC"), notifying M.W. that SNF services would not be covered after May 18, 2019. (ECF No. 60, ¶ 36); (ECF Nos. 61-12, 61-15). On May 17, 2019, M.W. was discharged from occupational therapy and physical therapy by Kane staff. (ECF Nos. 61-13, 61-14).

On May 18, 2019, M.W. was moved from SNF to Kane's long-term care ("LTC") facility. (ECF No. 55, ¶ 29). Nurse notes from the following day indicate that M.W.'s vitals were recorded and that she had a wound vac in place in LTC. (*Id.* ¶ 31); (ECF No. 56-4). On May 21, 2019, Kane staff examined M.W.'s wound, which measured at 10 centimeters long, 3 centimeters wide, and 9.2 centimeters deep. (*Id.* ¶ 32); (ECF No. 56-4). After this examination, a Kane nurse spoke with the office of M.W.'s vascular surgeon to alert them of the increased depth of M.W.'s wound. (*Id.* ¶ 34). Shortly thereafter, in the morning of May 21, Laughlin arrived at Kane to examine M.W.'s wound and advised Kane staff to continue with the same treatment. (*Id.* ¶ 35); (ECF

No. 56-4).

Kane nurses checked on M.W. on May 22, 2019, and again during the early morning of May 23. (*Id*. ¶ 37); (ECF No. 56-4, p. 6). Nurse notes from the evening of May 23, 2019 indicate that the skin on M.W.'s lower right leg was warm and dry and that the wound vac was intact. (*Id*. ¶ 38). According to M.W.'s therapy administration records ("TAR"), Kane staff applied Santyl cream to her wound every day from May 15, 2019, to May 28, 2019. (ECF No. 64, ¶ 35); (ECF No. 56-7, p. 2). Additionally, M.W.'s wound vac was changed, with white foam placed into all areas of tunnelling on May 14, 16, 18, 21, 23, and 25, 2019. (*Id*. ¶ 36); (ECF No. 56-7, p. 3). M.W. attended her follow up appointment with her vascular surgeon on May 28, 2019. (ECF No. 55, ¶ 42). After examining her wound, the physician had M.W. transported to UPMC Presbyterian for debridement, which was scheduled for May 30. (*Id*. ¶ 43); (ECF No. 69, p. 11). Ultimately, M.W.'s right leg was amputated at UPMC-Presbyterian in early June of 2019. (*Id*. ¶ 44); (ECF No. 64, ¶ 37).

B. Administrative Proceedings

After receiving the NOMNC from ALIC on May 16, 2019, M.W. appealed to the state Quality Improvement Organization ("QIO"), Livanta LLC. (ECF No. 64, 10). On May 17, 2019, after being verbally notified that the QIO affirmed ALIC's decision of noncoverage, M.W. submitted a request

for an expedited reconsideration by C2 Innovative Solutions, the Qualified Independent Contractor ("QIC"). (*Id*. ¶ 12). On May 22, 2019, the QIC issued a decision upholding the denial of coverage, explaining that, based on the medical record, "Medicare criteria for coverage of the skilled services at issue ha[d] not been satisfied." (ECF No. 61-18, p. 4). M.W. filed a timely request for review with the office of Medicare Hearings and Appeals ("OMHA"). *See* (ECF No. 61-16). In August of 2019, a hearing with the Administrative Law Judge ("ALJ") was held and, on September 9, 2019, the ALJ issued a decision upholding ALIC's termination of coverage because M.W. "no longer needed and did not receive a covered level of [SNF] care after the termination of Medicare coverage on May 18, 2019." (*Id*. at 10); (ECF No. 64, 18). M.W. filed a Request for Review of the ALJ Decision with the Medicare Appeals Council ("MAC"), dated November 1, 2019. (ECF No. 60, ¶ 71); (ECF No. 1-3, p. 2). Sometime in December of 2019 or January of 2020, M.W. received an Acknowledgment of Request for Review from the Departmental Appeals Board, stating that "it may be several months before the Medicare Appeals Council can act on your request for review." (ECF No. 61-19, p. 2). Beyond this Acknowledgement of Request for Review, Williams has not received a decision or any other communications from the MAC. (ECF No. 66-1, p. 152); (ECF No. 71, p. 24). M.W. died on May 11, 2020, and, on May 18, 2021, Williams initiated this action individually and on behalf of M.W.'s Estate. (ECF No. 1, ¶ 3).

