

# A RIGHT TO NO MEANINGFUL REVIEW: THE AFTERMATH OF SHALALA v. ILLINOIS COUNCIL ON LONG TERM CARE, INC.

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No one ever looks forward to entering a nursing home because it means leaving the things most dear to them: family, home, and independence. Nevertheless, without the current nursing home system,<sup>2</sup> many elderly and disabled persons, who require comprehensive treatment, would not have access to necessary care.<sup>3</sup> A viable nursing home industry is essential to our health care system, and regulations need to carefully balance public health and safety concerns against concern for the operational viability of the sector.<sup>4</sup> This balance has been disrupted by the abrogation of nursing home Due Process rights when in the U.S. Department of Health and Human Services (“HHS”). While the

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<sup>2</sup> Three main parties fund nursing homes: Medicare, Medicaid, and private parties. Of the payments received by nursing homes in 2001, Medicare accounted for 11.3%, Medicaid for 67%, and private payors were responsible for 38.9%. See TABLE 13: *Nursing Home Care Expenditures Aggregate and per Capita Amount, Percent Distribution and Average Annual Percent Change by Source of Funds: Selected Calendar Years 1980-2012, HCFA*, at <http://www.cms.hhs.gov/statistics/nhe/projections-2002> (last visited Mar. 21, 2004). Medicare spending on nursing home care totaled \$9.5 billion in 2000 and \$11.6 billion in 2001. *Id.*

<sup>3</sup> THE HONORABLE JOHN B. BREAUX, THE HONORABLE LARRY E. CRAIG, AND THE HONORABLE CHARLES E. GRASSLEY, STAFF OF GEN. ACCT. OFF., 107TH CONG., REPORT ON NURSING HOME EXPENDITURES AND QUALITY 3 (Comm. Print 2002). In 2000, nursing homes provided care to 1.6 million elderly and disabled persons and by 2050 nursing homes are projected to provide care to 6.6 million elderly and disabled persons. See TABLE 13: *Nursing Home Care Expenditures Aggregate and per Capita Amount, Percent Distribution and Average Annual Percent Change by Source of Funds: Selected Calendar Years 1980-2012, HCFA*, *supra* note 2.

<sup>4</sup> 133 CONG. REC. S5714-02 (1987). Providing care for the elderly in nursing homes is an enormous cost that “bankrupt all but the wealthiest nursing homes. *Id.* In 1987, the General Accounting Office reported that the federal government had not fulfilled its statutory assurances of reimbursing nursing homes at a level to provide high quality care. *Id.*

Constitution,<sup>5</sup> the Social Security Act,<sup>6</sup> and Medicare regulations<sup>7</sup> mandate that nursing homes be afforded Due Process rights when challenging noncompliance findings, HHS has unduly restricted nursing homes' rights by denying them access to Medicare<sup>8</sup> compliance hearings.

Congress tried to standardize the requirements of Due Process of law among federal administrative agency's with the passage of the Administrative Procedure Act ("APA").<sup>9</sup> Section 554 of the APA grants individuals a hearing *on the record* to challenge the deprivation of liberty or property,<sup>10</sup> while sections 702 and 704 guarantee individuals the right to appeal an agency's findings to federal court.<sup>11</sup> These rights to a hearing remain subordinate to each agency's governing statute,<sup>12</sup> which often limit the structure of the hearing process and the right to federal review.<sup>13</sup>

For instance, section 1320a-7a(c)(2) of the Social Security Act mandates that HHS provide nursing homes with a hearing *on the record* to appeal findings of alleged noncompliance with the Medicare regulations.<sup>14</sup> Access to agency

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<sup>5</sup> U.S. Cons. Amend. V and XIV.

<sup>6</sup> The Medicare Act is a section of the Social Security Act. *See* Title 18 of the Social Security Act, 42 U.S.C. § 1395. The hearing requirements and limitations concerning nursing homes are found both in the Social Security Act and the Medicare Act. Therefore, throughout the article both the Social Security Act and the Medicare Act are discussed.

<sup>7</sup> 42 C.F.R. §§ 498.5, 498.60-66 (2004).

<sup>8</sup> Medicare is a federal entitlement program to pay for health insurance for the elderly and disabled. *See* INSTITUTE OF MEDICINE, IMPROVING THE QUALITY OF CARE IN NURSING HOMES, App. A (1986) [hereinafter IOM Report]; *also* PETER A. CORNING, THE EVOLUTION OF MEDICARE: FROM IDEA TO LAW, App. A (1969). This article will primarily focus on issues relating to the Medicare Act because federal regulation of nursing homes takes place almost exclusively under Medicare. Even though nursing homes are similarly regulated under the Medicaid Act, each state administers its own Medicaid program based on distinct rules promulgated and implemented by that individual state. The federal government does provide guidance regarding Medicaid regulation; however, the federal government does not actively supervise the activities of regulating nursing homes other than in budgetary matters. Medicaid will only be discussed as it pertains to changes in the Medicare program.

<sup>9</sup> Pub. L. No. 89-554 (Sept. 6, 1966).

<sup>10</sup> 5 U.S.C. § 554 (1994).

<sup>11</sup> 5 U.S.C. §§ 702, 704 (1994).

<sup>12</sup> 5 U.S.C. §§ 554, 702, 704 (2004).

<sup>13</sup> *See Reno v. American-Arab Anti-Discrimination Committee*, 525 U.S. 471 (1999) (The Court ruled that the exclusive clause of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA) barred federal review of claims and causes originating from the Attorney General's action to commence proceedings, adjudicate cases, or execute removal orders.)

<sup>14</sup> 42 U.S.C. §§ 1320a-7a(c)(2) (2004).

review is limited by Section 1320a-7a(j)(1), which incorporates sections 405(g) and (h), that prohibits federal review of a case until HHS reviews the case and issues a final ruling.<sup>15</sup> HHS has further limited the Medicare compliance hearing process by denying nursing homes the right to challenge findings of noncompliance,<sup>16</sup> even though the findings are used against them in future proceedings to deprive the nursing home of property, such as Medicare payments.<sup>17</sup> This denial of nursing homes' Due Process rights in administrative hearing is significant because it is emblematic of the Federal administrative agency system<sup>18</sup> that was upheld by the Supreme Court's decision in the case styled as Shalala v. Illinois Council on Long Term Care, Inc. [hereinafter Ill. Council].<sup>19</sup>

In Ill. Council, the Illinois Council on Long Term Care ("Council")<sup>20</sup> argued that the statutory provisions that barred nursing homes from bringing a case in federal court until they had exhausted their administrative remedies, effectively denying nursing homes Due Process.<sup>21</sup> The Council averred that as a practical matter it was impossible to exhaust their administrative remedies, and thus negated their ability to seek federal review for procedural and Constitutional issues.<sup>22</sup> In response, the Secretary of HHS<sup>23</sup> ("Secretary") asserted that nursing homes were afforded the right to procedural Due Process protections, which included "the right of any dissatisfied nursing home to a *full evidentiary hearing*

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<sup>15</sup> 42 U.S.C. §§ 405(g) & (h) (2004).

<sup>16</sup> ALJs summarily dismiss nursing home appeals in Medicare noncompliance cases when HHS has not imposed a remedy. See Arcadia Acres, Inc., DAB No. CR424 (1996), *aff'd* DAB No. 1607 (1997); Jacinto City Healthcare Ctr., DAB No. CR627 (1999); Heritage Manor of Franklinton, DAB No. CR666 (2000); Lutheran Home – Caledonia, DAB No. CR 674 (2000), *aff'd* DAB No. 1753 (2000); Lakewood Plaza Nursing Ctr., DAB No. CR 691 (2000), *aff'd* DAB No. 1767 (2001); Lakeland Lodge Nursing Ctr., DAB No. CR893 (2002); Southwood Care Ctr., DAB No. CR1029 (2003); Highlands at Brighton, DAB No. CR1104 (2003); Manorcare Health Services Sandia, DAB No. CR1255 (2004).

<sup>17</sup> 42 C.F.R. §§ 498.5, 498.60-66 (2004).

<sup>18</sup> Recently there have been many actions challenging the denial of Due Process rights in agency hearing conducted by the Immigration and Naturalization Services. See Reno v. American-Arab Anti-Discrimination Committee, 525 U.S. 471 (1999); *also* McNary v. Haitian Refugee Center, Inc., 498 U.S. 479 (1991).

<sup>19</sup> Shalala v. Illinois Council on Long Term Care, Inc., 529 U.S. 1 (2000). [hereinafter Ill. Council]

<sup>20</sup> The Illinois Council on Long Term Care, incorporated under the laws of Illinois, is an association of approximately two hundred nursing homes doing business in Illinois. See Ill. Council, 1997 WL 158347, at \*1 (N.D.Ill. 1997).

<sup>21</sup> Ill. Council, 529 U.S. 1, 20-3 (2000).

<sup>22</sup> Id. at 20.

<sup>23</sup> At the time of the case the Secretary of Health and Human Services, hereafter referred as the Secretary, was Donna Shalala.

to challenge *any* findings of noncompliance.”<sup>24</sup> The Supreme Court ruled that nursing homes were barred from seeking federal review of a case until they had presented their case to HHS and received a final ruling, even if the claims were based on Constitutional issues.<sup>25</sup>

Notwithstanding the assertions made in Ill. Council, HHS has whittled away the very procedural Due Process rights that the Court relied upon in its ruling in Ill. Council. Since Ill. Council, the Administrative Law Judges (“ALJs”) have consistently ruled, and the Departmental Appeals Board (“DAB”)<sup>26</sup> has affirmed, that if HHS fails to impose or rescinds the remedies imposed for a nursing home’s alleged noncompliance, nursing homes do not have a right to a hearing even though the findings of noncompliance are not rescinded,<sup>27</sup> nor removed from the HHS website,<sup>28</sup> and are the basis for the imposition of remedies for future incidents of noncompliance.<sup>29</sup> In fact, this proposition was codified in the Code of Federal Regulations in 1996, four years before the Supreme Court heard and issued its ruling in Ill. Council.<sup>30</sup> Many of the ALJs have drastically reduced the full evidentiary hearing process<sup>31</sup> to direct testimony through submission of affidavit and in-person cross-examination of witnesses.<sup>32</sup>

As a result of these changes, nursing homes have been left without an opportunity to be heard in the agency proceeding and in federal court before the loss of their property, namely Medicare payments.<sup>33</sup> This contravenes the letter and spirit of the Due Process Clause of the Fifth Amendment that guarantees a right to process for the loss of property. In order to comply with traditional notions of procedural Due Process required by the Constitution, the Social Security Act, the Medicare regulations, and the APA, I argue that HHS must provide nursing homes with hearing rights in all cases and allow them to bypass

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<sup>24</sup> Ill. Council, 529 U.S. at 20 (emphasis added).

<sup>25</sup> Id. at 23.

<sup>26</sup> The Departmental Appeals Board (“DAB”) is the appellate branch of HHS’ hearing division. See 42 C.F.R. § 498.80 (2004). The Board is made up of three ALJs: Chief ALJ Ford, Ballard, and Garrett.

<sup>27</sup> See 42 C.F.R. § 498.3(b)(12) (2004) (this section was redesignated as § 498.3(b)(13) in 2001. See 65 Fed. Reg. 18549 (Apr. 7, 2000)).

<sup>28</sup> Ill. Council, 529 U.S. 1, 22 (2000).

<sup>29</sup> See 42 C.F.R. §§ 488.404(c)(2), 488.438(f)(1) and (3) (2004).

<sup>30</sup> See 61 Fed. Reg. 32347 (June 24, 1996) (codified as 42 C.F.R. §431.153(b) (2003)).

<sup>31</sup> 42 C.F.R. §§ 498.5, 498.60-66 (2004).

<sup>32</sup> Judicial Order from ALJ Kessel regarding pre-hearing findings (on file with author).

<sup>33</sup> No federal court has ruled that Medicare payments constitute property; however, most courts ignore this issue and simply review the merits of the case. See Matthews v. Eldridge, 424 U.S. 319 (1976); Ringer, 466 U.S. 602 (1984); Bowen v. Mich. Acad. of Family Physicians, 476 U.S. 667 (1986); Jordan Hosp., Inc. v. Shalala, 276 F.3d 72 (1st Cir. 2002).

the administrative system if the only challenge concerns Constitutional or statutory procedures.

This article will examine the failure of HHS to provide nursing homes with procedural Due Process rights by analyzing the Supreme Court decision in Ill. Council. Section II will briefly trace the history of Due Process in HHS hearings. The evolution of the survey and certification of nursing homes and the Due Process rights granted by HHS in nursing home hearings is discussed in Section III. Section IV reviews the pivotal case of Ill. Council, which barred nursing homes' access to federal courts to challenge the Constitutionality of HHS' actions, while the problems with the case and possible solutions to rectify these problems are addressed in Section V.

## II. BRIEF HISTORY OF DUE PROCESS IN HHS HEARINGS

The cornerstone of the American justice system, the Due Process Clause of the Fifth Amendment of the U.S. Constitution, guarantees that no person will "be deprived of life, liberty, or property, without due process of law."<sup>34</sup> Unfortunately, individuals are not always granted these Due Process rights when challenging the deprivation of liberty or property by Federal administrative agencies.<sup>35</sup> The abrogation of these protections during Federal administrative Agency adjudications has created an eternal tension between the agencies, the individuals regulated by the agencies, and the federal courts. This tension pervades the lives of every individual and business as Federal administrative agencies, such as HHS,<sup>36</sup> govern vital aspects of all daily living.

The two major events concerning Due Process in HHS administrative hearings were: the passage of the Administrative Procedure Act of 1946 and the Supreme Court's decisions discussing the Social Security Act and Medicare's bar to federal review.<sup>37</sup> Each of these actions constituted either an expansion or constriction of Due Process rights in HHS that have profoundly affected the Due Process rights of nursing homes.

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<sup>34</sup> U.S. CONS. AMEND. V and XIV. Based on the Supreme Court case of Santa Clara County v. S. Pac. R.R. Co., 118 U.S. 394 (1886), businesses (i.e. corporations) are considered persons under the law and thus are guaranteed due process under the law.

<sup>35</sup> Richard J. Pierce, Jr. *The Due Process Counterrevolution of the 1990s?*, 96 COLUM. L. REV. 1973 (1996).

<sup>36</sup> The U.S. Department of Health, Education, and Welfare was renamed the U.S. Department of Health and Human Services ("HHS") in 1980. *See* Department of Education Organization Act of 1979, Pub. L. No. 96-88, § 509(e), 93 Stat. 695 (1979) (codified as 20 U.S.C. § 3508 (2000)). For simplicity and continuity, this article refers to the agency only as the U.S. Department of Health and Human Services.

<sup>37</sup> Weinberger v. Salfi, 422 U.S. 749 (1975); Eldridge, 424 U.S. 319 (1976); Ringer, 466 U.S. 602 (1984); Bowen, 476 U.S. 667 (1986).

A. *The Administrative Procedure Act – Fairness in Administrative Agency hearings.*

As early as the 1920s, Congress began delegating broad powers to Federal administrative agencies to protect the health, safety and welfare of the public, but the Supreme Court regularly overturned these delegations.<sup>38</sup> After 1935, the Supreme Court upheld broad Congressional delegation of power to Federal administrative agencies, culminating in several cases in which the Court upheld delegation of power to agencies with little to no standards.<sup>39</sup> With the proliferation of Federal administrative agencies, Congress became concerned with the potential for administrative bias in Federal administrative hearings because agencies were granted significant discretion in their hearing procedures.<sup>40</sup> Because the agency served as the investigator, the prosecutor, and the judge, Congress questioned whether the agency could be genuinely impartial.<sup>41</sup> There were a series of bills introduced in Congress in the 1930s and 1940s aimed at correcting the problems of administrative tribunal review.<sup>42</sup>

In 1937, President Roosevelt also became concerned with the fairness of the administrative review process and created the Committee on Administrative

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<sup>38</sup> See Panama Refining Co. v. Ryan, 293 U.S. 388 (1935); A.L.A. Schechter Poultry Corp v. United States, 295 U.S. 495 (1935).

<sup>39</sup> See Yakus v. United States, 321 U.S. 414 (1944) (Court upheld broad delegation of power to Price Administrator to regulate commodity pricing); Lichter v. United States, 334 U.S. 742 (1948) (Court upheld statute giving the executive branch the power to recover profits from war contracts deemed excessive without defining what constituted excessive); Fahey v. Mallonee, 332 U.S. 245 (1947) (Court upheld Congressional delegation of power to Federal Loan Bank Board to issue regulations for when a conservator could be appointed to take over a mismanaged federal savings and loan association). The Court's decisions in these cases, leading to the independence of agencies from executive, legislative, and judicial controls, solidified the place of the Federal administrative agency as the "fourth branch" of the federal government. See KENNETH CULP DAVIS & RICHARD J PIERCE, JR., ADMINISTRATIVE LAW TREATISE (3d ed. 1994).

<sup>40</sup> Wong Yang Sung v. McGrath, 339 U.S. 33, 37-38 (1950) *citing* S. 5154, 70th Cong. (2d Sess. 1929).

<sup>41</sup> Wong Yang Sung, 339 U.S. at 41-42 *citing* ADMINISTRATIVE MANAGEMENT IN THE GOVERNMENT OF THE UNITED STATES, REPORT OF THE PRESIDENT'S COMMITTEE ON ADMINISTRATIVE MANAGEMENT 36-37 (1937).

<sup>42</sup> S. 1835, 73d Cong. (1st Sess. 1933); S. 3787, H.R. 12297, 74th Cong. (2d Sess. 1936); S. 3676, 75th Cong. (3d Sess. 1938); H.R. 6324, H.R. 4235, H.R. 4236, S. 915, S. 916, 76th Cong. (1st Sess. 1939); S. 674, S. 675, S. 918, H.R. 3464, H.R. 4238, H.R. 4782, 77th Cong. (1st Sess. 1941); H.R. 4314, H.R. 5081, H.R. 5237, S. 2030, 78th Cong. (2d Sess. 1944); H.R. 1203, S. 7, 79th Cong. (1st Sess. 1945).

Management.<sup>43</sup> Two years later, the President also directed the Attorney General to establish a new “committee of eminent lawyers, jurists, scholars, and administrators to review the entire administrative process in the various departments of the executive Government and to recommend improvements, including the suggestion of any needed legislation.”<sup>44</sup> Before the Attorney General’s Committee Report was issued, Congress passed the Walter-Logan bill that standardized the administrative review process. The Walter-Logan bill provided for a standard hearing process that included a right to appeal agency actions in writing, a right to a hearing before a three panel board, a right to call witnesses and compel documents, and a right to appeal the decision of the U.S. Circuit Courts of Appeal.<sup>45</sup> President Roosevelt vetoed the bill,<sup>46</sup> acknowledging the need for reform, but delaying his decision until the Attorney General Committee’s Report was issued.<sup>47</sup>

To instill a sense of fairness and eradicate the bias and arbitrary nature of agency hearings, the Attorney General Committee’s Report (“the Report”) recommended that agencies completely separate adjudication functions and personnel from those investigating and prosecuting claims.<sup>48</sup> However, in comparison to the Walter-Logan bill, the Report provided generalized guidelines for attaining these goals rather than providing specific procedures. Congress used the Report to craft the bill that was later entitled the Administrative Procedure Act of 1946.<sup>49</sup> Even though the broad language in the Report allowed the agency more flexibility in fulfilling the requirements of fairness, Congress tried to provide safeguards in the APA by making it clear that all agency decisions were reviewable by the federal courts unless Congress clearly withheld that right. The Senate Committee on the Judiciary stated:

Very rarely do statutes withhold judicial review. It has never been the policy of Congress to prevent the administration of its own statutes from being judicially confined to the scope of authority

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<sup>43</sup> ADMINISTRATIVE MANAGEMENT IN THE GOVERNMENT OF THE UNITED STATES, REPORT OF THE PRESIDENT’S COMMITTEE ON ADMINISTRATIVE MANAGEMENT 37 (1937).

<sup>44</sup> The quoted statement is from President Roosevelt’s message to Congress on December 18, 1940, vetoing the Walter-Logan Act of 1940. *See* H.R. 6324, 76th Cong. § 3-4 (3d Sess. 1940).

<sup>45</sup> 86 CONG. REC. 13674 (1940).

<sup>46</sup> S. 915, H.R. 6324, 76th Cong. (1st Sess. 1939). *See also* 86 CONG. REC. 13942--3 (1940), *reprinted in* H.R. DOC. NO. 986, 76th Cong. (3d Sess. 1940).

<sup>47</sup> 86 CONG. REC. at 13943.

<sup>48</sup> FINAL REPORT OF THE ATTORNEY GENERAL’S COMMITTEE ON ADMINISTRATIVE PROCEDURE 7 (1941) *contained in* S. Doc. No. 8, 77th Cong. (1st Sess. 1941).

<sup>49</sup> S. REP. No. 79-752, at 26 (1945).

granted or to the objectives specified. Its policy could not be otherwise, for in such a case statutes would in effect be blank checks drawn to the credit of some administrative officer or board.<sup>50</sup>

The House of Representatives Committee on Judiciary further said that there should be judicial review and stressed that when that review is limited the intent is clear.<sup>51</sup> The APA also afforded the right to some procedural safeguards on the agency level once the agency's governing statute granted hearing rights.<sup>52</sup> Most significantly, APA §554 provided that:

every case of adjudication required by statute to be determined *on the record* after opportunity of an agency hearing.<sup>53</sup>

This section explicitly grants a right to a full evidentiary hearing on the record. Although, Congress enacted the APA of 1946 to address issues of fairness in the administrative hearing process,<sup>54</sup> these rights to a hearing remain subordinate to each agency's governing statute,<sup>55</sup> which often limits the structure of the hearing process and the right to federal review.<sup>56</sup> For instance, the requirement of exhausting all administrative remedies before bringing a case in federal court only applies when provided by an agency's governing statute.<sup>57</sup> This is the case in hearings conducted by HHS in the long-term care arena.<sup>58</sup> The Social Security Act limits the reviewability of claims in both the administrative agency process and in the federal courts. Thus, after the passage of the APA, the main question for individuals challenging the actions of HHS under the Social

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<sup>50</sup> Bowen, 476 U.S. 667, 671 (1986), *citing* S. REP. NO. 79-752, at 26 (1945).

<sup>51</sup> H.R. REP. NO. 79-1980 at 41 (1946).

<sup>52</sup> 5 U.S.C. § 554 (1994).

<sup>53</sup> Id.

<sup>54</sup> Pub. L. No. 89-554 (Sept. 6, 1966). *See also* FINAL REPORT OF THE ATTORNEY GENERAL'S COMMITTEE ON ADMINISTRATIVE PROCEDURE 7 (1941) *contained in* S. DOC. NO. 8, 77th Cong. (1st Sess. 1941).

<sup>55</sup> 5 U.S.C. §§ 554, 702, 704 (2004).

<sup>56</sup> *See* Reno v. American-Arab Anti-Discrimination Committee, 525 U.S. 471 (1999) (The Court ruled that the exclusive clause of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA) barred federal review of claims and causes originating from the Attorney General's action to commence proceedings, adjudicate cases, or execute removal orders.)

<sup>57</sup> Darby v. Cisneros, 509 U.S. 137 (1993).

<sup>58</sup> *See* Heckler v. Ringer, 466 U.S. 602 (1984); Dallas Healthcare, Inc. v. Health & Human Servs. Comm'n, 921 F. Supp. 426 (N.D. Tex. 1996); Int'l Long Term Care, Inc. v. Shalala, 947 F. Supp. 15 (D.D.C. 1996); Michigan Ass'n of Homes & Service for the Aging, Inc. v. Shalala, 127 F.3d 496 (6th Cir. 1997).

Security Act was predicated on whether the agency had the right to limit federal review of Constitutional issues even if it meant no right to meaningful review.

B. *Can Federal Courts Review Due Process Challenges under the Social Security Act?*

Under 42 U.S.C. §§ 405(g) and 405(h), federal courts are barred from reviewing any Social Security action under 28 U.S.C. §§1331<sup>59</sup> and 1346<sup>60</sup> before HHS has issued a final ruling. Specifically, 42 U.S.C. § 405(g) states:

Any individual, after any *final decision* of the Commissioner of Social Security made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action ... Such action shall be brought in the district court of the United States.

(emphasis added).<sup>61</sup> This review is further limited by 42 U.S.C. § 405(h), which says:

No findings of fact or decision of the Commissioner of Social Security shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Commissioner of Social Security, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.<sup>62</sup>

This bar to federal review before a final decision from the Secretary was incorporated into the Medicare Act by 42 U.S.C. §§ 1320a-7a(c)(2) and (j)(1).<sup>63</sup> The “exhaustion” requirements in 42 U.S.C. § 405(g) & (h) has allowed the Secretary to channel all claims through the agency process. In 1975, the Supreme

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<sup>59</sup> “The district courts shall have original jurisdiction of all civil actions arising under the Constitution, Laws, or treaties of the United States.” 28 U.S.C. §1331 (2004).

<sup>60</sup> “The district courts shall have original jurisdiction concurrent, with the Federal Court of Claims of any civil claim against the United States for the recovery of any internal-revenue tax or any other civil action or claim against the United States, not exceeding \$10,000 in amount, founded either upon the Constitution, or any Act of Congress, or any regulation of an executive department, or upon any express or implied contract with the United States.” 28 U.S.C. §§1346 (2004).

<sup>61</sup> 42 U.S.C. § 405 (g) (2004).

<sup>62</sup> 42 U.S.C. § 405 (h) (2004).

<sup>63</sup> Under 42 U.S.C. § 1320a-7(c)(1), nursing homes are granted a right to a hearing. These hearing rights are limited by 42 U.S.C. § 1320a-7a(c)(2), which makes 42 U.S.C. §§ 405 (g) & (h) applicable to nursing home hearings.

Court decided a case entitled Weinberger v. Salfi,<sup>64</sup> establishing a broad rule barring all claims arising under the Social Security Act regardless of whether they involved Constitutional or statutory challenges. In Salfi, a class action suit was brought in federal district court challenging HHS' denial of Social Security benefits because of the duration of relationship requirement.<sup>65</sup> According to the duration requirement, the surviving spouse must have been married to the deceased worker for at least nine months before the death of the worker to receive Social Security benefits.<sup>66</sup> The class represented both members that had been denied and those that had not yet submitted claims for benefits.<sup>67</sup> The class asserted that the duration requirement was unconstitutional based on the Equal Protection Clause, and requested the immediate payment of benefits.<sup>68</sup> Even though, neither party raised the issue of jurisdiction nor did the resolution of jurisdiction issue resolve the entire case, the Supreme Court ruled that it did not have subject matter jurisdiction over the members of the class that had not presented their case to HHS.<sup>69</sup> Under 42 U.S.C. § 405(h), federal review was barred until two steps had been completed: the case had first been presented to the agency and the Secretary had issued a final ruling.<sup>70</sup>

The complaints argued that the section was merely an exhaustion requirement.<sup>71</sup> Courts usually require exhaustion “as a matter of preventing premature interference with agency processes, so that the agency may function efficiently and so that it may have an opportunity to correct its own errors, to afford the parties and the courts the benefit of its experience and expertise, and to compile a record which is adequate for judicial review.”<sup>72</sup> The complaints argued

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<sup>64</sup> Salfi, 422 U.S. 749 (1975).

<sup>65</sup> Id. at 754.

<sup>66</sup> Pub. L. No. 90-248 §§ 156(a) & (b), 81 Stat. 866 (1967) (codified as 42 U.S.C. §§ 416(c)(5) & (e)(2) (1970)).

<sup>67</sup> Salfi, 422 U.S. at 755.

<sup>68</sup> Id. The United States District Court for the Northern District of California ruled for the class and granted declaratory and injunctive relief. Id.

<sup>69</sup> Id. at 787. The dissent, written by Justice Brennan and joined by Justice Marshall, pointed out the fact that the jurisdictional issue was not raised by either party, was only discussed in passing in the oral arguments, and did not resolve the entire case. Id. at 787-89. Thus, the Court should not have discussed the jurisdiction issue. Id. at 789.

<sup>70</sup> Id. at 756.

<sup>71</sup> Furthermore, the dissent contended that the channeling provision of 42 U.S.C. § 405(h) was merely an exhaustion requirement for questions of fact and statutory interpretation. Id. at 789. To support this contention, Justice Brennan cited to the legislative history when the amendment was passed and the Social Security Board's discussion of the statute immediately after its passage. Id. at 790-792.

<sup>72</sup> Id. at 765. The two relevant exceptions to the exhaustion requirement in this case are: futility of review and irreparable harm. Abbott Laboratories v. Gardner, 387 U.S. 136, 148-149 (1967); McKart v. U.S., 395 U.S. 185, 197-201 (1969).

that completing the agency process was futile because the issue of Constitutionality is outside the scope of the Secretary's authority.<sup>73</sup> The Supreme Court held that 42 U.S.C. § 405(h) was not a mere exhaustion requirement, but that the federal review bar prohibited all federal review save for those actions mentioned in 42 U.S.C. § 405(g).<sup>74</sup> The Court announced that 42 U.S.C. § 405(h) was not limited to mere decisions of fact or law, but also applied to any action seeking to recover under the Social Security Act including Constitutional questions.<sup>75</sup>

Therefore, according to the Court, even Constitutional claims must first be brought to the agency, so that the Secretary may determine if the claims can be resolved under the Social Security Act.<sup>76</sup> Because the members of the class were seeking payment of Social Security benefits, their claims arose under the Act and were not reviewable until the claims were first presented to HHS and the Secretary issued a final ruling.<sup>77</sup> Nevertheless, the members of the claim that had presented their case to HHS were not barred by 42 U.S.C. § 405(h), so the court went on to address the substantive issue of the complaint.<sup>78</sup> The Supreme Court's decision to impose the subject matter jurisdiction requirement for all cases arising under the Social Security Act regardless of the content of the claim seemingly cut off Social Security claimants' access to the federal courts, but this was not the case in Matthews v. Eldridge.<sup>79</sup>

The Supreme Court allowed the Social Security recipient in Eldridge to bring a claim in federal court challenging the Constitutionality of the procedures afforded in a Social Security hearing even though he had not fulfilled the subject matter jurisdiction requirements of announced in Salfi. In Eldridge, Mr. Eldridge challenged the Secretary's decision to revoke his Social Security disability benefits prior to providing an evidentiary hearing.<sup>80</sup> Eldridge received a letter from the state agency administering Social Security benefits that his disability had ceased and thus his payments would be terminated.<sup>81</sup> Eldridge responded to the agency in writing disputing the characterization of his medical condition.<sup>82</sup> The state agency reviewed his response, but issued a final determination that

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<sup>73</sup> Salfi, 422 U.S. at 765.

<sup>74</sup> Id. at 758.

<sup>75</sup> Id. at 762.

<sup>76</sup> Id.

<sup>77</sup> Id. at 785. The dissent also asserted that the case did not arise under the Social Security Act. Instead, the claim arose under the Equal Protection Clause, a Constitutional matter. Id. at 795.

<sup>78</sup> Id. at 797.

<sup>79</sup> Eldridge, 424 U.S. 319 (1976).

<sup>80</sup> Id.

<sup>81</sup> Id. at 324.

<sup>82</sup> Id.

Eldridge's disability had ceased.<sup>83</sup> HHS accepted the state's determination and sent a letter to Eldridge stating that his benefits would be cancelled in July and granted him appeal rights.<sup>84</sup> Instead of appealing the determination, Eldridge filed suit in federal court challenging the Constitutionality of HHS' practice of granting only a post-termination hearing to appeal the termination of disability benefits rather than a pre-termination hearing. He also requested immediate reinstatement of his benefits pending such a hearing.<sup>85</sup> The Secretary moved for dismissal based on the Supreme Court's decision in Salfi that 42 U.S.C. § 405(h) required Eldridge to present the case to HHS and receive a final ruling before federal review.<sup>86</sup>

The Supreme Court ruled that Eldridge's letter to the state disputing the characterization of his medical condition fulfilled the "present requirement" of 42 U.S.C. § 405(h), even though Eldridge did not raise any Constitutional question in his letter.<sup>87</sup> This was not fatal to his claim because 42 U.S.C. § 405(h) only required a final decision on the issues relating to the Social Security Act, not that all issues be presented to HHS.<sup>88</sup> The Court also found that the finality requirement was waivable and waived the requirement because Eldridge's case was so significant "that deference to the agency's judgment is inappropriate."<sup>89</sup> Furthermore, Eldridge's Constitutional claims were collateral to his claim for future Social Security benefits. The Court reasoned that Eldridge's claim regarding the timing of the benefits hearing under the Social Security Act did not arise under the Social Security Act because without this review Eldridge's Constitutional claim would never be addressed.<sup>90</sup> Hence, the Court seemingly created an exception for Eldridge that if 42 U.S.C. § 405(h) would serve to bar federal review, then the case could be filed in federal court after presentment to agency. The Court's decision in Eldridge was a major shift from its decision in Salfi barring federal review until both steps were fulfilled. The exception applied in Eldridge was a mere aberration illustrated by the Court's subsequent decisions that returned to the strict requirements set forth in Salfi requiring presentment and a final agency decision before allowing federal review of an agency's action.

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<sup>83</sup> Id.

<sup>84</sup> Id.

<sup>85</sup> Id. at 324-325. The district court found that HHS' procedures violated Eldridge's Due Process rights because the hearing was a post-termination hearing rather than a pre-termination hearing that would ensure the uninterrupted payment of benefits to Eldridge. Id. at 326.

<sup>86</sup> Id. at 325.

<sup>87</sup> Id. at 329.

<sup>88</sup> Id.

<sup>89</sup> Id. at 330.

<sup>90</sup> Id. at 331.

In Heckler v. Ringer,<sup>91</sup> four Medicare recipients brought an action in federal court based on federal question jurisdiction challenging the disallowance of benefits to cover a surgical procedure to relieve respiratory distress.<sup>92</sup> Medicare patients seeking reimbursement for the procedure were awarded money to cover their surgery costs until 1980 when HHS issued a formal administrative ruling prohibiting reimbursement for the surgery.<sup>93</sup> Three of the four claimants had already had the surgery before 1980 and were seeking reimbursement, while Ringer, the fourth claimant, could not afford the surgery and was seeking money to undergo surgery.<sup>94</sup> Each claimant was at a different stage in the appeal process, but none of the claimants had received a final ruling from the Secretary.<sup>95</sup> The Supreme Court dismissed three of the claimants' cases because they had their surgery before the Secretary issued the administrative ruling and were not barred from reimbursement.<sup>96</sup>

The only remaining claimant, Ringer, had requested payment from HHS, but the Secretary was unwilling to issue a ruling in his case until he underwent the surgery. Ringer had not undergone the surgery because he was indigent and was seeking a judgment to obtain the money necessary for the surgery. In response to Ringer's case, the Court ruled that section 405(h) applied to his claim because although he maintained that the administrative ruling was unconstitutional, he was still seeking reimbursement of the award of benefits under the Medicare Act.<sup>97</sup> Thus, his claims arose under the Medicare Act.<sup>98</sup> According to the Court, regardless of whether his claim challenged the procedures of HHS or the substance of HHS' actions, 42 U.S.C. § 405(h) barred federal courts from ruling on these claims, if they arose under the Medicare Act, until a final action from the Secretary.<sup>99</sup>

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<sup>91</sup> Ringer, 466 U.S. 602 (1984).

<sup>92</sup> Id. at 605. Their claims were dismissed by the United States District Court for the Central District of California for lack of subject matter jurisdiction and reinstated by the United States Court of Appeals for the Ninth Circuit.

<sup>93</sup> Medicare Program, 45 Fed. Reg. 71426-71427 (1980). (Because of the lack of acceptance by the medical community over the effectiveness of the surgery, the Secretary issued an administrative instruction to all fiscal intermediaries and ALJs that no payment is to be made for Medicare claims for the surgical procedure to relieve respiratory distress. Ringer, 466 U.S. at 607).

<sup>94</sup> Ringer, 466 U.S. at 609.

<sup>95</sup> Id. at 610.