II. LEGAL STANDARD

Summary judgment is warranted if the Court is satisfied that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(a); see also *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986). A fact is material if it must be decided to resolve the substantive claim or defense to which the motion is directed. See *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242,248 (1986). A genuine dispute of material fact exists "if the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Id.* The Court must view the evidence presented in the light most favorable to the nonmoving party. *Id.* at 255. It refrains from making credibility determinations or weighing the evidence. *Id.* "[R]eal questions about credibility, gaps in the evidence, and doubts as to the sufficiency of the movant's proof' will defeat a motion for summary judgment. *El v. Se. Pa. Transp. Auth.*, 479 F.3d 232,238 (3d Cir. 2007). "When both parties move for summary judgment, '[t]he court must rule on each party's motion on an individual and separate basis, determining for each side whether a judgment may be entered in accordance with the Rule 56 standard.'" *Auto- Owners Ins. Co. v. Stevens & Ricci Inc.*, 835 F.3d 388, 402 (3d Cir. 2016) (quoting l0A CHARLES ALAN WRIGHT ET AL., FEDERAL PRACTICE AND PROCEDURE § 2720 (3d ed. 2016)).

III. Analysis

A. Williams' Motion for Summary Judgment (ECF No. 63).

Williams moves for summary judgment on his claim against Kane (Count I) and his three claims against Aetna (Counts II-IV). (ECF No. 63). In support of his motion for summary judgment, Williams claims that M.W. received a lower level of wound care in the LTC, and that "[m]onitoring and assessment of [M.W.'s] wound was discontinued after May 23, 2019, and therefore 'daily' wound care services did not occur according to the Vascular surgeon's order; nor to Kane's wound care policy or the FNHRA's requirements." (*Id.* at 3). From this, Williams surmises that "the only issue that remains is whether a right leg above knee amputation of [M.W.] following [M.W.'s] follow-up appointment dated May 28, 2019 would be considered a decline in her wound." (*Id.*). Williams then concludes that the amputation of M.W.'s leg "would be considered a decline in her wound." (*Id.*).

As the moving party, Williams bears the burden of showing that these facts "cannot be genuinely disputed by citing to particular parts of materials in the record--i.e., depositions, documents, affidavits, stipulations, or other materials[.]" *Mosaka-Wright v. LaRoche Coll.*, No. 11 CV 1139, 2012 WL 3060151, at *2 (W.D. Pa. July 25, 2012), aff'd sub nom. *Mosaka-Wright v. La Roche Coll.*, 523 F. App'x 886

(3d Cir. 2013). Williams provides no support for any of his factual assertions. In fact, his motion and supporting memorandum contain no citations to the record. Thus, Williams has failed to establish that any of his factual claims are undisputed based on the record. The Court "will not scour the record where movant has not cited it to see if the record might relate in some way to what he might be driving at[.]" *United States v. Grados*, No. 2:16-CR-57-KRG-KAP, 2021 WL 231373, at *3 (W.D. Pa. Jan. 4, 2021).

Williams' motion and supporting memorandum also fail to "address applicable law" and explain why he "is entitled to judgment as a matter of law" as required by the Local Rules of the United States District Court for the Western District of Pennsylvania. LCvR 56(B)(2). Williams does not distinguish between his claim against Kane and his claims against the Aetna Defendants. He does not specify which facts (or what legal arguments) support each specific claim. In fact, Williams fails to discuss any of the individual claims or the essential elements of those claims. He fails to cite any of the relevant statutes, regulations, or case law and makes no attempt to apply the governing law to the facts in the record. Williams' motion for summary judgment utterly fails to establish that the facts put forth are undisputed or to explain why he is entitled to judgment as a matter of law. Given these deficiencies, Williams' motion for summary judgment (ECF No. 63) will be denied. Aetna's Motion to Strike Plaintiff's Appendix Exhibits B and C (ECF

No. 74) will be denied as moot.

B. Kane's Motion for Summary Judgment (ECF No. 54)

At Count I of the Complaint, Williams brings a claim against Kane under 42 U.S.C. § 1983 ("Section 1983" or "1983").[1] (ECF No. 1). "A prima facie case under § 1983 requires a plaintiff to demonstrate: (1) a person deprived him of a federal right; and (2) the person who deprived him of that right acted under color of state or territorial law." *Groman v. Twp. of Manalapan,* 47 F.3d 628, 633 (3d Cir. 1995). Kane does not "dispute that the alleged actions were under color of state law." (ECF No. 57, p. 5). Williams claims that Kane deprived M.W. of her civil rights by violating the FNHRA. To establish a 1983 claim against Kane, Williams must not only show that M.W.'s rights were violated by a Kane employee; but that the violation of M.W.'s rights was "caused by action taken pursuant to a municipal policy or custom." *Robinson v. Fair Acres Geriatric Ctr*., 722 F. App'x 194, 198 (3d Cir. 2018). Williams must also show that the municipal policy or custom "was the proximate cause of the injuries suffered." *Bielevicz v. Dubinon*, 915 F.2d 845, 850 (3d Cir. 1990).

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[1] Despite being titled as a claim for negligence (See ECF No. 1, p. 12), "Count I of the Complaint asserts a § 1983 claim, not negligence." (ECF No. 68, p. 5).

Kane moves for summary judgment on Williams' 1983 claim (ECF No. 54), arguing that Williams cannot establish that a Kane employee violated M.W.'s FNHRA rights, and, even if the evidence created a question of fact regarding whether an employee violated M.W.'s FNHRA rights, "the claim would still fail because no violation was caused by Kane policies." (ECF No. 57, p. 10).

Under the FNHRA, nursing facilities must "maintain clinical records on all residents, which records include the plans of care ... and the residents' assessments ... as well as the results of any pre-admission screening[.]" 42 U.S.C. § 1396r (b)(6)(C). Williams claims that Kane nurses violated M.W.'s FNHRA rights by failing to sufficiently document and monitor M.W.'s wound from May 24, 2019, to May 28, 2019, the day M.W. was transported to UPMC Presbyterian Hospital for amputation. (ECF No. 68, pp. 6-7). Williams bases this claim on a gap in Kane's General Progress Notes ("GPN") for M.W.'s wound from May 24, 2019, to May 28, 2019 (ECF No. 56-4), arguing that the gap shows that "daily wound care services did not occur according to the Vascular surgeon's order; nor to Kane's wound care policy or the FNHRA's requirements[]" on those dates. (ECF No. 68, p. 4) (cleaned up).

Despite a lack of notes in the GPN on these dates, Kane still maintained a TAR, which indicates that a Kane employee approved and documented the cleaning and treatment of M.W.'s wound in

accordance with the vascular surgeon's most recent instructions every day from May 22, 2019 to May 28, 2019. (ECF No. 56-7). As Williams points out, however, Kane's own wound care policies and the FNHRA, in certain circumstances, require more than documenting the cleaning and treatment provided. Kane's wound care policy requires staff to "[m]onitor and document progress of the wound in the GPN and notify physician promptly if wound should appear more acute or worsen." (ECF No. 56-13, p. 3). Under the FNHRA, Kane is required to maintain clinical records of "the residents' assessments[.]" 42 U.S.C. § 1396r (b)(6)(C). A gap in the GPN does not necessarily mean that the FNHRA or Kane's wound care policy have been violated. If the status of M.W.'s wound stayed the same from May 24, 2019, to May 28, 2019, the gap in the GPN would not violate Kane's wound care policy; the policy would only be violated if Kane staff failed to document progress or to report deterioration. Under the FNHRA, Kane was required to update M.W.'s clinical records with any change to the assessment of M.W.'s wound, but, if there was no change to the assessment of M.W.'s wound, no action would be required to maintain M.W.'s clinical records. Thus, to show that Kane staff violated the FNHRA, Williams must establish that the condition of M.W.'s wound changed from May 24 to May 28.

In an attempt to do so, Williams relies on the expert testimony of Beverley Williams ("Beverley"),[2] who claims that M.W.'s wound had gotten worse between May 23, 2019, and May 28, 2019. (ECF No. 56-12, pp. 27, 34). As Kane points out, however, Beverley was unable to explain the basis for her assertion that there was a "huge difference" in M.W.'s wound from May 24, 2019, to May 28, 2019. She testified that she was not in M.W.'s room when wound care services were provided on the days in question, she has not spoken with the staff members who provided those services, and she could not offer an opinion on the size of M.W.'s wound when it was examined by the vascular surgeon on May 28, 2019. (*Id*.). She further testified that she only reviewed the medical records contained in Kane's chart and that she did not review any of the medical records from M.W.'s vascular surgeon. (*Id*. at 11, 28). Nothing in the record-beyond Beverley's assertion--supports the notion that the condition of M.W.'s wound worsened from May 24 to May 28.