<sup>96</sup> Id.

<sup>97</sup> Under 42 U.S.C. § 1320a-7(c)(1), nursing homes are granted a right to a hearing. These hearing rights are limited by 42 U.S.C. § 1320a-7a(c)(2), which makes 42 U.S.C. §§ 405 (g) & (h) applicable to nursing home hearings.

<sup>98</sup> Id.

<sup>99</sup> Id. at 615.

Even though the Secretary had drafted an exception to the subject matter jurisdiction requirement to allow cases to go to federal court after the reconsideration stage “when the only factor precluding award of benefits is a statutory provision which the claimant challenges as unconstitutional,”<sup>100</sup> the Court ruled that the exception did not apply in this case because the Constitutional claims were inextricably linked with their benefits claims.<sup>101</sup> Furthermore, the Court ruled that the claimant seeking money to have the surgery still had an avenue of review even if there was a presumption against reimbursement. Thus, Ringer’s case was dismissed for lack of subject matter jurisdiction. Effectively, this left Ringer with no avenue for review because he had no right to agency review until after he underwent the surgery, which he could not afford to have.<sup>102</sup> Although the Court’s decision in Ringer left him with no meaningful review, the Court did not allow this as an exception to section 405(h) until its decision in Bowen v. Michigan Academy of Family Physicians.<sup>103</sup>

In Bowen, an association of family physicians filed a lawsuit challenging the validity of a HHS regulation permitting lower payments for similar services based on the type of physician providing the care.<sup>104</sup> The Secretary argued that Congress had prohibited any federal review of amount determinations under Medicare Part B.<sup>105</sup> According to the Secretary, 42 U.S.C. § 405(g) only granted hearing rights to those under Medicare Part A and 42 U.S.C. § 405(h) precluded all administrative and judicial review of claims not noted in 42 U.S.C. § 405(g). The Supreme Court ruled that the legislative history of the APA proved otherwise. Specifically, the Senate and House Judiciary Committee Report stated that there is a presumption of review unless explicitly stated.<sup>106</sup> Moreover, the legislative history from 42 U.S.C. §§ 405(g), (h) confined all amount determinations solely to the agency “to avoid overloading the courts with quite minor affairs.”<sup>107</sup> Therefore, the Court ruled because Congress neither granted

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<sup>100</sup> Id. at 611, 614.

<sup>101</sup> Id.

<sup>102</sup> The dissent, authored by Justice Stevens and joined by Justices Brennan and Marshall, agreed with the court’s decision concerning the three claimants that had the surgery before 1980. Id. at 628. However, the dissent reiterated their argument from Salfi that Ringer was not barred by 42 U.S.C. § 405(h) because his claim arose under the Constitution not the Medicare Act. Id. at 630. Moreover, the dissent asserted that Ringer had no other avenue for review because the Secretary refused to issue a ruling on his case until he actually had the surgery, which he was unable to afford. Id. at 630-631. Thus, until he raised the money to have the surgery he was prohibited for bring any agency action or federal claim to challenge the denial of payment. Id. at 629.

<sup>103</sup> Bowen, 476 U.S. 667, 678 (1986).

<sup>104</sup> Id.

<sup>105</sup> Id. at 669.

<sup>106</sup> H.R. REP. NO. 79-1980, at 41 (1946). S. REP. NO. 79-752, at 26 (1945).

<sup>107</sup> Bowen, 476 U.S. at 677 (1986) *citing* 118 CONG. REC. 33992 (1972).

HHS the authority to review all other claims nor clearly prohibited federal review of these issues, the physicians' claims regarding the Constitutionality of the regulations was reviewable. Finally, the physicians did not have to present the claim to HHS or wait until the Secretary issued a final ruling as required by Salfi and Ringer because in this instance there was no agency hearing process, so the only means of review was federal review.

The Court ruled that Congress rarely withholds judicial review and it is questionable whether Congress can prohibit any federal review of issues concerning Constitutional questions.<sup>108</sup> The Court's decision in Bowen that Congress did not intend to prevent federal review harkens back to the principles espoused by the Senate Committee on the Judiciary when discussing the APA. Nevertheless, the Court's decisions in Salfi and Ringer showed that if HHS provided any means by which individuals could obtain agency review, the requirements of section 405(h) had to be fulfilled before submitting the case for federal review. HHS stretched the limitations of the Supreme Court's rulings when it implemented a strict Medicare regulatory scheme to regulate nursing homes in 1995, which on paper provides agency review, but in reality forecloses agency and federal review.

### **III. HISTORY OF THE MEDICARE NURSING HOME HEARING PROCESS GOVERNED BY HHS**

The principal health care program funded and directly administered by HHS is the Health Insurance for the Elderly and Disabled program, better known as Medicare.<sup>109</sup> Medicare consists of three parts that pay for sundry care for the elderly: Part A (Hospital Insurance), Part B (Supplemental Medical Insurance), and Part C (Medicare Managed Care).<sup>110</sup> Part A covers nursing home care for persons over the age of 65, if residence at a nursing home follows within 30 days

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<sup>108</sup> Bowen, 472 U.S. at 681, fn12.

<sup>109</sup> *See* Social Security Act, 42 U.S.C. § 1395 (2004). Initially, the Office of Nursing Home Affairs, a division of HHS, administered Medicare. INSTITUTE OF MEDICINE, IMPROVING THE QUALITY OF CARE IN NURSING HOMES, 244 (App. A) (1986) [hereinafter IOM Report]. In 1977, the Centers for Medicare & Medicaid Services, formerly known as the Health Care Financing Administration ("HCFA"), was created to administer and regulate Medicare. *See* Pub. L. No. 95-135, 91 Stat. 1166 (1977); 66 Fed. Reg. 35,437-03 (July 5, 2001). This article refers to the agency as HCFA when referring to specific cases, otherwise the agency will be referred to as HHS to prevent any confusion.

<sup>110</sup> *See* Social Security Act, 42 U.S.C. §§ 1395c, 1395j, 1395w-21 (2004). Medicare covers up to 100 days of care received at a nursing home. *See* Social Security Act, 42 U.S.C. §§ 1395c (2004). However, Part A does not cover any nursing home services if the patient who requires skilled nursing or skilled rehabilitation services can receive these services on an outpatient basis.

of a hospitalization of three or more days, and is certified as medically necessary.<sup>111</sup> Medicare covers up to 100 days of care received at a nursing home.<sup>112</sup> Nursing homes are subject to Medicare regulations as a result of their receipt of Medicare funds.

To participate in the Medicare program, nursing homes must submit to a certification process, which includes a thorough inspection of the facility and patients to ensure that they comply with the Medicare regulations.<sup>113</sup> Once the nursing home is certified to participate in Medicare, HHS contracts with State health agencies<sup>114</sup> to conduct annual re-certification inspections of each Medicare certified nursing home.<sup>115</sup> This re-certification process is called survey and certification.<sup>116</sup> HHS aggressively regulates the nursing home industry through its survey and certification process, citing nursing homes for noncompliance with the Medicare regulations.<sup>117</sup> The federal nursing home survey and certification process under Medicare has changed substantially since its advent in 1965.<sup>118</sup> The most significant changes occurred with the passage of the Nursing Home Reform Act, a part of the Omnibus Reconciliation Act of 1987.<sup>119</sup> The Nursing Home Reform Act not only changed the survey and certification regulations, but it also altered the structure of the hearing process used by nursing homes to challenge the survey findings.

#### *A. The Evolution of Survey and Certification Regulations Used to Police Nursing Homes*

Since the passage of the Social Security Act of 1935, the federal government has been providing funding to nursing homes, but federal regulation

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<sup>111</sup> See Social Security Act, 42 U.S.C. §§ 1395c (2004); *History of Medicare and Medicaid*, available at <http://www.cms.hhs.gov/about/history/ssachr.asp> (last modified Sept. 16, 2004).

<sup>112</sup> See Social Security Act, 42 U.S.C. §§ 1395c (2004). However, Part A does not cover any nursing home services if the patient who requires skilled nursing or skilled rehabilitation services can receive these services on an outpatient basis.

<sup>113</sup> See 42 C.F.R. §§ 488.3(a)(2), (b)(2), (b)(3) (2004).

<sup>114</sup> The State agency in Illinois responsible for conducting surveys of nursing homes is the Illinois Department of Public Health. See 210 ILL. COMP. STAT. §§ 45/1-109, 45/3-212 (2004).

<sup>115</sup> Survey Frequency, 42 C.F.R. § 488.308(a) (2004).

<sup>116</sup> Survey & Certification of Long-Term Care Facilities, 42 C.F.R. § 488, Subpart E (2004).

<sup>117</sup> See HHS Fact Sheet, *Assuring quality care for nursing home residents*, available at <http://www.cms.hhs.gov/media/press/release.asp?Counter=384> (last visited Mar. 15, 2004).

<sup>118</sup> Institute of Medicine, *Improving the Quality of Care in Nursing Homes*, 238 (App. A) (1986).

<sup>119</sup> Pub. L. No. 100-203 §§ 4201-4218, 105 Stat. 1107 (1987).

of the care provided by nursing homes did not begin until the passage of the Medicare and Medicaid Acts in 1965. Throughout the 1970s, HHS monitored the capacity of nursing homes to provide quality care, but it did not monitor whether the nursing home was actually providing quality care until the 1980s.<sup>120</sup> In 1987, Congress passed a set of quality of care standards, which are still in effect, that authorized HHS to aggressively police nursing homes.

*1. Certification of Nursing Homes under Medicare prior to 1987.* – In 1965, Congress enacted the Medicare and Medicaid Acts<sup>121</sup> increasing federal funding to nursing homes.<sup>122</sup> Medicare funded care provided in “extended care facilities” (“ECFs”) while skilled nursing services were funded under Medicaid.<sup>123</sup> To participate in either Medicare or Medicaid a facility had to meet certain health and safety standards. Initially, the Medicare standards were so severe that only about ten percent of the 6,000 nursing homes that applied to participate in the program achieved full compliance.<sup>124</sup> Another fifty percent were allowed to participate in the program for being in “substantial compliance” with the Medicare standards.<sup>125</sup> Therefore, the purpose of the first nursing home enforcement standards:

was to allow some substandard facilities to participate in the [Medicare] program while encouraging them to achieve compliance, rather than to bar such facilities until they were in compliance.<sup>126</sup>

Congress amended the Medicare program in 1967 creating less rigorous regulatory standards of participation and established intermediate care facilities (“ICFs”) under Medicaid.<sup>127</sup> The establishment of ICFs allowed nursing homes that could not meet the ECF standards of Medicare or the skilled nursing services

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<sup>120</sup> See HHS Fact Sheet, *Assuring quality care for nursing home residents*, available at <http://www.cms.hhs.gov/media/press/release.asp?Counter=384> (last visited Mar. 15, 2004); also IOM Report, *supra* note 7, at 15.

<sup>121</sup> Medicaid is also a federally funded program; however, the States administer this program. See Social Security Act, 42 U.S.C. § 1396 (2004).

<sup>122</sup> IOM Report, *supra* note 7, at 240.

<sup>123</sup> *Id.* at 241. Extended care facilities paid for care for patients needing post-hospital treatment below the level of skilled nursing care. *Id.*

<sup>124</sup> *Id.* at 242.

<sup>125</sup> *Id.* at 148, 233, *citing* Senate Comm. On Finance, 91st Cong. Report on Medicare and Medicaid: Problems, Issues, and Alternatives.

<sup>126</sup> IOM Report, *supra* note 7, at 148.

<sup>127</sup> *Id.* These regulations were first published in 1968 and revised in 1969. See 33 Fed. Reg. 12925 (Sept. 12, 1968); 34 Fed. Reg. 9782-9784 (June 24, 1969).

standards of Medicaid to receive federal funding.<sup>128</sup> Without these changes people who needed nursing care would have been left with no option for care.<sup>129</sup> Nevertheless, even with these changes many nursing homes still were unable to fulfill the requirements of Medicare or Medicaid.<sup>130</sup>

Due to nationally reported incidents of nursing home quality problems, the Senate Finance Committee chaired by Senator Frank Moss began a series of hearings and studies of nursing home quality from 1969 to 1973, which affected both Medicare and Medicaid.<sup>131</sup> In 1971, as the Finance Committee was studying nursing home quality, President Nixon made several speeches on the deplorable conditions of nursing homes. During one speech in particular at a New Hampshire nursing home, Nixon announced an eight-point plan to improve regulation of nursing homes.<sup>132</sup> Subsequently, Congress made several of Nixon's points into law, including "full federal funding of survey and certification activities, redefined Medicare ECFs and Medicaid SNFs into 'skilled nursing facilities' ("SNFs"), and directed [HHS] to develop a single set of standards for Medicare and Medicaid SNFs."<sup>133</sup> Passed in 1972, the law also created a new HHS division, the Office of Nursing Home Affairs, to conduct a "comprehensive study" of federal policies concerning long-term care and to coordinate enforcement efforts.<sup>134</sup> The final survey and certification regulations were promulgated in 1974.<sup>135</sup>

According to the experts, even though these regulations were heralded by many for trying to address quality of care problems in nursing homes, the regulations did little to rectify the problems for two reasons: lack of sanctioning

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<sup>128</sup> *Id.*

<sup>129</sup> STEVENS, *WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID* 140 (The Free Press, 1940).

<sup>130</sup> IOM Report, *supra* note 7, at 243.

<sup>131</sup> *Id.* at 242-243.

<sup>132</sup> *Id.* at 243. *See also*, STEVENS, *supra* note at 123, at 255 *citing* MSA Medicaid (newsletter).

<sup>133</sup> IOM Report, *supra* note 7, at 244. These points were a part of Nixon's welfare reform bill. *Id.*

<sup>134</sup> *Id.*

<sup>135</sup> 39 Fed. Reg. 2238-2257 (Jan. 17, 1974). Under these regulations, HHS created an office in the federal regional offices to regulate and oversee state enforcement efforts of all long-term care facilities. IOM Report, *supra* note 7, at 245 *citing* HHS, Public Health Services, Office of Long Term Care, *Five Years of Accomplishments of the Office of Long Term Care 1971-1976* (Oct. 1976). Nevertheless, many states chose not to implement or enforce these regulations. *See IOM Study on Nursing Home Regulation Before the Subcomm. on Oversight & Investigation, Subcomm. on Health & Environment with Select Committee on Aging, Subcomm. on Health And Long Term Care House Comm. on Energy & Commerce, 99th Congress 9* (1986); *also* IOM Report, *supra* note 7, at 244-245.

power given to the states and failure to survey the patient's actual condition.<sup>136</sup> If a facility was found in violation of the regulations, HHS required the states to try to resolve the case before reporting the problem to HHS or the police.<sup>137</sup> To resolve the case, states were mandated to send a notice of the violations to the facility and give the facility a 30 to 60 day grace period to correct the violation.<sup>138</sup> Once the facility failed to reach compliance by the end of that time period, then and only then, could the state impose the sanction of termination.<sup>139</sup>

Furthermore, HHS focused its regulation of nursing homes on the facility's ability to provide required services to residents in the facility, not the quality of the services provided.<sup>140</sup> Several efforts were made by HHS to redirect the focus of the certification to quality of care by developing a patient oriented assessment tool; however, these efforts failed for a plethora of reasons. First, the tool HHS developed was too complex to use as a regulatory tool.<sup>141</sup> Second, the cost estimates of implementing the regulations were estimated from \$135 million to \$435 million annually,<sup>142</sup> which would have bankrupt the entire nursing home industry. Third, the change in administration from President Carter to President Regan ushered in a change in perspective of nursing home quality issues in the White House and HHS.<sup>143</sup>

On July 14, 1980, HHS published new rules to shift the focus from facility-oriented reviews to concentrate on patient care.<sup>144</sup> President Regan immediately rescinded these regulations, leaving the 1974 regulations in place.<sup>145</sup> In 1981, HHS created the Task Force on Regulatory Reform to reevaluate the proposed rules.<sup>146</sup> The Task Force recommended to retain most of the 1980 regulations, but suggested the deletion of some sections and deference to state law.<sup>147</sup> This report was used to craft new regulations, which received major protest from the public and members of Congress, so the Secretary decided to concentrate on changing the procedures for applying the standards rather than changing the 1974 survey and certification regulations.<sup>148</sup> These new procedures included reducing the inspection requirements of facilities with good compliance

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<sup>136</sup> IOM Report, *supra* note 7, at 148 & 245-246.

<sup>137</sup> *Id.* at 148.

<sup>138</sup> *Id.*

<sup>139</sup> *Id.*

<sup>140</sup> *Id.* at 245-246.

<sup>141</sup> *Id.* at 246.

<sup>142</sup> *Id.* at 247.

<sup>143</sup> *Id.*

<sup>144</sup> 45 Fed. Reg. 47368-47385 (July 14, 1980).

<sup>145</sup> IOM Report, *supra* note 7, at 247.

<sup>146</sup> *Id.*, See also Robert Pear, U.S. May Ease Regulation of Nursing Home Industry, N.Y. TIMES, SEPT. 7, 2001, at A1.

<sup>147</sup> IOM Report, *supra* note 7, at 247-8.

<sup>148</sup> *Id.*

records and replacing government certification with accreditation by the Joint Commission on Accreditation of Healthcare Organizations, the same body that accredits hospitals.<sup>149</sup> In May of 1982, HHS announced the implementation of these proposed changes.<sup>150</sup> Members of Congress and the public viewed these changes as a means to reduce federal oversight of the nursing home industry.<sup>151</sup> Thus, Congress imposed a moratorium on the proposed changes and ordered the Institute of Medicine (“IOM”) of the National Academy of Sciences to study the quality of care provided in nursing homes and publish a Report [hereinafter IOM Report].<sup>152</sup>

To compile a study of quality of care in nursing homes, the IOM formed a Committee consisting of twenty members with knowledge and experience in the regulation of nursing homes.<sup>153</sup> Data for the Report was collected from sundry places. Public hearings were held in five different cities;<sup>154</sup> reports from 1978 HHS hearings and congressional hearings on nursing home quality were reviewed; surveys were mailed to every state licensure and certification director; and case studies were conducted in six states.<sup>155</sup> The case studies were particularly important to the Report because Committee members conducted interviews of all interested parties, including nursing home administrators and federal and state regulators and conducted site visits of nursing homes.<sup>156</sup> The Committee compiled its research and published its recommendations in March of 1986 to change the regulation of nursing homes to ensure that residents were provided quality care.<sup>157</sup>

According to the IOM Report, most consumers, long-term care providers, and state regulators felt that nursing homes were safer in 1986 than prior to the 1974 regulations, but there was room for improvement.<sup>158</sup> Consequently, the IOM recommended forty-eight changes, “with regulatory criteria, with the process of inspecting and certifying nursing homes, with the enforcement process, with the ombudsman program, and with issues requiring further study.”<sup>159</sup> Important recommended changes included eliminating the distinction between SNFs, ECFs, and ICFs, making quality of care and life conditions of participation

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<sup>149</sup> IOM Report, *supra* note 7, at 248.

<sup>150</sup> *Id.* at 1.

<sup>151</sup> *Id.* at 248

<sup>152</sup> *Id.*

<sup>153</sup> *Id.* at v-vi.

<sup>154</sup> *Id.* at vi-vii. The hearings were held in Atlanta, Dallas, Los Angeles, Minneapolis, and Philadelphia. *Id.* at vii.

<sup>155</sup> *Id.* The Committee studied regulation of nursing homes in California, Connecticut, Georgia, Maryland, Minnesota, and Texas. *Id.*

<sup>156</sup> *Id.* at vi.

<sup>157</sup> *Id.* at 1.

<sup>158</sup> *Id.* at 6.

<sup>159</sup> *Id.* at 25.

for both the Medicare and Medicaid program, consolidating the Medicare and Medicaid survey and certification requirements, strengthening the federal oversight of survey operations, and implementing a set of intermediate sanctions to penalize nursing homes out of compliance with Medicare.<sup>160</sup> The IOM Report served as the basis for statutory changes in the regulation of nursing homes.<sup>161</sup> In addition to these recommendations, Congress used several federal court decisions concerning nursing homes to draft the Nursing Home Reform Act.<sup>162</sup> The most influential case was, In re Estate of Smith v. Heckler<sup>163</sup> in which the United States Court of Appeals for the Tenth Circuit required HHS to change the Medicare and Medicaid regulations from a facility-oriented focus to a patient and outcome oriented approach.<sup>164</sup>

2. *Judicial order for change.* – Medicaid recipients residing in Colorado nursing homes brought a class action civil rights suit<sup>165</sup> against the Secretary in the United States District Court for the District of Colorado.<sup>166</sup> The Medicaid recipients asserted that the Secretary violated their Constitutional right to receive quality medical and psychosocial care in nursing homes by failing to fulfill his

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<sup>160</sup> Id. at 71-170.

<sup>161</sup> See also *IOM Study on Nursing Home Regulation Before the Subcomm. on Oversight & Investigation, Subcomm. on Health & Environment with Select Committee on Aging, Subcomm. on Health And Long Term Care House Comm. on Energy & Commerce, 99th Congress 8 (2d Sess. 1986)* (statement of Dr. Katz, Chair, the Committee on Nursing Home Regulation that authored the IOM Report).

<sup>162</sup> H.R. REP. NO. 100-391, at 452 and 470 (1987).

<sup>163</sup> In re Estate of Smith v. Heckler, 747 F.2d 583, 588 (1984). In fact, this opinion was referred to in the IOM Report as support for their contention that Medicare regulations should be changed from facility-oriented to patient-oriented regulations. IOM Report, *supra* note 7, at 15.

<sup>164</sup> Id. at 74-77.

<sup>165</sup> The Plaintiffs brought this action under 42 U.S.C. §1983, seeking remedies for alleged violations of their constitutional right to be provided quality care in nursing homes certified to participate in the Medicaid program. See In re Estate of Smith v. O'Halloran, 557 F. Supp. 289, 290 (1983). The case was first filed on May 16, 1975, but did not go to trial until May 17, 1982.

<sup>166</sup> The defendants of the suit included the Secretary, all the nursing home owners and administrators of Medicaid certified nursing homes in Colorado, and the officers of the Colorado Department of Social Services and the Colorado Department of Health. O'Halloran, 557 F. Supp. at 290 (1983). The State officials were dropped from the suit in exchange for their stipulation that the State would file a complaint against the Secretary seeking a revision of the Medicaid nursing home enforcement system. Id. at 290-291. Pursuant to the stipulation of dismissal the Colorado Attorney General filed a suit against the Secretary seeking declaratory and injunctive relief for the Secretary's alleged failure to fulfill the mandate of the Social Security of 1935 by not effectively regulating Medicaid nursing homes. Id. at 291.

statutory duty under Medicaid to regulate the actual care provided in nursing homes.<sup>167</sup> The Secretary argued that HHS had fulfilled the requirements of Medicaid by publishing advisory enforcement standards governing state inspection of Medicaid certified nursing homes.<sup>168</sup> Each side's arguments centered on the duties of the Secretary under the Medicaid Act.

The Medicaid Act authorized the Secretary to fund state plans to provide "health care to needy persons through agreements with private and public persons and institutions capable of providing such services."<sup>169</sup> Under 42 U.S.C. § 1396(a), the Secretary could only approve state plans, which included the condition that the plan must provide a description of the methods of inspection the state would use to certify that the nursing homes provided care of high quality.<sup>170</sup> The Secretary had the authority to "look behind" the state's determination of a nursing home's compliance with the state Medicaid plan.<sup>171</sup> Based on the "look behind" provision, if the Secretary found that the state plan was deficient and the state failed to show that it had implemented an effective inspection program, the Secretary had to reduce the percentage of federal funds given to the state's Medicaid program.<sup>172</sup>

The Secretary argued that the agency fulfilled its duty by promulgating regulations and developing forms to be used by the States to certify the compliance of nursing homes.<sup>173</sup> However, according to the plaintiffs, these forms were deficient because they were "facility-oriented" not "patient-oriented."<sup>174</sup> The forms only required states to review the physical appearance of the facility and theoretical capability of a nursing home to render quality care, instead of regulating the actual care provided to patients in nursing homes, which according to the Medicaid recipients violated the "look behind" provision.<sup>175</sup> Agreeing with the Secretary, the court ruled that HHS had fulfilled the

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<sup>167</sup> Although the States administer the Medicaid program, the Plaintiffs argued that the Secretary had a duty to regulate Colorado's Medicaid plan based on the powers Congress granted the Secretary under Medicaid. *Id.* at 295.

<sup>168</sup> *Id.*

<sup>169</sup> See *Harris v. McRae*, 448 U.S. 297, 308-9 (1980).

<sup>170</sup> See 42 U.S.C. §§ 1396a(a)(22), 1396a(a)(28), 1395x(j) (2004).

<sup>171</sup> See 42 U.S.C. § 1396(a)(b) (2004). This "look behind" provision was passed as part of the Omnibus Reconciliation Act of 1980, the same bill that created alternative sanctions to termination of long-term care facilities. See Pub. L. No. 96-499, § 916, 94 Stat. 2599 (1980).

<sup>172</sup> See 42 U.S.C. § 1395b(g)(3) (2004).

<sup>173</sup> HHS provided the states with Form SSA-1569 to certify the compliance of nursing home's with the Medicaid requirements. See *O'Halloran*, 557 F. Supp. at 295.

<sup>174</sup> *Id.*

<sup>175</sup> *Id.* In fact, out of the 541 questions contained in the form only 30 were related to patient care or required actual patient observation. See *Heckler*, 747 F.2d 583, 588 (1984).

requirements of the Medicaid Act by promulgating regulations and providing forms to the States, reasoning that the duty to ensure that the residents of nursing homes received quality care was up to the Colorado Department of Health through its licensure powers.<sup>176</sup>

In 1984, the plaintiffs appealed the case to the United States Court of Appeals for the Tenth Circuit.<sup>177</sup> Reversing the district court's decision, the court ruled that the Secretary had violated the plaintiffs' Constitutional rights by promulgating a "facility-oriented" rather than a "patient-oriented" enforcement system to regulate nursing home care.<sup>178</sup> Because the purpose of the Medicaid Act was to provide high quality medical care to needy persons, the court reasoned that the use of the facility-oriented scheme, which failed to survey the quality of patient care violated the dictates of the Medicaid Act.<sup>179</sup> The court reviewed the legislative history of the "look behind" provision and found that Congress passed the law "to assure that federal matching funds are being used to reimburse only those SNFs and ICFs that actually comply with Medicaid requirements."<sup>180</sup>

Consequently, the court ruled that by granting the Secretary the "look behind" authority Congress mandated the Secretary to make an independent determination of whether a Medicaid certified nursing home actually meets the requirements of the state plan irrespective of the State's findings when the Secretary had cause.<sup>181</sup> According to Congress, cause included complaints made to the Secretary by the residents, advocates, or others about the quality of care or condition of the facility.<sup>182</sup> Because the residents in this case had complained to the Secretary about the quality of care and the Secretary failed to use his authority under the "look behind" provision, the court remanded the case back to the district court and ordered the court to compel the Secretary to revise and implement new Medicaid regulations that focused on the quality of care furnished Medicaid recipients in nursing homes.<sup>183</sup>

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<sup>176</sup> O'Halloran, 557 F. Supp. at 296.

<sup>177</sup> Heckler, 747 F.2d 583 (1984).

<sup>178</sup> Id. at 587.

<sup>179</sup> Id. at 590.

<sup>180</sup> H.R. REP. NO. 96-1167, at 57 (1980), *reprinted in* U.S.C.C.A.N. 5526, 5570 (1990).

<sup>181</sup> Id.; *see also* H.R. CONF. REP. 96-1479, at 140-41 (1980).

<sup>182</sup> H.R. CONF. REP. 96-1479, at 141 (1980).

<sup>183</sup> Heckler, 747 F.2d at 591. On June 10, 1985, the United States District Court for the District of Colorado ordered the Secretary to promulgate new regulations consistent with the Court of Appeals mandate. *See HHS Plan of Compliance with Court Order in Smith v. Heckler*, 1985 WL 56558 (D.Colo. 1985). Nevertheless, the Secretary failed to meet all the objectives of the order and was ordered to revise its regulations and finally found in contempt of the order in 1987. *See In re Estate of Smith v. Bowen*, 656 F. Supp. 1093 (D. Colo. 1987). *See also In re Estate of Smith v. Bowen*, 675 F. Supp. 586 (D. Colo. 1987). In 1988, the Secretary submitted the passage of the Nursing Home

This decision by the Court of Appeals,<sup>184</sup> not only affected Medicaid regulations, but it also influenced the regulation of Medicare certified nursing homes because the facility-oriented enforcement system HHS advised the States to use in regulating Medicaid certified facilities was the same system HHS used in regulating Medicare certified facilities.<sup>185</sup> Thus, the decision also called into question the validity of the Medicare regulations. This class action lawsuit, coupled with the findings of the IOM Report, were the catalyst for significant Congressional changes in the way that nursing homes were regulated under Medicare.<sup>186</sup>

3. *The Nursing Home Reform Act of 1987.* – The Nursing Home Reform Act, which changed the entire survey and certification process, was the culmination of class action suits, the IOM Report, and numerous hearings held by Congress. On March 21, 1986, Representative Claude Pepper offered the Nursing Home Resident Protection Act of 1986 to implement and expand the IOM’s recommendation.<sup>187</sup> The Act included seven sections and proposed penalizing the nursing home as well as the states for noncompliance with the Medicare and Medicaid Acts. In fact, Section II made nursing home owners and operators *criminally liable* for “harm to residents of their facilities caused by facility negligence or other wrongdoing” and created a private right of action to allow residents and advocates to sue nursing homes under Medicare and Medicaid for noncompliance with the federal standards.<sup>188</sup> Additionally, Section V provided the federal government with the power to penalize states that did not “carry out enforcement actions against noncompliant nursing homes” by withholding funding for survey and certification.<sup>189</sup> These suggestions were not enacted.<sup>190</sup>

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Reform Act as means of compliance, but the court ruled that, “the passage of the OBRA [of 1987] in no way modifies or preempts the tenth Circuit’s decision.” Smith v. Bowen, 1988 WL 235574 (D. Colo. 1988). In June, the Secretary finally enacted regulations in compliance with the court’s order, amending both the Medicaid and Medicare regulations. See 53 Fed. Reg. 22850-01 (June 17, 1988).

<sup>184</sup> See O’Halloran, 557 F. Supp. at 290, *rev’d sub. nom.*, Heckler, 747 F.2d 583.

<sup>185</sup> See 42 U.S.C. § 1395x(j)(15) (2004).

<sup>186</sup> See Beverly Health & Rehab. Servs., Inc. v. Thompson, 223 F. Supp. 2d 73, 87 (D.C. Cir. 2002). See also *IOM Study on Nursing Home Regulation Before the Subcomm. on Oversight & Investigation, Subcomm. on Health & Environment with Select Committee on Aging, Subcomm. on Health And Long Term Care House Comm. on Energy & Commerce*, 99th Congress 8 (2d Sess. 1986) (statement of Dr. Katz, Chair, the Committee on Nursing Home Regulation that authored the IOM Report).

<sup>187</sup> See 132 Cong. Rec. E937-02 (daily ed. Mar. 21, 1986) (statement of Rep. Pepper).

<sup>188</sup> Id.

<sup>189</sup> Id.

Four days later, the House of Representative's Committee on Energy & Commerce held a hearing concerning the IOM Report and examined the quality of health care provided in nursing homes.<sup>191</sup> The hearing centered on the testimony of Dr. Katz, the Chair of the Committee on Nursing Home Regulation that authored the IOM Report, who reiterated the recommendations of the Report.<sup>192</sup> Several more hearings were held by the Senate Special Committee on Aging<sup>193</sup> and the Committee on Energy and Commerce regarding nursing home reform.<sup>194</sup> On October 15, 1986, Representatives Pete Stark and Henry Waxman introduced the Medicare Skilled Nursing Home Quality Care Amendments of 1986 (H.R. 5712), a companion to the Medicaid Skilled Nursing Home Quality Care Amendments of 1986 (H.R. 5450),<sup>195</sup> to improve the nursing home regulatory system.<sup>196</sup> The bill was based on the IOM's Report but was not enacted due to Congress' early adjournment.<sup>197</sup>

On June 24, 1987, Representatives Pete Stark and several other Representatives introduced the Medicare Skilled Nursing Home Quality Care Amendments of 1987, a companion to the Medicaid Skilled Nursing Home Quality Care Amendments of 1987 (H.R. 2270), which included significant revisions from the bills offered in 1986 including a twenty-four hour registered nursing staff requirement for all nursing homes.<sup>198</sup> These bills were initially disregarded because many Congressmen were worried that it would "have made it impossible for small, rural ICFs to stay open because it offered no flexibility in

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<sup>190</sup> *Id.* Some of the proposed changes did make it into the Nursing Home Reform Act of 1987 such as making compliance with resident's rights to autonomy and respect a condition of participation. *Id.*

<sup>191</sup> IOM Report on Nursing Home Regulation, *supra* note 121 at 8; also IOM Report, *supra* note 7, at 2.

<sup>192</sup> See also IOM Study on Nursing Home Regulation Before the Subcomm. on Oversight & Investigation, Subcomm. on Health & Environment with Select Committee on Aging, Subcomm. on Health And Long Term Care House Comm. on Energy & Commerce, 99th Congress 8 (1986) (statement of Dr. Katz, Chair, the Committee on Nursing Home Regulation that authored the IOM Report).

<sup>193</sup> A.D. Joseph Emerzian and Timothy Stampp, *Nursing Home Reform: Its Legislative History and Economic Impact Upon Nursing Homes*, BENEFITS Q. 19, 24-24 (1993), citing *Nursing Home Care: The Unfinished Agenda Before Special Committee on Aging*, 99th Congress (2d Sess. 1986).

<sup>194</sup> 132 CONG. REC. E3627-02 (1986).

<sup>195</sup> 132 CONG. REC. E2998-02 (1986). The bill was similar to the final Nursing Home Reform Act of 1987 in some ways. It included all of the same sections as the Nursing Home Reform Act of 1987, except the annual report section and the detailed chart with effective dates.

<sup>196</sup> 132 CONG. REC. E3627-02 (1986).

<sup>197</sup> 133 CONG. REC. S8050-03 (1987).

<sup>198</sup> 133 CONG. REC. E2598-01 (1987).

meeting the increased staffing requirements.”<sup>199</sup> On April 29, 1987, Senator George Mitchell and several other Senators introduced the Medicare and Medicaid Skilled Nursing Home Quality Care Amendments of 1986 (S. 1106).<sup>200</sup> This bill along with the H.R. 2270 became the Nursing Home Reform Act of 1987. The Senate bill noted the improvements in nursing home quality care since 1967, but noted that residents still received ‘shockingly deficient-care’ in substandard quality nursing homes.<sup>201</sup> The Senate bill also included a grant program for innovative practices in nursing homes that provide a maximum \$25,000 grant to nursing homes that enhanced quality of care for residents.<sup>202</sup> The final Nursing Home Reform Act<sup>203</sup> was a compromise of both the Senate and House of Representatives bills and did not include the grant provision.<sup>204</sup>

The Nursing Home Reform Act included seven specific sections regulating the care of Medicare and Medicaid certified nursing homes: requirements for nursing facilities use of resident assessments, survey and certification process, enforcement process, personal needs allowance, effective dates, and annual report.<sup>205</sup> The most relevant changes were included in the survey and certification and enforcement sections. The survey and certification section created a system by which nursing homes would be inspected annually and the enforcement section directed HHS to impose remedies such as denial of payment for new admissions, civil money penalties, and temporary management.<sup>206</sup> The enforcement section also required HHS and the states to impose harsher remedies for repeated noncompliance.<sup>207</sup> In addition, to these changes the Nursing Home Reform Act included a time table that mandated that HHS and the States make certain changes by specific dates.<sup>208</sup> Subsequently, HHS published a final rule without comments on November 10, 1994 effective July 10, 1995.<sup>209</sup> Even though it took eight years before these regulations became effective, they still govern the survey and certification process today.

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<sup>199</sup> 133 CONG. REC. H29905-03 (1987).