Williams argues that Kane cannot use the lack of any documented change in M.W.'s wound status from May 24 to May 28 as evidence that the wound did not worsen in that time. To do so, Williams argues, would be to reward Kane for the very "gap" in medical records that forms the crux of Williams' claim against Kane. While true, Williams still bears

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[2] Beverley Williams is the wife of Plaintiff Darrell Williams. See (ECF No. 56-12, p. 8).

the ultimate burden of establishing that Kane violated M.W.'s FNHRA rights and could have satisfied that burden through expert witnesses, depositions, or by citing to relevant medical records. Outside of the testimony of Beverley--who was not with M.W. for the days in question, had not spoken to the Kane staff or the vascular surgeon who treated M.W., and had not reviewed any of the vascular surgeon's records--Williams provides no such evidence. He did not depose the Kane staff who treated M.W. on the dates in question or the vascular surgeon who ultimately performed M.W.'s amputation. Given the lack of evidence that the condition of M.W. 's wound changed during this period, Williams has failed to establish that the five-day gap in Kane's GPN was a violation of Kane's internal wound care policies or the FNHRA.

Even if Williams could show that a Kane employee violated M.W.'s FNHRA rights, he has still failed to show that the violation was "caused by action taken pursuant to a municipal policy or custom." *Robinson*, 722 F. App'x at 198. Williams argues that the violation of M.W.'s FNHRA rights "was caused by the Kane's 'custom' of repeated failure of the LTC nurses to document wound status[.]" (ECF No. 68, p. 9). In the § 1983 context, customs "include only 'practices of state officials ... so permanent and well settled as to constitute a custom or usage with the force of law.'" *Robinson*, 722 F. App'x at 198 (quoting *Monell v. Dep't of Social Servs.*, 436 U.S. 658, 691 (1978)). Even if Kane staffs failure

to document any changes to M.W.'s wound status in the GPN for five days was a violation of M.W.'s FNHRA rights, there is nothing in the record to indicate that Kane nurses failing to document wound status is "permanent" and "well settled." A lack of notes in M.W.'s GPN for five days is not sufficient evidence to establish that Kane nurses' failure to document wound status was "so permanent and well settled as to constitute a custom or usage with the force of law." *Monell*, 436 U.S. at 691.

Even if Williams could establish that Kane nurses engaged in a custom of failing to document wound status, he has also failed to show causation. *Berg v. Cnty. of Allegheny*, 219 F.3d 261, 276 (3d Cir. 2000) ("Once a§ 1983 plaintiff identifies a municipal policy or custom, he must demonstrate that, through its deliberate conduct, the municipality was the 'moving force' behind the injury alleged." (internal quotations omitted)). Williams' causation argument-that "Kane's LTC wound care practice was the proximate cause of M.W.'s injuries suffered[]"-is based only Beverly's opinion that, had M.W.'s wound been more closely monitored between May 23, 2019, and May 28, 2019, amputation of M.W.'s leg may have been avoidable. (ECF No. 68, p. 7); (ECF No. 56-12, pp. 27, 34). Here again, Beverley was unable to establish the basis for this opinion and Williams is unable to point to any other evidence to establish causation.

In certain circumstances, causation can be established by "demonstrat[ing] that the municipal action was taken with 'deliberate indifference' as to its known or obvious consequences." *Board of County Comm'rs of Bryan County v. Brown*, 520 U.S. 397,404 (1997). To show that a municipality's actions constitute "deliberate indifference" under § 1983, "it must be shown that (1) municipal policymakers know that employees will confront a particular situation; (2) the situation involves a difficult choice or a history of employees mishandling; and (3) the wrong choice by an employee will frequently cause deprivation of constitutional rights." *Carter v. City of Philadelphia*, 181 F.3d 339, 357 (3d Cir. 1999) (footnote omitted). Failure to train, monitor, or supervise employees can "be considered deliberate indifference...where the failure has caused a pattern of violations." *Berg*, 219 F.3d at 276. Even if Williams could show that Kane staff violated M.W.'s rights and that those violations were caused by Kane's failure to properly train or monitor nurses who were responsible for documenting M.W.'s wound status, he presents no evidence to show that the failure caused a pattern of violations. Other than the five-day gap in M.W.'s GPN, Williams does not allege any violations by Kane, let alone a "pattern of violations." Additionally, nothing in the record indicates that Kane nurses' documentation of wound status involved a difficult choice, a history of being mishandled, or a "pattern of violations."