<sup>200</sup> 133 CONG. REC. S5714-02 (1987).

<sup>201</sup> *Id.*

<sup>202</sup> *Id.*

<sup>203</sup> Pub. L. No. 100-203, §§ 4201-4218, 105 Stat. 1107 (1987).

<sup>204</sup> See generally, David Bohm, *Striving for Quality Health in America’s Nursing Homes: Tracing the History of Nursing Homes and Noting the Effect of Recent Federal Government Initiatives to Ensure Quality Care in the Nursing Home Setting*, 4 DEPAUL J. HEALTH CARE L. 317 (2001).

<sup>205</sup> H.R. REP. NO. 100-391 (2d Sess. 1987).

<sup>206</sup> *Id.* at 465-77.

<sup>207</sup> *Id.* at 474.

<sup>208</sup> *Id.* at 497-99.

<sup>209</sup> See 59 Fed. Reg. 56116 (Nov. 10, 1994); 60 Fed. Reg. 50441 (Sept. 29, 1995).

There have been no drastic changes in the regulations governing the hearing process since these amendments.

Under the current survey and certification system, once a nursing home is certified to participate in Medicare, the home is visited every nine to fifteen months,<sup>210</sup> a standard survey, by a State health agency survey team<sup>211</sup> comprised of nurses, nutritionists, social workers, and physical therapists to certify continued compliance with the Medicare regulations.<sup>212</sup> If the survey team finds the nursing home out of compliance with the Medicare regulations it cites the facility for a deficiency<sup>213</sup> and assigns a scope and severity level to the deficiency based on the egregiousness of the offense. The scope is the number of residents affected and the severity level refers to the seriousness of the harm.<sup>214</sup> The scope and severity of each deficiency assigned is based on a matrix shown below in Table 1.

**Table 1**

<b>Severity</b>			
Immediate Jeopardy	J	K	L
Actual Harm	G	H	I
Potential for more than minimal harm, but not immediate	D	E	F

<sup>210</sup> See 42 C.F.R. §§ 488.3(a)(2), (b)(2), (b)(3) (2004).

<sup>211</sup> See 42 C.F.R. § 488.308(a) (2004).

<sup>212</sup> 42 U.S.C. § 1395i-3(g)(2). The majority of nursing homes are also certified to participate in the Medicaid program. See 42 C.F.R. § 488.300 (2004). Thus, the survey team usually cites the nursing home for both Medicare and Medicaid violations. That is where the similarity ends. Unlike the Medicare hearing process, States usually provide nursing homes with an opportunity to refute survey findings during an informal hearing process. 42 C.F.R. § 488.331(a)(1) (2004). In addition, the State affords the nursing home the opportunity to challenge all noncompliance findings in a full evidentiary hearing. 42 C.F.R. § 431.153(i) (2004).

<sup>213</sup> There are a total of 190 possible deficiencies divided into seventeen different categories, for which HHS can cite a nursing home. See The Office of the Inspector General, *Nursing Home Deficiency Trends and Survey and Certification Process Consistency 1*, OEI-02-01-00600, March 2004. Most deficiencies are categorized into three main areas: quality of care (42 C.F.R. § 483.25); quality of life (42 C.F.R. § 483.15); and resident behavior and facility practice (42 C.F.R. § 483.13).

<sup>214</sup> 42 C.F.R. § 488.404(b) (2004). The scope of the deficiency means whether the deficiency was isolated, constituted a pattern of behavior, or was widespread. See 42 C.F.R. § 488.404(b)(2) (2004). The severity is whether a facility's deficiencies caused: no actual harm with a potential for minimal harm; no actual harm with a potential for more than minimal harm, but not immediate jeopardy; actual harm that is not immediate jeopardy; or immediate jeopardy to a resident's health or safety. See 42 C.F.R. § 488.404(b)(1) (2004).

jeopardy			
No actual harm with a potential for minimal harm	A	B	C
	Isolate	Pattern	Widespread
<b>Scope</b>			

All of the alleged deficiencies are then recorded with the corresponding letter to denote scope and severity level on a Statement of Deficiencies and sent to HHS for approval.<sup>215</sup> Once HHS approves the findings of noncompliance, it posts its findings on its website and notifies the nursing home ombudsman, the physicians and skilled nursing facility administration licensing board, and the State Medicaid fraud and abuse control units.<sup>216</sup> Upon approval from HHS, the State agency sends a copy of the Statement of Deficiencies to the offending nursing home along with a letter noting all the remedies imposed.<sup>217</sup> Remedies that may be imposed includes directed plan of correction, state monitoring, directed in-service training, denial of payment for new admissions, denial of payment for all Medicare patients, a civil money penalty from \$50 -\$10,000, and temporary management.<sup>218</sup> HHS also sends the nursing home a letter confirming the imposition of a remedy and the duration of each imposed remedy.<sup>219</sup> If the nursing home decides to appeal the alleged noncompliance findings it bears the burden of proof and must file a hearing request within sixty days from the date of both the state's and HHS' letter.<sup>220</sup> The hearing request is sent to HHS' judicial board then assigned to a specific ALJ.

<sup>215</sup> 42 C.F.R. §§ 488.330(d), 488.402(f)(1) (2004). The Statement of Deficiencies (“SOD”) details the nursing home’s violations of the Medicare regulations and factual incidents to support these allegations. *Id.* The SOD is issued prior to a nursing home requesting a hearing. 42 C.F.R. § 488.18(b)(1) (2004).

<sup>216</sup> 42 U.S.C. § 1395i-3(g)(5). The information remains posted until the next annual survey is conducted.

<sup>217</sup> See 42 C.F.R. §§ 488.18(b)(1) (2004), 488.402(f)(2) (2004).

<sup>218</sup> See 42 C.F.R. § 488.404 (2004). A nursing home is out of compliance with the Medicare regulations, if the deficiency creates more than a potential for causing minimal harm. 42 C.F.R. § 488.301 (2004). Remedies are only imposed if a nursing home is not in substantial compliance with the Medicare regulations. 42 C.F.R. § 488.400 (2004).

<sup>219</sup> 42 C.F.R. § 488.402 (2004).

<sup>220</sup> 42 C.F.R. §§ 498.5(k), 498.40(c)(1) (2004). Usually to preserve its hearing rights, nursing homes *must* file an appeal to each letter it receives that discusses the imposition of remedies even if the information is duplicated. See Concourse Rehab. & Nursing v. Thompson, 2004 WL 434434 (S.D.N.Y. 2004).

The hearing process varies based on which of the eight ALJs is presiding over the case;<sup>221</sup> hearings can last from one to five days and include only cross-examination testimony.<sup>222</sup> Once the ALJ issues a ruling, the nursing home has sixty days to appeal the decision to the DAB.<sup>223</sup> After receiving a ruling from the DAB, the nursing home may appeal the case to federal district court. This whole hearing process usually takes a number of years to reach the federal level.<sup>224</sup> The current hearing system is a drastic change from the structure of initial nursing home hearings that only allowed informal hearings for the imposition of remedies other than termination.<sup>225</sup>

### *B. Expanding the Structure of Nursing Home Hearings*

The structure of nursing homes hearings has always been connected to the severity of the sanctions imposed for noncompliance. Prior to 1980, termination was the only federal sanction that HHS could impose on nursing homes out of compliance with the Medicare regulations.<sup>226</sup> HHS, however, did grant the facility a full evidentiary hearing either before termination or within 120 days after the termination became effective.<sup>227</sup> In 1980, with the passage of the Omnibus Reconciliation Act of 1980 (“OBRA of 1980”), Congress created a new intermediate sanction, denial of payments for new Medicare admissions, and granted the Secretary of HHS the authority to impose this remedy for nursing home deficiencies that did not cause immediate jeopardy<sup>228</sup> to patients.<sup>229</sup>

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<sup>221</sup> There are eight HHS ALJs to cover all of the nursing homes cases nationwide. The Chief ALJ is Silva and he serves with the following ALJs in order of seniority: ALJ Kessel, Hughes, Anglada, Montano, Smith, Sickendick, and Blair.

<sup>222</sup> Pre-hearing orders of individual ALJs (on file with the author).

<sup>223</sup> 42 C.F.R. § 498.80 (2004).

<sup>224</sup> See *Lutheran Home – Caledonia*, DAB No. CR 674 (2000), *aff’d* DAB No. 1753 (2000); *Lakewood Plaza Nursing Ctr.*, DAB No. CR 691 (2000), *aff’d* DAB No. 1767 (2001).

<sup>225</sup> See 50 Fed. Reg. 7191, 7194 (codified as 42 C.F.R. § 442.118 (1986))

<sup>226</sup> See 50 Fed. Reg. 7191, 7191 (Feb. 21, 1985).

<sup>227</sup> See 50 Fed. Reg. at 7191. From 1980 to 1984, there were 967 voluntary nursing home cancellations of participation in Medicare and only 159 terminations from the Medicare program. IOM Report, *supra* note 7, at 156. HHS used termination of a facility from Medicare as the last resort. HHS provided nursing homes with several opportunities to become complaint through follow-up visits. *Id.* at 148. Even once a facility was de-certified from the program, HHS would allow the facility to re-enter the Medicare program, if the facility provided “reasonable assurance” that the deficiencies that caused termination would not be repeated. STEVENS, *supra* note 123 at 149, *citing* HHS, Survey and Certification National Review, Unpublished Briefing Materials, Health Standards and Quality Bureau, Health Care Financing Administration (1984).

<sup>228</sup> Immediate Jeopardy is defined as “a situation in which the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.” See 42 C.F.R. § 489.3

Under this provision, a facility found out of compliance with the Medicare regulations was first given the opportunity to develop and implement a plan of correction for its deficiencies.<sup>230</sup> If the facility was unable to fulfill the requirements set forth in the plan of correction, the Secretary then had the right to impose the sanction of denial of payments for new admissions.<sup>231</sup> Congress created this new process and sanction because it would “serve to protect beneficiaries both by giving the skilled nursing facility an incentive to correct deficiencies in a timely manner and by forestalling the need for traumatic transfers of large numbers of patients during the time needed improvements are being made in the facility.”<sup>232</sup> Nevertheless, Congress cautioned the Secretary not to use the sanction to allow facilities who placed their patients in immediate jeopardy to stay in the Medicare program.<sup>233</sup> Congress also created an informal hearing process for nursing facilities to challenge the imposition of the intermediate sanction, denial of payments for new admissions.<sup>234</sup>

Although Congress granted the Secretary the power to impose the new sanction in 1980, HHS did not issue proposed rules to implement this authority until 1985.<sup>235</sup> As directed by Congress, HHS proposed the new sanction and a new corresponding hearing process. Before the imposition of this intermediate sanction, the nursing home would be granted a hearing<sup>236</sup> in front of a hearing officer.<sup>237</sup> This hearing allowed a nursing home the opportunity to present

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(2004). The States now have the authority to impose this remedy for Medicare violations. *See* 42 CFR § 488.408 (2004).

<sup>229</sup> *See* Omnibus Reconciliation Act of 1980 (“OBRA of 1980”), Pub. L. No. 96-499, §916, 94 Stat. 2599 (1980).

<sup>230</sup> H.R. REP. NO. 96-1167, at 56 (1980), *reprinted in* 1980 U.S.C.C.A.N. 5526, 5568-5571.

<sup>231</sup> *Id.*

<sup>232</sup> H.R. REP. NO. 96-1167, at 57. Congress recognized that states already had a full array of sanctions for Medicaid and said that this rule would not pre-empt these sanctions.

<sup>233</sup> *Id.*

<sup>234</sup> In creating this new hearing process, Congress clearly stated that the process would not preclude nursing homes from seeking judicial review for factual disputes concerning noncompliance. *Id.*

<sup>235</sup> The final rule was designated as 42 C.F.R. § 442.118 (1986). The delay between the passage of the OBRA of 1980 and the promulgation of regulations was due to the change in administration and its focus on privatizing nursing home regulation.

<sup>236</sup> 50 Fed. Reg. 7191, 7192 (Feb. 21, 1985). In the legislative history, Congress made a point to note that it was not altering access or the process of the full evidentiary hearing for termination. H.R. CONF. REP. NO. 96-1479, 141 (1980), *reprinted in* 1980 U.S.C.C.A.N. 5903, 5932.

<sup>237</sup> *See* 50 Fed. Reg. 7191, 7193 (Feb. 21, 1985); 51 Fed. Reg. 24484, 24487 (July 3, 1986).

evidence in person or in writing that proved it was in substantial compliance.<sup>238</sup> HHS would then issue a written ruling to the facility.<sup>239</sup> Even though, HHS granted nursing homes these hearing rights to appeal the intermediate sanction, it specifically limited the hearing to “something less than a full evidentiary hearing.”<sup>240</sup> In the background discussion of the proposed rule, HHS specifically stated, “we believe that since the imposition of a denial of payments as compared with terminations is a lesser and temporary sanction, a hearing less than a full evidentiary hearing would satisfy all due process requirements.”<sup>241</sup> Therefore, according to HHS, the hearing nursing homes received for the imposition of this intermediate sanction would only be an “informal” one.<sup>242</sup> Nursing homes were only granted a full evidentiary hearing when HHS threatened termination from the Medicare Program.<sup>243</sup> This dichotomy between a formal and informal hearing continued until 1987, with the passage of the Nursing Home Reform Act.<sup>244</sup>

In the Nursing Home Reform Act, Congress changed the severity of the sanctions as well as the structure of the hearing process. These changes were based on the recommendations made in the IOM Report.<sup>245</sup> According to the IOM Report, more nursing homes would comply if the sanction was imposed prior to a hearing.<sup>246</sup> Moreover, to prevent frivolous appeals, the IOM Committee suggested that facilities not be given a stay from termination during the appeals process and that deficiency findings be solely based on the events that occurred during the survey and not the condition of the facility at the time of the hearing.<sup>247</sup>

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<sup>238</sup> See 50 Fed. Reg. at 7194; 51 Fed. Reg. at 24487.

<sup>239</sup> See 50 Fed. Reg. at 7194; 51 Fed. Reg. at 24491.

<sup>240</sup> 50 Fed. Reg. at 7194. See 51 Fed. Reg. at 24487.

<sup>241</sup> See 50 Fed. Reg. at 7194.

<sup>242</sup> *Id.*; see also 51 Fed. Reg. at 24487. HHS failed to provide a definition of a full evidentiary hearing versus an informal hearing in the Federal Register, so the definition for the Administrative Procedure Act controls. See Administrative Procedure Act of 1946 (“APA”), 5 U.S.C. § 554 (1994). According to the APA, a formal hearing is defined as, “every case of adjudication required by statute to be determined on the record after opportunity of an agency hearing ...” *Id.*

<sup>243</sup> 50 Fed. Reg. 7191, 7194 (Feb. 21, 1985). Congress purposely did not alter nursing homes access to a full evidentiary hearing to challenge termination from Medicare. H.R. CONF. REP. NO. 96-1479, 141 (1980).

<sup>244</sup> Pub. L. No. 100-203, §§ 4201-4218, 105 Stat. 1107 (1987).

<sup>245</sup> During the hearings, Dr. Katz, the Chair of the Committee on Nursing Home Regulation that authored the IOM Report, recommended that the appeal process for alleged violations of the Medicare regulations be made “less attractive” for “really bad facilities.” See *IOM Study on Nursing Home Regulation*; *supra* note 128 at 9 & 12. This practice was implemented in the regulations, but was applied to all nursing homes appealing alleged violations of the Medicare Act.

<sup>246</sup> IOM Report, *supra* note 7, at 159.

<sup>247</sup> *Id.*

In response to these recommendations, in the Nursing Home Reform Act of 1987 Congress added several more sanctions, now entitled “remedies,” to the Medicare Program.<sup>248</sup> Congress also mandated that HHS take into account repeat deficiencies when imposing these remedies and made it harder for a facility that has been terminated from Medicare program to re-enter the program.<sup>249</sup> Additionally, Congress combined the formal hearing for termination and the informal hearing for other sanctions into a single hearing process.<sup>250</sup> This process was implemented in 1995, when HHS promulgated the hearing process regulations. The relevant regulations are 42 C.F.R. §§ 498.60,<sup>251</sup> 498.62,<sup>252</sup> and 498.66.<sup>253</sup> Under these new regulations nursing homes are granted the right to present evidence in front of an ALJ,<sup>254</sup> unlike the original informal hearing process where nursing homes would present evidence to a hearing officer.<sup>255</sup> The new regulations also gave nursing homes the right to examine their own witnesses<sup>256</sup> and bring any participant to the hearing not limited to their representatives and technical advisors.<sup>257</sup> Even though, nursing homes were granted a full evidentiary hearing, it was limited to cases in which HHS had imposed remedies.<sup>258</sup> Without the imposition of remedies the nursing home was not granted any right to a hearing, but the findings remained on HHS’ website and were used for the imposition of future remedies. Hence, nursing homes file a suit federal court to challenge the lack of procedural Due Process protections afforded them in Medicare compliance hearings.<sup>259</sup>

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<sup>248</sup> H.R. REP. NO. 100-391 (2d Sess. 1987) (codified as 60 Fed. Reg. 50118 (Sept. 28, 1995)).

<sup>249</sup> Nursing Home Reform Act, Pub. L. No. 100-203, §§ 4201-4218, 105 Stat. 1107 (1987). These sections were based on the recommendations made in the IOM Report. IOM Report, *supra* note 7, at 155-156.

<sup>250</sup> H.R. REP. NO. 100-391 (2d Sess. 1987) (codified as 52 Fed. Reg. 22444, 22447-22448 (June 12, 1987)).

<sup>251</sup> This regulation defines the conduct of nursing home hearings, which is left to the discretion of the ALJ within certain limits. *See* 42 C.F.R. § 498.60 (2004). One particular limit is how witnesses are treated. *See* 42 C.F.R. § 498.62 (2004).

<sup>252</sup> This regulation states that, “the representative of each party is permitted to examine his or her own witnesses subject to interrogation by the representative of the other party.” 42 C.F.R. § 498.62 (2004).

<sup>253</sup> This rule governs nursing homes’ right to waive their right to appear and present evidence at an in-person hearing. 42 C.F.R. § 498.66 (2004).