Williams has failed to show that Kane's five-day gap in M.W.'s GPN constituted a violation of M.W.'s FNHRA rights. Even if he had done so, Williams also failed to establish causation or that any violation was caused by a Kane policy or custom. Kane's motion for summary judgment (ECF No. 54) will be granted.

B. Aetna's Motion for Summary Judgment (ECF No. 58)

Aetna moves for summary judgment on the claims against it for breach of fiduciary duty (Count II), breach of contract (Count III), and breach of good faith and fair dealing (Count IV). (ECF No. 58).

1. Count II: Breach of Fiduciary Duty

Williams claims that Kane violated its fiduciary duty under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 et seq. (Count II). (ECF No. 1, ¶¶ 67, 71). ERISA-and the duties it imposes on fiduciaries-only applies to employee benefit plans, which, according to the statute's definition, must be "established or maintained by an employer or by an employee organization, or by both[.]" 29 U.S.C. §§ 1002(1), (2). M.W.'s plan was not established or maintained by an employer or employee organization. Rather, M.W. was a member of a Medicare Advantage PPO Plan offered by Aetna. (ECF No. 61-2); (ECF No. 1, ¶ 20). The Plan explicitly stated that it was "a Medicare

Advantage PPO Plan[.]" (ECF No. 61-2, p. 3). Because Aetna's coverage of M.W. was not an employer health plan governed by ERISA, Williams cannot pursue a claim for breach of fiduciary duty under ERISA.

In his response to Aetna's motion for summary judgment, Williams attempts to shift the allegation by arguing that "[i]n view of the entirety of the Complaint, Count II of the Complaint alleges that Aetna breach[ed] its fiduciary duty under the Medicare laws, rules, and guidelines on coverage for SNF services." (ECF No. 70, p. 5). However, the Complaint explicitly alleges that Aetna "is a fiduciary of the Plan within the meaning of [ERISA]" and that he is "entitled to relief under [ERISA]." (ECF No. 1, ¶¶ 67, 71). Nothing in the Complaint indicates that Williams intended to assert his breach of fiduciary duty claim under "the Medicare laws" and Williams "may not expand his claims to assert new theories for the first time in response to a summary judgment motion." *Ward v. Noonan*, 147 F. Supp. 3d 262, 280 n.17 (M.D. Pa. 2015). As such, the Court construes Williams' breach of fiduciary duty claim as being brought pursuant to ERISA. Because the Plan at issue is not governed by ERISA, Aetna's motion for summary judgment (ECF No. 58) will be granted as it relates to Williams' claim for breach of fiduciary duty (Count II).

2. Counts III & IV: Breach of Contract and Breach of Good Faith and Fair Dealing

a. Exhaustion of Administrative Remedies

Williams also brings claims against Aetna for breach of contract (Count III) and breach of good faith and fair dealing (Count IV). Aetna first argues that both claims should be dismissed at summary judgment because M.W. failed to exhaust the administrative remedies available under the Medicare appeals process. "Title 42 U.S.C. § 405(h), ... makes § 405(g) the sole avenue for judicial review of all 'claim[s] arising under'" 42 U.S.C. § 1395 et seq. ("Medicare Act"). *Heckler v. Ringer*, 466 U.S. 602, 602 (1984). *See also Shalala v. Illinois Council on Long Term Care, Inc.,* 529 U.S. 1, 13 (2000) (Section 405(h) "demands the 'channeling' of virtually all legal attacks through the agency[.]"). A claim "arises under" the Medicare Act if "'both the standing and the substantive basis for the presentation' of the claims is the Medicare Act[,]" or if the claim is "inextricably intertwined" with a claim for Medicare benefits. *In re Univ. Med. Ctr.*, 973 F.2d 1065, 1073 (3d Cir. 1992) (quoting *Heckler*, 466 U.S. at 615). Williams' claims against Aetna are based on the allegation that Aetna wrongfully denied M.W. Medicare coverage for her to stay at Kane's SNF facility after May 18, 2019. There is no dispute that these claims "arise under" the Medicare Act. *See* (ECF No. 70, p. 6) ("The Plaintiffs claims are governed by the Medicare rules and regulations[.]").

Under § 405(g), a plaintiff may bring a claim "arising under" the Medicare Act in district court only after he "has pressed the claim through all designated levels of administrative review[]"and has been given a "final decision" from the Secretary of Health and Human Services. *Heckler*, 466 U.S. at 606. *See also Kopstein v. Indep. Blue Cross*, 339 F. App'x 261, 264 (3d Cir. 2009) ("A final agency ruling is ... 'central to the requisite grant of subject-matter jurisdiction' under the Medicare Act."). After the Medicare insurer "makes an initial determination on an application for Medicare benefits and/or entitlement of an individual to receive Medicare benefits[,]" there are four levels of administrative review that must be exhausted before a plaintiff is entitled to judicial review. 42 C.P.R. § 405.904(a)(l). First, if the enrollee is not satisfied with the initial determination, he may request—and "[t]he organization shall provide"--reconsideration by a QIO contracted by the Centers for Medicare Studies ("CMS"). 42 U.S.C. § 1395w-22(g)(2)(A). *See also id.* Next, "[r]econsiderations that affirm a denial of coverage, in whole or in part[,]" are reviewed by QIC. *Id.* § 1395w-22(g)(4). If the enrollee remains unsatisfied after this review by the QIC, the third level of administrative review requires him to request a hearing before an ALJ. 42 C.P.R. § 405.904(a)(l). As the final step, "[i]f the beneficiary obtains a hearing before an ALJ and is dissatisfied with the decision of the ALJ, or if the beneficiary requests a hearing and no hearing is conducted," he may request a review from the MAC. *Id.* §§ 422.608, 405.904(a)(l).

There is no dispute that M.W. exhausted the first three levels of administrative review. After being informed of Aetna's initial determination that she was not covered to stay in Kane's SNF after May 18, 2019, M.W. appealed to the QIO, which affirmed Aetna's initial determination of noncoverage. (ECF No. 64, ¶ 10); (ECF No. 1, ¶ 31). M.W. then submitted a request for an expedited reconsideration by the QIC, C2 Innovative Solutions. (ECF No. 1-2, p. 7). When the QIC returned an unfavorable decision to M.W., she filed a timely request for review with the OMHA and participated in a hearing in front of the ALJ in August of 2019. After receiving an unsatisfactory decision from the ALJ, M.W. filed a Request for Review of the ALJ Decision with the MAC, dated November 1, 2019. (ECF No. 1-3, p. 2); (ECF No. 1, ¶ 49); (ECF No. 60, ¶ 71). Sometime in December of 2019 or January of 2020, M.W. received an Acknowledgment of Request for Review from the Departmental Appeals Board, stating that "it may be several months before the Medicare Appeals Council can act on your request for review." (ECF No. 61-19, p. 2).

Williams claims that "[t]here are no November, 2019 appeals still pending in the MAC," but provides no evidence that M.W. received a final decision from the MAC. (ECF No. 70, p. 6). Williams testified that, as of January 26, 2023, he had not received a decision on the appeal filed with the MAC. (ECF No. 66-1, pp. 152-53). He further testified that, aside from the Acknowledgement of Request for Review, he

has not received anything from the MAC. (*Id*. at 152). As M.W.'s representative, Williams could have requested judicial escalation from the MAC if no decision was rendered 90 calendar days after M.W. filed her Request for Review. 42 C.P.R. § 405.1132. Williams admits that he has not done so; nor has he had any other communications with the MAC. (ECF No. 66-1, pp. 152-53). A plaintiff is entitled to judicial review only after they have received an adverse final decision. *See* 20 C.P.R. § 404.900 ("If you are dissatisfied with our final decision, you may request judicial review by filing an action in a Federal district court."). Given this, and because there is no evidence that Williams or M.W. received a final decision from the MAC, he has failed to establish that he or M.W. exhausted each step of the administrative review process.

b. Preemption

Even if Williams had received a final decision from the MAC, his breach of contract and breach of good faith and fair dealing claims are preempted by the Medicare Act. Congress can displace state law where preemption is the "clear and manifest purpose of Congress." *Rice v. Santa Fe Elevator Corp*., 331 U.S. 218, 230 (1947). The Medicare Act contains an express preemption provision, which says that "[t]he standards established under this part shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to MA plans which are offered

by MA organizations under this part." 42 U.S.C. § 1395w-26(b)(3). The existence of this clause, however, "does not immediately end the inquiry because the question of the substance and scope of Congress' displacement of state law still remains." *Altria Grp., Inc. v. Good*, 555 U.S. 70, 76 (2008). Here, the Court must determine whether the Medicare Act's preemption provision preempts state common law claims; namely, claims for breach of contract and breach of good faith and fair dealing.