<sup>254</sup> 42 C.F.R. §§ 498.45, 498.60 (2004).

<sup>255</sup> 51 Fed. Reg. 24484, 24491 (July 3, 1986).

<sup>256</sup> 42 C.F.R. § 498.62 (2004).

<sup>257</sup> 42 C.F.R. § 498.60 (2004).

<sup>258</sup> 42 C.F.R. §§ 498.3(b)(13), 488.406 (2004).

<sup>259</sup> HHS has continued to issue nursing home regulations to strengthen enforcement. *See* HHS Fact Sheet, *Assuring quality care for nursing home residents*, available at <http://www.cms.hhs.gov/media/press/release.asp?Counter=384> (last visited

#### IV. JUDICIAL REVIEW IN NURSING HOME PROCEEDINGS

The failure of HHS to actually grant nursing homes the broad procedural Due Process rights granted in the Nursing Home Reform Act and codified in the Medicare regulations, the right to a full evidentiary hearing for any findings of noncompliance, was the basis of the case entitled Shalala v. Illinois Council on Long Term Care, Inc.<sup>260</sup> As a result of nursing homes' dissatisfaction with the new Medicare regulations, the Illinois Council on Long Term Care, Inc., on behalf of its members, sued HHS Secretary Donna Shalala in the United States District Court for the Northern District of Illinois for the violation of their Constitutional right to Due Process.<sup>261</sup> The case ultimately reached the U.S. Supreme Court, which deferred to the Secretary's interpretations.

##### A. *The District Court case*

Prior to the implementation of the Nursing Home Reform Act regulations, only six percent of nursing homes in Illinois were found noncompliant,<sup>262</sup> while in 1995 when the regulations took effect, seventy percent of nursing homes in Illinois were found out of compliance with the regulations.<sup>263</sup> The Illinois Council for Long Term Care ("Council") filed a complaint seeking injunctive and declaratory relief from the Secretary's and the Illinois Department of Public Health's use of the Medicare regulations proscribed by Congress in the Nursing Home Reform Act, claiming that the drastic change in noncompliance rates was due to unconstitutionally vague standards. Moreover, the Council submitted that the appeals process to challenge noncompliance findings was meaningless and thus violated the Due Process Clause of the Fifth Amendment of the U.S. Constitution.

Instead of addressing these issues, HHS collaterally attacked the Council's claims by arguing that the federal court lacked subject matter jurisdiction under 28 U.S.C. §§1331<sup>264</sup> and 1346<sup>265</sup> to hear the case because the case arose under the

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Mar. 15, 2004). As a result, a nursing home with one deficiency where the resident suffered actual harm was traditionally assessed a civil money penalty of \$100 per day.

Id. Now, however, the same facility is being fined upwards of \$300 per day. Id.

<sup>260</sup> See Ill. Council, 529 U.S. 1 (2000).

<sup>261</sup> Ill. Council, 1997 WL 158347 (N.D.Ill. 1997).

<sup>262</sup> Id. at \*1.

<sup>263</sup> Id.

<sup>264</sup> "The district courts shall have original jurisdiction of all civil actions arising under the Constitution, Laws, or treaties of the United States." 28 U.S.C. §1331 (2004).

<sup>265</sup> "The district courts shall have original jurisdiction concurrent, with the Federal Court of Claims of any civil claim against the United States for the recovery of any internal-revenue tax or any other civil action or claim against the United States, not exceeding \$10,000 in amount, founded either upon the Constitution, or any Act of

Medicare Act.<sup>266</sup> Under 42 U.S.C. §§ 405(g) and 405(h), federal courts are barred from reviewing any Social Security action under 28 U.S.C. §§1331 and 1346 before HHS has issued a final ruling. Specifically, 42 U.S.C. § 405(g) limits federal review to final decisions issued by the Secretary. This review is further limited by 42 U.S.C. § 405(h), which prohibits federal review of claims based on federal question jurisdiction unless the statute authorizes review and the Secretary issues a final decision. This bar to federal review before a final decision from the Secretary was incorporated into the Medicare Act by 42 U.S.C. §§1320a-7a(c)(2) and (j)(1).<sup>267</sup>

The requirements in 42 U.S.C. § 405(g) & (h) allowed the Secretary to channel all nursing home claims through the agency in a special review process. Because the Council bypassed this process in filing this case, HHS asserted the district court did not have subject matter jurisdiction. Based on this bar, HHS requested that the court dismiss the case because the Council never presented the case to HHS and failed to receive a final agency ruling before presenting the issue to federal court.<sup>268</sup> In response to HHS' arguments, the Council contended that the district court did have subject matter jurisdiction because: the claims did not arise under the Medicare Act; HHS had no authority to decide Constitutional or statutory challenges; there was no other avenue for judicial review of Due Process claims and thus under Bowen immediate federal review was appropriate; and some claims arose under the Medicaid Act, which did not include a subject matter jurisdiction bar.<sup>269</sup>

First, the court found that the Council's complaints did arise under the Medicare Act because the complaints addressed the failure of HHS to comply with the Medicare Act, required the analysis of provisions of the Medicare Act, and the resolution of the case would directly impact the "applicability and enforceability of the Medicare Act."<sup>270</sup> Second, although only the federal courts

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Congress, or any regulation of an executive department, or upon any express or implied contract with the United States." 28 U.S.C. §§1346 (2004).

<sup>266</sup> Ill. Council, 1997 WL 158347, at \*2.

<sup>267</sup> Under 42 U.S.C. §§ 1320a-7a(c)(2), nursing homes are granted a right to a hearing. These hearing rights are limited by 42 U.S.C. § 1320a-7a(j)(1), which makes 42 U.S.C. §§ 405(g) & (h) applicable to nursing home hearings. The Court discussed 42 U.S.C. § 1395cc(h)(1) (2004) as the section that provided hearing rights to nursing homes to challenge noncompliance findings; however, this section only applies to those challenging the Secretary's determinations that are *not* providers of services under the Medicare Act. The section that nursing homes provides nursing homes with hearing rights is 42 U.S.C. § 1320a-7a(c)(2) (2004), which is used throughout the paper instead of § 1395cc(h)(1).

<sup>268</sup> Ill. Council, 1997 WL 158347, \*2 (N.D.Ill. 1997).

<sup>269</sup> Id.

<sup>270</sup> Id.

have the authority to decide constitutional or statutory challenges<sup>271</sup> and the Medicare regulations specifically state that the Secretary will not hear appeals challenging the method of the survey or the choice of remedies,<sup>272</sup> the court ruled that 42 U.S.C. §§ 405(g) & (h) required these challenges to first be presented to HHS for resolution. Presuming that the central reason for the Council's case was the attainment of benefits, the court reasoned that the federal review bar would allow the "Secretary an opportunity prior to Constitutional litigation to determine whether plaintiff's claims are either invalid or resolvable under some other provision of the Medicare Act."<sup>273</sup>

Third, the the court held that the exception for immediate federal review created by the Supreme Court in Bowen no longer applied to Medicare cases.<sup>274</sup> In Bowen, the Supreme Court ruled that physician challenges concerning the receipt of benefits under Medicare Part B could be heard in federal court prior to presentment of the issue to HHS because there was no other avenue for review in HHS.<sup>275</sup> Given that Congress revised the Medicare Act to grant hearing rights to all providers under the Medicare Act after the Bowen case, the court ruled that the Bowen exceptio was void and the Council had to present the case first to HHS.<sup>276</sup> Finally, the court determined that any resolution of the Council's Medicaid issues would effect Medicare, allowing the nursing home to get their Medicare claims in through the back door.<sup>277</sup>

Summarily rejecting all of the Council's contentions, the district court dismissed the case for lack of subject matter jurisdiction. The Council appealed the dismissal to the United States Court of Appeal for the Seventh Circuit, which reversed the district court's dismissal and remanded the case to the district court for further review.

### *B. Upon Appeal to the Seventh Circuit*

In its appeal to the Seventh Circuit, the Council reasserted its claims that the regulations violated the Due Process Clause of the Fifth Amendment because the regulations were too vague and failed to provide any opportunity to be heard

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<sup>271</sup> Marbury v. Madison, 5 U.S. 137, 163 (1803); U.S. v. Nourse, 34 U.S. 8, 28-29 (1835).

<sup>272</sup> 42 C.F.R. § 488.408 (2004).

<sup>273</sup> Ill. Council, 1997 WL 158347, \*2. This bar is understandable when a nursing home is challenging the Medicare regulations, which the Secretary has the authority to change. However, when the channeling provision limits the federal review of Constitutional challenges to the Medicare Act, the Secretary's review of the issue is meaningless because the Secretary has no authority to issue a ruling or even make changes to the Medicare Act.

<sup>274</sup> Id. at \*3.

<sup>275</sup> Bowen, 476 U.S. 667 (1986).

<sup>276</sup> Ill. Council, 1997 WL 158347, \*3 (N.D.Ill. 1997).

<sup>277</sup> Id. at \*4.

before penalties were imposed.<sup>278</sup> Additionally, the Council argued that the State Operations Manual used by state surveyors had not undergone the notice and comment period required by the APA and thus could not be used by HHS to regulate nursing homes.<sup>279</sup> The Secretary again asserted that the Medicare claims were not reviewable based on 42 U.S.C. §§ 405(g) & (h).<sup>280</sup> HHS also asserted that the Medicaid claims were not ripe.<sup>281</sup> To resolve the issue, the court reviewed three prominent Supreme Court cases: Salfi,<sup>282</sup> Ringer,<sup>283</sup> and Bowen.<sup>284</sup>

According to the Seventh Circuit, even though the Council's challenges were based on the Constitution and the APA, the Supreme Court said in Salfi and Ringer that any claims for payments arise under the Medicare Act and claims arising under Medicare regardless of the legal theory must be channeled through the administrative process.<sup>285</sup> But in Bowen, the Supreme Court held that as applied to Medicare, 42 U.S.C. § 405(h) addressed "only amount determinations, that is calculations of reimbursement by the fiscal intermediary that implement the Medicare program and that matters which Congress did not delegate to private carriers, such as challenges to the validity of the Secretary's instructions and regulations are cognizable in course of law."<sup>286</sup> The Seventh Circuit followed the Bowen decision, which presented an exception to the subject matter jurisdiction bar of federal review for cases that would not otherwise have any meaningful review.<sup>287</sup> The Secretary restated its arguments from the district court, that the Bowen exception to 42 U.S.C. §§ 405(g) & (h) only applied to claims that would never reach federal courts, but because Congress amended the Medicare Act this exception was void.<sup>288</sup> According the Seventh Circuit, Bowen did not create an exception as the Secretary asserted and the district court accepted.<sup>289</sup> Rather, Bowen said that the legislative history of 42 U.S.C. §§ 405(g) & (h) only applied to "amount determinations."<sup>290</sup>

Furthermore, the Seventh Circuit concluded that the Supreme Court's precedent did not support the Secretary's arguments.<sup>291</sup> In an immigration case

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<sup>278</sup> Ill. Council, 143 F.3d 1072 (1998).

<sup>279</sup> Id. at 1074.

<sup>280</sup> Id.

<sup>281</sup> Id.

<sup>282</sup> Salfi, 422 U.S. 749 (1975).

<sup>283</sup> Ringer, 466 U.S. 602 (1984).

<sup>284</sup> Bowen, 476 U.S. 667 (1986).

<sup>285</sup> Ill. Council, 1143 F.3d 1072, 1074-1075 (1998).

<sup>286</sup> Id. at 1075.

<sup>287</sup> Id.

<sup>288</sup> Id.

<sup>289</sup> Id. at 1075-1076.

<sup>290</sup> Bowen, 476 U.S. at 678-81.

<sup>291</sup> Ill. Council, 143 F.3d at 1075.

decided in 1991, the Supreme Court reiterated the rule created in Bowen that 42 U.S.C. § 405(h) did not require Medicare regulatory challenges to be channeled through the agency if the challenge was separate from reimbursement requests.<sup>292</sup> The Seventh Circuit had also ruled several times since Bowen that there was a difference between pre-enforcement challenges to Medicare regulations that are allowed and requests for payments that are barred until a final decision by the Secretary.<sup>293</sup> For the aforementioned reasons, the Seventh Circuit Court of Appeals vacated the district court's decision and remanded the case for further review, ruling that the exhaustion requirement of 42 U.S.C. §§ 405(g) & (h) did not prohibit the Council from bringing their Constitutional challenges.<sup>294</sup>

### C. *The Final Answer: the Supreme Court*

HHS appealed the Seventh Circuits ruling to the Supreme Court, reiterating its contention that federal courts did not have subject matter jurisdiction over the case and thus the case should have been dismissed.<sup>295</sup> The Council argued that: (1) certain terms in the Medicare regulations such as “substantial compliance” were unconstitutionally vague; (2) the regulations and the State Operations Manual would allow inconsistent survey results in violation of 42 U.S.C. §1395i-3(g)(2)(D) and exceeded the mandate of the Medicare Act; (3) the regulations created administrative procedures inconsistent with the Due Process Clause; and (4) the State Operations Manual and other publications used by surveyors in citing nursing homes for deficiencies was not promulgated in accordance with the rulemaking requirements mandated by the APA.<sup>296</sup> Before resolving the Council's substantive claims, the Court first had to determine whether it had subject matter jurisdiction by discussing its precedent.

In Salfi, the Court ruled that 42 U.S.C. § 405(h) created a *nonwaivable* and *nonexcusable* requirement that an individual present a claim to the Secretary before seeking federal review when the claim arose under the Social Security

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<sup>292</sup> McNary v. Haitian Refugee Center, Inc., 498 U.S. 479, 497 (1991).

<sup>293</sup> See Martin v. Shalala, 63 F.3d 497 503-505 (7th Cir. 1995); Bodimetric Health Servs., Inc. v. Aetna Life & Casualty, 903 F.2d 480, 483-87 (7th Cir. 1990).

<sup>294</sup> Ill. Council, 143 F.3d at 1078.

<sup>295</sup> Several other cases had been brought challenging the Constitutionality of the Medicare regulations, but many have been dismissed for lack of subject matter jurisdiction. See Mich. Ass'n. of Homes and Servs. for Aging, 127 F.3d 496, 500-01 (6th Cir. 1997); Am. Acad. of Dermatology v. HHS, 118 F.3d 1495, 1499-1501 (11th Cir. 1997); St. Francis Med. Ctr. v. Shalala, 32 F.3d 805, 812-13 (3rd Cir. 1994), cert. denied, 514 U.S. 1016 (1995); Farkas v. Blue Cross & Blue Shield, 24 F.3d 853, 855-860 (6th Cir. 1994); Abbey v. Sullivan, 978 F.2d 37, 41-44 (2nd Cir 1992); Nat'l Kidney Patients Ass'n. v. Sullivan, 958 F.2d 1127, 1130-1134 (D.C. Cir. cert. denied, 506 U.S. 1049 (1993)). The Supreme Court granted certiorari to resolve the conflict in the Circuits regarding its ruling in Bowen and whether it created an exception to 42 U.S.C. §§ 405(g) & (h). Therefore, the Court did not discuss the Council's Medicaid claims.

<sup>296</sup> Ill. Council, 529 U.S. 1, 7 (2000).

Act.<sup>297</sup> A claim arose under the Social Security Act when the Act provided “both the standing and the substantive basis for the presentation of th[e] Constitutional contentions.”<sup>298</sup> Because the class members included requests for the payment of Social Security benefits, making it clear that the claims arose under the Social Security Act, the Court dismissed the claims of all the members.<sup>299</sup> The Court in Ill. Council noted that the Council’s arguments did not contain any claim for benefits like the parties in Salfi but was still barred by the channeling provision by the Court’s decision in Ringer. The Court in Ringer ruled that 42 U.S.C. § 405(h) prevented federal review of a challenge to the Secretary’s issuance of an administrative ruling denying reimbursement for a particular medical procedure where “both the standing and substantive basis for the presentation” of a claim is the Medicare Act.<sup>300</sup>

Based on these cases, the Court in Ill. Council reasoned that 42 U.S.C. § 405(h) was a channeling provision that required *all* cases to be presented to the agency.<sup>301</sup> Furthermore, the Court ruled that the requirement was more than an exhaustion requirement, which provides for exceptions to presentment, but an absolute requirement.<sup>302</sup> Even though the Court noted that this ruling might cause some hardship, the complexities of Medicare and the need for the Secretary to have an opportunity to “apply, interpret, or revise policies, regulations, or statutes without possibly premature interference by different individual courts applying ripeness and exhaustion exceptions on a case by case basis” justified this channeling procedure.<sup>303</sup> Additionally, the Court found no reason to distinguish between how 42 U.S.C. § 405(h) was applied to amount determinations versus Constitutional challenges.<sup>304</sup> The Council submitted that the Court’s decisions in McNary v. Haitian Refugee Center, Inc.,<sup>305</sup> Eldridge,<sup>306</sup> and Bowen<sup>307</sup> provided exceptions to this absolute channeling rule.

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<sup>297</sup> Id. at 15.

<sup>298</sup> Salfi, 422 U.S. 749, 760-761 (1975).

<sup>299</sup> Ill. Council, 529 U.S. at 11. The Court in Ill. Council incorrectly states that the claims of all the class members in Salfi were dismissed. *See Salfi*, 422 U.S. 749, 797 (1975).

<sup>300</sup> Ringer, 466 U.S. 602, 615 (1984) *quoting Salfi*, 422 U.S. at 760-761. This rule applies to both present and future claims for benefits. Ringer, 466 U.S. at 621-622.

<sup>301</sup> Ill. Council, 529 U.S. at 12.

<sup>302</sup> Id. at 13.

<sup>303</sup> Id.

<sup>304</sup> Id. at 14.

<sup>305</sup> McNary, 498 U.S. 479 (1991) (The Court held that individuals challenging the Immigration and Naturalization Services administration of the Special Agricultural Workers provisions of the Immigration Reform Control Act to determine the adjustment status of immigrants could be reviewed in federal court based on federal question jurisdiction to evaluate issues concerning the Due Process Clause, even though the statute barred federal question jurisdiction.).