The language "any State law or regulation"-with no qualifying provisions-reflects an intent to include common law claims. *See Fleckv. KDI Sylvan Pools Inc.*, 981 F.2d 107, 115 (3d Cir. 1992) ("The word 'any' is generally used in the sense of 'all' or 'every' and its meaning is most comprehensive."). This does not mean, however, that the Medicare Act preempts all state common law claims; only those that are inconsistent with "the standards established" by the Medicare Act. 42 U.S.C. § 1395w-26(b)(3). As Williams acknowledges, his breach of contract and breach of good faith and fair dealing claims are premised on the allegation that Aetna wrongfully denied M.W. specific coverage under the Medicare regulations and guidelines. See (ECF No. 70, p. 6) ("The Plaintiffs claims are governed by the Medicare rules and regulations[.]"). Williams does not claim that Aetna was subject to any contractual obligations beyond its obligation to comply with the Medicare Act. At their core, Williams' breach of contract and breach of good faith and fair dealing claims are

coverage disputes. The Medicare regulations and the CMS Medicare Benefit Policy Manual establish the standards for Medicare coverage of SNF services. *See* 42 C.P.R. § 409.31; (ECF No. 61-4). The Medicare Act's administrative appeal process is the exclusive avenue for resolving "disputes involving a covered individual's dissatisfaction with a Medicare decision[.]" *Wilson v. Chestnut Hill Healthcare*, No. CIV.A. 99-CV-1468, 2000 WL 204368, at *3 (E.D. Pa. Feb. 22, 2000). At the conclusion of that administrative appeal process, Williams would have been entitled to seek judicial review under 42 U.S.C. § 405(g). He cannot, however, assert a "breach of contract claim [as] a backdoor attempt to enforce the Act's requirements and to secure a remedy for [Aetna's] alleged failure to provide [coverage]." *Do Sung Uhm v. Humana, Inc.*, 620 F.3d 1134, 1143 (9th Cir. 2010).

Because Williams has not established that he exhausted all available administrative remedies, the Court does not have valid subject-matter jurisdiction over his breach of contract (Count III) and breach of good faith and fair dealing (Count IV) claims. Even if Williams did exhaust the available administrative remedies, both claims are preempted by the Medicare Act. Aetna's motion for summary judgment (ECF No. 58) will be granted. The Court need not address the issue of whether Aetna Inc. or Aetna Health Inc. are proper parties to this action.

IV. CONCLUSION

For the reasons set forth above, Williams' Motion for Summary Judgment (ECF No. 63) will be denied; Kane's Motion for Summary Judgment (ECF No. 54) will be granted; and Aetna's Motion for Summary Judgment (ECF No. 58) will be granted. Aetna's Motion to Strike Plaintiffs Appendix Exhibits B and C (ECF No. 74) will be denied as moot. Orders of Court will follow.

Dated: 6-28-23 BY THE COURT:

/s/ William S. Stickman IV
WILLIAM S. STICKMAN IV
United States District Judge

APPENDIX C

UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

No. 23-2190

DARRELL E. WILLIAMS
Appellant,

v.

ALLEGHENY COUNTY, as owner and operator of John J. Kane Regional Center-SC, DBA Kane Scott Center; AETNA HEALTH INC; AETNA INC; AETNA LIFE INSURANCE CO

(W.D. Pa No.: 2-21-cv-00656)

Present: CHAGARES, Chief Judge, HARDIMAN, SHWARTZ, RESTREPO, BIBAS, PORTER, MATEY, PHIPPS, FREEMAN, MONTGOMERY-REEVES, CHUNG, SMITH and FISHER*, *Circuit Judges*

SUR PETITION FOR REHEARING
WITH SUGGESTION FOR REHEARING IN BANC

*Judges Smith and Fisher's votes are limited to panel rehearing only.

The petition for rehearing filed by Appellant, Darrell E. Williams, in the above-entitled case having been submitted to the judges who participated in the decision of this Court and to all the other available circuit judges of the circuit in regular active service, and no judge who concurred in the decision having asked for rehearing, and a majority of the judges of the circuit in regular service not having voted for rehearing, the petition for rehearing by the panel and the Court en banc, is denied.

BY THE COURT:

s/ D. Michael Fisher
Circuit Judge

Dated: September 11, 2024
Lmr/cc: All Counsel of Record