<sup>306</sup> Eldridge, 424 U.S. 319 (1976)

In response to the Council's arguments the Court ruled that the decision in McNary involved different language and a different statute, which precluded any review of claims even after a final decision from the agency.<sup>308</sup> Thus, according to the Court, if McNary had come under the Medicare Act then it would have been barred from federal review.<sup>309</sup> The Court in Ill. Council ruled that in Eldridge, the claimant seeking Social Security disability benefits had presented the case first to the agency as required by 42 U.S.C. § 405(h) unlike the Council.<sup>310</sup> Even though, Eldridge had not completed the process and received a final ruling, presentment was enough because his Constitutional claims were collateral to his claims for benefits according to the Court in Ill. Council.<sup>311</sup> Hence, the decision in Eldridge did not assist the Council because the failed to present their case to HHS.<sup>312</sup>

The Court in Ill. Council also ruled that the exception to 42 U.S.C. § 405(h) announced in Bowen, only applied in instances when the provision would foreclose any review because a serious Constitutional issue would be raised if 42 U.S.C. § 405(h) was constructed to deny, rather than delay judicial review of Constitutional claims.<sup>313</sup> Moreover, the Court rejected the Seventh Circuit's decision that Bowen created a new rule that 42 U.S.C. § 405(h) only applied to amount determinations because it would overrule Salfi and Ringer. The Court opined that in Bowen if it had planned to overrule these cases then it would have said so in its opinion.<sup>314</sup> The difference between Salfi/Ringer and Bowen is the difference between postponement of review (Salfi and Ringer) and total preclusion (Bowen).<sup>315</sup> Consequently, the Court reviewed the Council's claims to ascertain whether the regulations would prevent any judicial review, and thus whether the Bowen exception applied.

The Council argued that HHS' application of its channeling provision to the portion of the Medicare statute and regulations governing nursing home hearings amounted to the "practical equivalent of a total denial of judicial review."<sup>316</sup> According to the Council, nursing homes were granted access to the special review process only when termination was imposed, not when the Secretary imposed any other remedy.<sup>317</sup> The Secretary asserted that any

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<sup>307</sup> Bowen, 476 U.S. 667 (1986).

<sup>308</sup> Ill. Council, 529 U.S. 1, 14 (2000).

<sup>309</sup> Id.

<sup>310</sup> Id. at 15.

<sup>311</sup> Id.

<sup>312</sup> Id.

<sup>313</sup> Id. at 17-18.

<sup>314</sup> Id.

<sup>315</sup> Id. at 19.

<sup>316</sup> See Ill. Council, 529 U.S. 1, 20 (2000), citing McNary, 498 U.S. 479, 497 (1991).

<sup>317</sup> Ill. Council, 529 U.S. at 21 (2000).

“dissatisfied” nursing home was entitled to have reviewed any determination that it failed to comply substantially with the statute, agreements, or regulations, regardless of the remedy imposed during the normal hearing process.<sup>318</sup> The Court deferred to the Secretary’s interpretation because it was reasonable.<sup>319</sup>

The Council also argued that under 42 C.F.R. § 498.3(b)(12), unless a remedy was imposed no hearing was granted. If no remedy was imposed, then a nursing home could fail to complete a plan of correction; however, the Secretary could then terminate the facility from Medicare participation.<sup>320</sup> No facility would risk termination to bring a Constitutional challenge, so these regulations precluded federal review. This is unconstitutional because the findings are used in later surveys as a means for harsh sanctions and are posted on the Internet.<sup>321</sup> The Secretary summarily denied these practices and asserted that only minor penalties would be imposed for failing to submit a plan of correction.<sup>322</sup> The Secretary also stated that HHS does not “cause providers to suffer more severe penalties in later enforcement actions based on findings that are unreviewable,” but conceded that the findings of noncompliance remain on the internet with a place for the nursing home to post a reply.<sup>323</sup>

Based on the Secretary’s representations of the HHS hearing process for nursing homes, the Court reasoned that its interpretation would not absolutely bar nursing homes from obtaining judicial review.<sup>324</sup> Although the Court found that the language of the statute and 42 C.F.R. 498.3 was not free from ambiguity,<sup>325</sup> the Secretary’s interpretation that nursing homes were permitted to a hearing for findings of noncompliance and had access to a special review channel for these hearings was reasonable and legally permissible.<sup>326</sup> The Court further reasoned that the:

procedural Medicare regulations<sup>327</sup> limiting the extent to which the agency itself would provide the administrative review channel leading to judicial review ... does not amount to a denial of review so as to entitle challenger to avoid special review channel created under Medicare statutes, but, rather, the challenger remains free,

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<sup>318</sup> Id.

<sup>319</sup> Id. at 21, *relying on* Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984).

<sup>320</sup> Id.

<sup>321</sup> Id.; *See also* 42 C.F.R. § 498.3(b)(12) (2004).

<sup>322</sup> Id. at 22.

<sup>323</sup> Id.

<sup>324</sup> Ill. Council, 529 U.S. at 23-4 (2000).

<sup>325</sup> *See* 42 CFR §§ 498.3(b)(12), 498.1(a)-(b) (2004).

<sup>326</sup> Ill. Council, 529 U.S. at 21 (2000).

<sup>327</sup> *See* Social Security Act, 42 U.S.C. §§ 405(h), 1395cc(h)(1), 1395ii (2004); 28 U.S.C. § 1331 (2004); 42 C.F.R. §§ 431.153(b), 488.408(g)(2), 498.3(d)(10)(ii) (2004).

after following the special review route, to contest in court the lawfulness of any regulation or statute upon which an agency determination depends.<sup>328</sup>

The Council also challenged the regulatory procedures that prevented challenges to the level of nursing noncompliance or imposition of penalty.<sup>329</sup> Because the Council brought this suit as a preemptory challenge to the regulations it was unable to provide specific facts to rebut the Secretary's claims. The Court noted, however, that even if in individual cases the process resulted in a denial of judicial review, the Bowen exception was based on preclusion of review for an entire industry rather than the hardship of just one individual.<sup>330</sup> In cases in which the hardship was not industry wide, the Court deferred to the agency process because it provides the agency opportunity to "apply, interpret, or revise policies, regulations, or statutes without possibly premature interference by different individual courts applying ripeness and exhaustion exceptions on a case by case basis," but the agency can waive steps in process to reach federal court or the court can waive those steps even when no hearing has been held.<sup>331</sup>

The Court's decision in II. Council limited the application of the Bowen exception to section 405(h) to cases in which there was no agency hearing process. Thus, because Medicare regulations mandated a hearing process for nursing homes challenging deficiencies, nursing homes had to present its case to HHS and receive a final agency ruling before submitting a case in federal court. Currently, HHS is not complying with the mandated hearing process of the Medicare regulations. Specifically, the Secretary's interpretation of the regulations that govern the nursing home hearing process, upon which the Court relied, was never adopted by the agency.<sup>332</sup> Nursing homes do not have the right to appeal determinations of noncompliance unless a certain remedy is imposed.<sup>333</sup> Moreover, nursing homes are not granted access to a full evidentiary hearing leaving nursing homes without the procedural due process rights that the Court relied upon in its ruling.

## **V. THE REALITY OF NURSING HOME HEARINGS AFTER SHALALA: A RIGHT TO NO MEANINGFUL REVIEW, THROUGH WRITTEN SUBMISSIONS**

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<sup>328</sup> III. Council, 529 U.S. 1, 20 (2000).

<sup>329</sup> Id. at 23.

<sup>330</sup> Id. at 22. Individual hardship is addressed by excusing steps in the channeling process once the individual has presented the case to the agency, which is nonwaivable and nonexcusable. Id. at 22-23.

<sup>331</sup> Id. at 24.

<sup>332</sup> *See* 42 C.F.R. § 488.046 (2004).

<sup>333</sup> Id.

The Secretary's interpretations of the regulations in Ill. Council are contrary to what actually happens within the nursing home hearing process.<sup>334</sup> Hence, as the Council argued in Ill. Council, the prohibition of federal review of Constitutional challenges prior to presentment and final ruling by HHS amounts to the "practical equivalent of a total denial of judicial review."<sup>335</sup> Nursing homes are prevented from receiving any evidentiary hearing unless HHS imposes appealable remedies or termination. This directly contradicts the Secretary's interpretation of the Medicare regulations offered in Ill. Council, upon which the Court relied in making its decision to bar nursing homes from federal courts.<sup>336</sup> Once a nursing home is granted a hearing, the hearing process is so limited that there is no meaningful review of claims. The ALJs have begun to limit the hearing process to written direct testimony and in-person cross-examination. This is contrary to the Medicare Act and regulations, the Congressional intent of the Medicare Act and regulations, and the rules of the APA § 554.

#### A. *The Right to No Meaningful Review*

In Ill. Council, the Secretary stated, "any 'dissatisfied' nursing home was entitled to review any determination that it failed to comply substantially with the statute, agreements, or regulations, whether termination or some other remedy was imposed."<sup>337</sup> Even though the Secretary offered a clear interpretation of 42 C.F.R. § 498.3 in Ill. Council, the rest of HHS, including HHS counsel and ALJs, do not abide by this interpretation. Beginning in 1996, four years prior to the ruling in Ill. Council and continuing through the present, HHS attorneys have filed Motions to Dismiss in nursing home cases where the remedy imposed has been rescinded but the allegations of noncompliance remain posted on the internet and within the nursing home's compliance file for use in future inspections.<sup>338</sup>

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<sup>334</sup> ALJs summarily dismiss nursing home appeals in Medicare noncompliance cases when HHS has not imposed a remedy. See Arcadia Acres, Inc., DAB No. CR424 (1996), *aff'd* DAB No. 1607 (1997); Jacinto City Healthcare Ctr., DAB No. CR627 (1999); Heritage Manor of Franklinton, DAB No. CR666 (2000); Lutheran Home – Caledonia, DAB No. CR 674 (2000), *aff'd* DAB No. 1753 (2000); Lakewood Plaza Nursing Ctr., DAB No. CR 691 (2000), *aff'd* DAB No. 1767 (2001); Lakeland Lodge Nursing Ctr., DAB No. CR893 (2002); Southwood Care Ctr., DAB No. CR1029 (2003); Highlands at Brighton, DAB No. CR1104 (2003); Manorcare Health Services Sandia, DAB No. CR1255 (2004).

<sup>335</sup> See in Ill. Council, 529 U.S. at 20 (2000), *citing McNary*, 498 U.S. 479, 497 (1991).

<sup>336</sup> Ill. Council, 529 U.S. at 21 (2000).

<sup>337</sup> Id.

<sup>338</sup> See Arcadia Acres, Inc., DAB No. CR424 (1996), *aff'd* DAB No. 1607 (1997); Jacinto City Healthcare Ctr., DAB No. CR627 (1999); Heritage Manor of Franklinton, DAB No. CR666 (2000); Lutheran Home – Caledonia, DAB No. CR 674 (2000), *aff'd* DAB No. 1753 (2000); Lakewood Plaza Nursing Ctr., DAB No. CR 691 (2000), *aff'd* DAB No. 1767 (2001); Lakeland Lodge Nursing Ctr., DAB No. CR893

In six cases<sup>339</sup> decided by ALJs where HHS did not impose remedies, the ALJ dismissed the cases reasoning that the nursing home did not have a right to a hearing under the regulations if no remedy was imposed.<sup>340</sup> For instance the first case decided by HHS on this issue was Arcadia Acres, Inc. v. HCFA.<sup>341</sup> In Arcadia Acres, the facility challenged findings of noncompliance based on surveys conducted on November 21, 1995 and January 18, 1996. HHS sent Arcadia Acres a letter on March 4, 1996 imposing the remedy of denial of payments for new admissions, which HHS rescinded on April 1, 1996. Arcadia Acres timely filed its hearing request, but the ALJ granted HHS' Motion to Dismiss. HHS asserted that the 42 C.F.R. § 498.3(b)(12)<sup>342</sup> of the Medicare regulations only provided a nursing home a right to a hearing once a remedy was imposed. Arcadia Acres contended that HHS would use these noncompliance findings to determine the amount of penalties for future noncompliance findings. Arcadia Acres asked the ALJ to proceed "to a hearing on the findings of deficiencies in order to protect against 'injustice' resulting from unjust and inadequate survey results and because, '[i]f not in the instant appeal, where else will Arcadia Acres have a forum?'"<sup>343</sup>

To resolve the case, the ALJ referred to the Secretary's response during the notice and comment period of 42 C.F.R. § 498.3(b)(12), which said:

Comment: Several commenters wanted a right to appeal all deficiencies even if no remedy was imposed.

Response: We are not accepting this suggestion because if *no remedy* is imposed the provider has suffered *no injury* calling for appeal.

(emphasis added).<sup>344</sup> Thus, the ALJ ruled in favor of HHS because when promulgating the compliance regulations the Secretary specifically rejected the claim that any dissatisfied nursing home had a right to appeal noncompliance findings *unless* a remedy was imposed. The ALJ further held that the possibility of HHS' imposing sanctions against the facility in the future on the basis of its

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(2002); Southwood Care Ctr., DAB No. CR1029 (2003); Highlands at Brighton, DAB No. CR1104 (2003); Manorcare Health Services Sandia, DAB No. CR1255 (2004).

<sup>339</sup> Id.

<sup>340</sup> 42 C.F.R. § 488.3 (2004).

<sup>341</sup> Arcadia Acres, Inc., DAB No. CR424 (1996), *aff'd* DAB No. 1607 (1997) (no internal page numbers available for citation).

<sup>342</sup> This section was redesignated as 498.3(b)(13) in 2000. *See* 65 Fed. Reg. 18549 (Apr. 7, 2000). Only the imposition of certain remedies grants the nursing home appeal rights. *See* 42 C.F.R. §§ 498.3(b)(13), 488.406 (2004).

<sup>343</sup> Id.

<sup>344</sup> Id. *citing* 59 Fed. Reg. 56116; 56158 (Nov. 10, 1994).

findings of noncompliance was speculative and outside any definition of “initial determination” entitling the facility to a hearing under 42 C.F.R. §§498.3(b)(13) & (d) and 488.330(e)(3).

Contrary to the ALJ’s holding in Arcadia Acres, this practice is not speculative and does cause nursing homes financial and reputation harm. HHS does regularly use these unappealable findings of noncompliance that are not adjudicated for future actions as mandated by the federal regulations.<sup>345</sup> In fact, according to 42 C.F.R. § 488.404, HHS is *mandated* to consider the nursing home’s history of noncompliance in determining which remedies to impose.<sup>346</sup> Moreover, 42 C.F.R. § 488.438 requires HHS to consider a facility’s history of noncompliance and any repeat deficiencies when determining the amount of civil money penalty it will impose.<sup>347</sup> Thus, HHS consistently penalizes a nursing home for these unappealable findings of noncompliance. Not only does this contradict the Secretary’s statements in Ill. Council that nursing homes are afforded hearing rights regardless of whether a remedy is imposed, but it also contradicts the ALJ’s finding in Arcadia Acres, Inc. that nursing homes are afforded all rights of due process under the regulations. This practice also prevents nursing homes from any meaningful review to challenge the alleged noncompliance findings that remain part of the public record of the nursing home.

In reviewing the nursing homes case in Ill. Council, the Supreme Court focused on the fact that even if HHS’ administrative review process barred the claims of some the process was still meaningful because it did not bar an entire industry and served the objectives of the exhaustion doctrine: allowing the agency to apply, interpret, or revise policies, regulations, or statutes without possibly premature interference by different individual courts applying ripeness and exhaustion exceptions on a case by case basis.<sup>348</sup> The practice of HHS does bar the entire industry from obtaining review because no nursing home has the right to review if a remedy is not imposed. Furthermore, because the nursing homes cases are summarily dismissed each time the objectives stated in Ill.Council are not met. There is no opportunity for Secretary to correct errors and no record is compiled for the federal court because cases are summarily dismissed without any record.<sup>349</sup> Furthermore, Constitutional arguments do not appear on the record

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<sup>345</sup> 42 C.F.R. §§ See 42 C.F.R. §§ 488.404(c)(2), 488.438(f)(1) and (3) (2004).

See also Arcadia Acres, Inc., DAB No. CR887 (2002).

<sup>346</sup> Id.

<sup>347</sup> Id.

<sup>348</sup> Ill. Council, 529 U.S. at 24 (2000).

<sup>349</sup> See Arcadia Acres, Inc., DAB No. CR424 (1996), *aff’d* DAB No. 1607 (1997); Jacinto City Healthcare Ctr., DAB No. CR627 (1999); Heritage Manor of Franklinton, DAB No. CR666 (2002); Lutheran Home – Caledonia, DAB No. CR 674 (2000), *aff’d* DAB No. 1753 (2000); Lakewood Plaza Nursing Ctr., DAB No. CR 691 (2000), *aff’d* DAB No. 1767 (2001); Lakeland Lodge Nursing Ctr., DAB No. CR893

because ALJs either ignore arguments or dismiss them before the nursing home can preserve its arguments.<sup>350</sup>

Hence, the nursing home industry should be allowed to bring cases in federal court for review without having to present claims to HHS and receiving a final ruling from HHS, because just like the physicians in Bowen, the nursing home industry has been left without access to any meaningful review. Even when nursing homes are afforded a hearing, the hearing process conducted is minimal at best. In fact, the actual hearing process has been limited to the submission of all direct testimony through affidavits and in-person cross-examination.<sup>351</sup> Although the current Medicare regulations that grant nursing homes procedural Due Process guarantee a right to a full evidentiary hearing on the record,<sup>352</sup> ALJs of HHS have seemingly reverted back to the “informal hearing” process used by HHS in 1986, without any formal change in the rules.

#### *B. Full Evidentiary Hearings Through Written Submission*

Beginning in 2002, some of the eight ALJ’s decided to reconsider what 42 C.F.R. Part 498 meant when it said a full and fair hearing must be conducted.<sup>353</sup> Three of the ALJs began to require that all direct testimony of witnesses be submitted through written submissions, only allowing the participants to cross-examine witnesses at their full evidentiary hearing.<sup>354</sup> The ALJ’s, employees of HHS, made this modification without issuing any new rulings, regulations, or policy memos justifying this change. These changes are arbitrarily applied -- not all ALJs prevent in-court testimony -- and directly contradict the plain language of the statute and regulations governing nursing home hearings, are contrary to Congress’ intent when it created the full evidentiary hearing process, and violate the APA.<sup>355</sup>

*1. Plain Language of Medicare Statute and Regulations.* - Section 1320a-7a(c)(2) of the Medicare Act mandates that nursing homes be granted:

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(2002); Southwood Care Ctr., DAB No. CR1029 (2003); Highlands at Brighton, DAB No. CR1104 (2003); Manorcare Health Services Sandia, DAB No. CR1255 (2004).

<sup>350</sup> Beverly Health & Rehab. Servs., Inc. v. Thompson, 223 F. Supp. 2d 73, 87 (D.C. Cir. 2002).

<sup>351</sup> See Judicial Order from ALJ Kessel regarding pre-hearing submissions. (on file with author).

<sup>352</sup> See 42 C.F.R. §§ 498.60, 498.62, 498.66 (2004).

<sup>353</sup> According to 42 C.F.R. Part 498, which governs the hearing process, in-person witness testimony is a required element of the nursing home hearing. Id. In fact, the regulations state that witnesses will testify at the in-person hearing, without any mention that this testimony is limited to cross-examination. Id.

<sup>354</sup> See Judicial order from ALJ Kessel regarding pre-hearing submissions. (On file with author).

<sup>355</sup> See 42 C.F.R. §§ 498.60, 498.62, 498.66 (2004).

an opportunity for the determination to be made *on the record* after a hearing at which the person is entitled to be represented by counsel, to present witnesses and to cross-examine witnesses against the person.

(emphasis added).<sup>356</sup> This was further codified in the Medicare regulations.<sup>357</sup> According to 42 C.F.R. § 498.60, the ALJ must inquire fully into all matters at issue and receive into evidence the testimony of witnesses and any documents that are relevant and material at the in-person hearing.<sup>358</sup> Clearly, this means that witnesses are required to present their entire testimony at the in-person hearing, because the regulation does not distinguish between direct or cross examination of witnesses. This regulation further states that the ALJ decides the order in which the evidence and the arguments of the parties are presented and the conduct of the hearing.<sup>359</sup> Although, ALJs may decide the conduct of the hearing, this authority is limited by 42 C.F.R. § 498.62, which governs witness's testimony.<sup>360</sup> The regulation states:

The representative of each party *is permitted to examine his or her own witnesses subject to interrogation by the representative of the other party*. The ALJ may ask any questions that he or she deems necessary. The ALJ rules upon any objection made by either party as to the propriety of any question.

(emphasis added).<sup>361</sup> Therefore, according to 42 C.F.R. §498.62, a witness' entire testimony shall be given at the in-person hearing so that the ALJ may ask questions and rule upon objections.

Furthermore, if direct testimony is in the form of an affidavit, the ALJ will not be able to ask timely questions regarding the witnesses' testimony which may serve to clarify some disputed issues of material fact. Also, the questions asked of witnesses never appear in their affidavit. Therefore, the opportunity for parties to make objections "to the propriety of any question" as required by 42 C.F.R. §498.62 is non-existent. Instead of being granted the opportunity to keep inadmissible statements out of evidence, parties are limited to filing broad motions to strike witness statements, requiring the ALJ to review the statement and then determine its admissibility. Moreover, the submission of direct testimony through affidavits violates the requirements of 42 C.F.R. §498.66.

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<sup>356</sup> 42 U.S.C. § 1320a-7a(c)(2) (2004).

<sup>357</sup> See 42 C.F.R. §§ 498.60, 498.62, 498.66 (2004).

<sup>358</sup> 42 C.F.R. §§ 498.60.

<sup>359</sup> Id.

<sup>360</sup> Id.

<sup>361</sup> See 42 C.F.R. § 498.62.

According to 42 C.F.R. §498.66, a party must file a written waiver of the right to appear and present evidence to waive its right to an oral hearing.<sup>362</sup> In fact, 42 C.F.R. §498.66 states that an oral hearing must be conducted unless “an affected party wishes to waive its right to appear and present evidence at the hearing,” by filing “a written waiver with the ALJ.”<sup>363</sup> Even when a nursing home has not submitted a written waiver of its right to appear and present evidence, ALJs are implementing these policies. This contravenes the plain meaning of the regulation, because in these cases there has been no admission of fact by either party; thus, the ALJ must conduct an oral hearing because it is “necessary to clarify the facts at issue.”<sup>364</sup> Furthermore, some ALJs intentionally disregard the legislative and agency history behind the creation of a formal agency hearing process when they fail to grant a full evidentiary hearing.

2. *Congressional and Agency Intent.* – In 1986, nursing homes were only granted limited procedural due process rights to challenge the intermediate sanction<sup>365</sup> of denial of payments for new Medicare admissions.<sup>366</sup> However, in 1987, Congress abolished this informal hearing process and granted nursing homes to a formal hearing.<sup>367</sup> . In 1995, HHS implemented these changes and promulgated new hearing regulations, re-structuring the hearing process to include the right to a full evidentiary hearing before an ALJ if there were genuine issues of material fact in dispute.<sup>368</sup> These rights included witnesses testifying at hearing.<sup>369</sup> Therefore, it is clear from these changes HHS intended to give nursing homes a full evidentiary for both termination and remedies.<sup>370</sup> Additionally, when the nursing home hearing process is compared to the hearing process of laboratories, it is clear that HHS intended to grant nursing homes the right to a full evidentiary hearing.

One of the main purposes of granting nursing homes the right to a hearing was to afford them the right to effectively challenge HHS’ findings of noncompliance.<sup>371</sup> Furthermore, when HHS wanted to limit an agency’s hearing process it was quite clear. For example, when HHS created a hearing process for

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<sup>362</sup> 42 C.F.R. § 498.66.

<sup>363</sup> Id.

<sup>364</sup> Id.

<sup>365</sup> Additional intermediate sanctions, now entitled remedies, were added to the federal regulations. For further discussion *supra* Section II.A.3.

<sup>366</sup> 51 Fed. Reg. 24484, 24491 (July 3, 1986).

<sup>367</sup> H.R. REP. NO. 100-391 at 470 (2d Sess. 1987). HHS combined the formal hearing for termination and the informal hearing for other remedies into one hearing process. *See* 52 Fed. Reg. 22444, 22447-22448 (June 12, 1987).

<sup>368</sup> 60 Fed. Reg. 50118 (Sept. 28, 1995).

<sup>369</sup> 42 C.F.R. § 498.62 (2004).

<sup>370</sup> 52 Fed. Reg. at 22444-22445.

<sup>371</sup> *See* 52 Fed. Reg. at 22447.

laboratories under the Clinical Improvement Amendments of 1988 (“CLIA”)<sup>372</sup> codified in Subpart D of 42 C.F.R. Part 488, HHS specifically limited the rights of laboratories.<sup>373</sup> According to 42 C.F.R. § 488.201, a laboratory dissatisfied with HHS’ determination has a right to seek reconsideration regardless of whether a remedy has been imposed.<sup>374</sup> CLIA laboratories are given an informal hearing in front of a hearing officer.<sup>375</sup> In addition, laboratories are allowed to present witness testimony at the hearing.<sup>376</sup> Although laboratories are afforded these rights, this process is only minimal compared to nursing home hearings.

First, the process for laboratories is entitled “informal hearing”<sup>377</sup> while the process for nursing homes is called a “hearing.”<sup>378</sup> Second, the hearing process for laboratories is conducted in front of a hearing officer,<sup>379</sup> while nursing homes have the right to present evidence to an ALJ.<sup>380</sup> Furthermore, laboratories are limited to who can be witnesses and participants in the informal hearing,<sup>381</sup> whereas, nursing home are granted the unlimited option of bringing to the hearing anyone whose “presence the ALJ considers necessary or proper.”<sup>382</sup> Hence, when HHS wanted to limit the due process rights afforded in a hearing it stated so clearly in the regulations governing laboratories. Notwithstanding these facts, some ALJs have rejected this change in the regulations some seventeen years later by requiring nursing homes to submit direct testimony through affidavits reverting back to an “informal hearing” process. HHS did not state that nursing homes were only entitled to an informal hearing, so nursing homes are entitled to a full evidentiary hearing. Furthermore, once Congress and HHS provided nursing homes with a hearing *on the record*, APA §554 requires that nursing homes be granted a full evidentiary hearing.

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<sup>372</sup> On October 31 1988, the Clinical Improvement Amendments of 1988 (“CLIA”) was enacted to revise the Clinical Laboratory Improvement Act of 1967. CLIA made every laboratory in the country that tests human specimens for health reasons subject to federal regulation regardless of whether it participated in a government program or its tested specimens in interstate commerce. *See* 57 Fed. Reg. 33992 (July 31, 1992).

<sup>373</sup> *See* 42 C.F.R. §488.201 (2004).

<sup>374</sup> *See* 42 C.F.R. §488.201 (2004).

<sup>375</sup> *Id.*

<sup>376</sup> 42 C.F.R. § 488.205 (2004).

<sup>377</sup> *Id.*

<sup>378</sup> *See* 42 C.F.R. § 498.40 (2004).

<sup>379</sup> *See* 42 C.F.R. § 488.207 (2004).

<sup>380</sup> *See* 42 C.F.R. § 498.5 (2004).

<sup>381</sup> The witnesses are limited to authorized representatives, technical advisors, and a legal counsel. *See* 42 C.F.R. § 488.207(b)(1).

<sup>382</sup> 42 C.F.R. § 498.60 (2004).

3. *The Administrative Procedure Act*. – Section 554 of the APA provides that:

every case of adjudication required by statute to be determined *on the record* after opportunity of an agency hearing.<sup>383</sup>

(emphasis added). Before the section 554 of the APA can apply, the statute must clearly mandate a hearing on the record. Moreover, the Supreme Court has “also implied that formal adjudication procedures are only necessary when a statute uses the magic words ‘on the record’.”<sup>384</sup> Thus, HHS is required to provide nursing homes a right to a hearing if the Medicare statute provides a hearing on the record. This proposition was recently affirmed by the U.S. Court of Appeals for the Sixth Circuit in the case styled, Crestview Parke Care Ctr. v. Thompson.<sup>385</sup>

In Crestview, a skilled nursing home located in Ohio was surveyed by the Ohio Department of Health on August 29, 1999, and found out of compliance with the Medicare regulations.<sup>386</sup> The Ohio Department of Health revisited the facility four times before finding the facility in compliance on October 21, 1999.<sup>387</sup> HHS imposed a \$400 a day civil money penalty from October 2<sup>nd</sup> to October 21<sup>st</sup>.<sup>388</sup> Crestview appealed the imposition of the \$400 a day civil money penalty challenging the facts supporting the penalty to an ALJ on December 30, 1999. Crestview and HHS participated in a pre-hearing conference with the ALJ on September 10, 2001.<sup>389</sup> Subsequently, the parties exchanged pre-hearing briefs. On December 12, 2001, the ALJ informed the parties that the case would be resolved without an in-person hearing because there were no genuine issues of material fact.<sup>390</sup> The ALJ ruled in favor of HHS, finding that the \$400 civil money penalty and the DAB affirmed the ALJ’s ruling.<sup>391</sup> Crestview appealed the case to the United States Court of Appeals for the Sixth Circuit.

The Court ruled that nursing homes had a right to an in-person hearing based on APA § 554 and the Medicare statute and regulations.<sup>392</sup> The Court held that APA § 554 provided a right to an in-person hearing if the statute required the

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<sup>383</sup> APA, 5 U.S.C. § 554 (1994).

<sup>384</sup> Crestview Parke Care Ctr. v. Thompson, 373 F.3d 743, 748 (6th Cir. 2004), *relying on* PBGC v. LTV Corp., 496 U.S. 633, 654-55 (1990) (affirming agency’s use of informal hearing process without an oral hearing because statute did not require the hearing to be on the record).

<sup>385</sup> Crestview Parke, 373 F.3d 743 (6th Cir. 2004).

<sup>386</sup> Id. at 744.

<sup>387</sup> Id. at 745.

<sup>388</sup> Id.

<sup>389</sup> Id.

<sup>390</sup> Id. at 746.

<sup>391</sup> Id.

<sup>392</sup> Id. at 748.

agency to grant an opportunity to be heard *on the record*.<sup>393</sup> Because section 1320a-7a(c)(2) of the Social Security Act guaranteed nursing homes the right to a hearing *on the record* with in-person witness testimony, the Court held that Crestview was entitled to an in-person hearing.<sup>394</sup> Even with this ruling, some ALJs still limit the hearing to in-person cross-examination.<sup>395</sup>

Nursing homes have no right to a hearing to challenge any finding of noncompliance and even when granted a hearing there is no meaningful review because some ALJs are limiting the formal hearing process to written direct testimony and in-person cross-examination. HHS reasons that without the imposition of the remedy, nursing homes are not harmed. However, this is not the case. HHS is required under 42 U.S.C. § 1395i-3(g)(5) to report their findings to the public by posting it on their website. This is harm to the nursing home's reputation. Additionally, HHS is required under 42 C.F.R. §§ 488.404 and 488.438 to take into consideration the compliance history of the facility, which includes these unreviewable findings of noncompliance. This causes nursing home's financial harm.

When a nursing home actually gains access to the hearing process some ALJs have limited the hearing process to in-person cross-examination directly contradicting the plain language of the Medicare Act and regulations, the intent of the Medicare Act and regulations, and the APA. Thus, when the Supreme Court ruled in III. Council that nursing homes were prohibited by 42 U.S.C. §§ 405(g) and (h) from seeking federal court review unless the nursing home presented that case to HHS and received a final ruling, the Court effectively barred nursing homes from any meaningful review. To resolve these issues nursing homes could file a lawsuit with proof that the hearing process is meaningless or HHS could comply with the Medicare regulations.

### C. Solutions

To preserve fairness and Due Process in Medicare compliance hearings, HHS should return to providing nursing homes with a full evidentiary hearing that includes witness testimony. To ensure timely resolution of cases to protect the lives of nursing home residents and permit nursing homes an opportunity to protect their financial interests and reputation, HHS should also hire more ALJs to hear cases. If a nursing home is not afforded a hearing, then HHS should post the facility's hearing request on their website along with their alleged non-compliance findings.

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<sup>393</sup> *Id.*

<sup>394</sup> *Id.* at 748. The court further noted that the Medicare regulations 42 C.F.R. §§ 498.3(a)(1), 488.330(e)(3)(ii), 498.60-62, 498.66 clearly provided nursing homes the right to an in person hearing. *Id.* at 749. For further discussion of these regulatory requirements *supra* Section V.B.1.

<sup>395</sup> *See* Judicial Order from ALJ Kessel regarding pre-hearing findings (on file with author).

Finally, HHS should automatically waive the finality requirement for Constitutional challenges so that nursing homes can immediately enter federal court. This would allow HHS to save time and money bypassing menial debates concerning compliance when the nursing home is only challenging the Constitutionality of the procedures used. The implementation of these solutions would not entail any additional expense and would actually improve the system for the benefit of the nursing homes as well as the residents. The timely resolution of nursing home compliance hearings ensures that instead of wasting time on fight allegations of noncompliance the nursing home can focus on the quality of residents.

### CONCLUSION

The failure of Federal administrative agencies to provide the Due Process rights guaranteed by the agency's governing statute, regulations, and policy statements contravenes the protections guaranteed by the Due Process Clause: the fundamental right of Americans regulated by the federal government to receive due process of law when deprived of life, liberty, or property. HHS' limitation of nursing homes' hearing rights is one example of this contravention. Understandably, the money spent by HHS justifies rigorous regulation of nursing homes to ensure that residents receive quality care. However, arbitrary and capricious regulation of nursing homes that leaves them without any avenue to challenge the agency's actions violates the procedural Due Process rights guaranteed by the Fifth Amendment of the U.S. Constitution. The Supreme Court's ruling in Ill. Council upholding the bar to federal review until presentment to HHS and a final agency ruling, even if the claims are Constitutional in nature, created a fundamental flaw in the nursing home hearing process. Nursing homes cannot obtain agency review for certain claims and thus are barred from federal review, yet these unreviewable claims are then used against them in later proceedings.<sup>396</sup>

This abrogation of rights has pushed the industry to near collapse, because not only do alleged violations of Medicare regulations serve as the basis for Medicaid actions,<sup>397</sup> but these findings are also used by insurance companies in determining yearly insurance premiums for nursing homes.<sup>398</sup> Therefore,

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<sup>396</sup> 42 C.F.R. §§ 498.5, 498.60-66 (2004).

<sup>397</sup> See 77 Ill. ADMIN. CODE §§ 300.200 (e)(1), (f) (2002). See generally, Social Security Act, 42 U.S.C. § 1395i-3 (g)(1)(A) (1994).

<sup>398</sup> Currently in many states such as Texas, Florida and Illinois there is an insurance crisis for nursing homes. Many nursing homes are forced to operate without insurance because insurance companies are unwilling to offer nursing homes with less than perfect compliance histories reasonable insurance rates. See Kendall Anderson, *Nursing homes pay premium to survive: Soaring liability costs blamed for closure of nonprofit care centers*, DALLAS MORNING NEWS, July 25, 2002 at 21A. Liability

procedural due process rights,<sup>399</sup> or lack thereof, afforded nursing homes during hearings to challenge alleged violations of the Medicare regulations are paramount to a nursing home's continued operation. To comply with the Medicare statute and regulations, HHS should provide nursing homes with timely full evidentiary hearings and allow facilities with Constitutional challenges that the agency has no authority to decide proceed to federal court. By putting these solutions into place, HHS can streamline the process so that cases are quickly and fairly resolved, while still protecting the care provided nursing home residents.

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insurance rates, tied to litigation costs and the quality of care, have increased on average 1,000 percent since 1998. Id.

<sup>399</sup> Procedural due process rights are an integral part of a full and fair hearing in federal and state courts. *See* APA, 5 U.S.C. §§ 554 and 556 (1994). *See also* FINAL REPORT OF THE ATTORNEY GENERAL'S COMMITTEE ON ADMINISTRATIVE PROCEDURE 7 (1941), *contained in* S. Doc. No. 8, 77th Cong. (1<sup>st</sup> Sess. 1941).