No. 98-1109

In the Supreme Court of the United States

OCTOBER TERM, 1998

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS

v.

ILLINOIS COUNCIL ON LONG TERM CARE, INC.

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

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether 42 U.S.C. 405(h), incorporated into the Medicare Act by 42 U.S.C. 1395ii, permits skilled nursing facilities participating in the Medicare program to obtain judicial review under 28 U.S.C. 1331 and 1346 (1994 & Supp. II 1996) to challenge the validity of Medicare regulations.

PARTIES TO THE PROCEEDING

Petitioners are Donna E. Shalala, Secretary of the Department of Health and Human Services and Anthony J. Tirone, Deputy Director of the United States Office of Survey and Certification, Health Standards and Quality Bureau, Health Care Financing Administration. Petitioners were named as defendants/appellees in the court of appeals. Both petitioners appear in their official capacities only. John R. Lumpkin, M.D., Director of the Illinois Department of Public Health, was also a defendant/appellee in the court of appeals.

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PETITION FOR A WRIT OF CERTIORARI

The Solicitor General, on behalf of the Secretary of Health and Human Services and the other federal party, respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Seventh Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-12a) is reported at 143 F.3d 1072. The opinion of the district court (App., *infra*, 13a-21a) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on May 8, 1998. A petition for rehearing was denied on

August 13, 1998. (App., *infra*, 22a-23a). On November 2, 1998, Justice Stevens extended the time within which to file a petition for a writ of certiorari to and including December 12, 1998. On December 4, 1998, Justice Stevens further extended the time within which to file a petition for a writ of certiorari to and including January 10, 1999. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTORY PROVISIONS INVOLVED

The provisions of 42 U.S.C. 405(g), 405(h), 1395cc(h), and 1395ii are reproduced at App., *infra*, 24a-27a.

STATEMENT

1. In Title XVIII of the Social Security Act, Congress established the federally funded Medicare program to provide health insurance to the elderly and disabled. 42 U.S.C. 1395 *et seq.* Part A of the program provides insurance for covered in-patient hospital and related post-hospital services, including skilled nursing care and related services for residents of qualified skilled nursing facilities. 42 U.S.C. 1395d, 1395i-3, 1395x(j).[1] When patient beneficiaries receive those services, the Secretary reimburses the providers of the services under the Medicare Act and the Secretary's implementing regulations. 42 U.S.C. 1395f(b)(1), 1395x(v)(1)(A).

Skilled nursing facilities must comply with statutory standards for health, safety, and quality of care. 42 U.S.C. 1395i-3(a)-(d); 42 C.F.R. 483.1-483.75.[2] To en-

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[1] Part B of Medicare is a voluntary supplementary insurance program covering physician charges and other medical services. 42 U.S.C. 1395k, 1395*l*, 1395x(s).

[2] Nursing facilities also must comply with similar standards in order to participate in the Medicaid program. 42 U.S.C. 1396r(a)-(d) (1994 & Supp. II 1996). The Medicaid program, established in

force compliance with those standards, the Act vests the Secretary with authority to impose a broad range of remedies upon a finding of a violation, including direction of a plan for correcting statutory violations, imposition of civil money penalties, denial of further reimbursement for services rendered after the deficiency is discovered, appointment of temporary management, and termination of a facility's right to participate in Medicare. 42 U.S.C. 1395i-3(h)(2); 42 C.F.R. 488.406.

The Act also sets forth comprehensive procedures for administrative and judicial review of enforcement measures taken by the Secretary. If a remedy or sanction is imposed, a nursing facility has a right to an evidentiary hearing before an administrative law judge (ALJ) to contest a finding of a statutory or regulatory violation. 42 C.F.R. 498.3(b)(12), 498.40-498.78.[3] The facility may appeal an adverse hearing decision to the Departmental Appeals Board, which may modify, affirm, or reverse the ALJ's decision. 42 C.F.R. 498.80-498.88. Such a decision is the final decision of the Secretary. 42 C.F.R. 498.90(a). A provider may obtain judicial review of the Secretary's final decision after a hearing by filing an action in district court within 60

1965 by Title XIX of the Social Security Act, 42 U.S.C. 1396 *et seq.*, is a cooperative federal-state program to provide medical care to needy individuals.

[3] Providers have no right to a hearing, however, if they acquiesce in a finding of deficient care and voluntarily correct the deficiency before a remedy takes effect, or if the provider is subject to the loss of approval for a nurse-aide training program or additional monitoring of the provider's operations. 42 C.F.R. 498.3(b)(12) and (d)(10)(iii). A provider also generally may not challenge an assessment of the violation's scope and severity or the resulting choice of enforcement remedies. 42 C.F.R. 498.3(d)(10)-(11).

days. 42 U.S.C. 1395cc(h)(1) (incorporating 42 U.S.C. 405(g)).[4] Finally, Section 205(h) of Title II of the Social Security Act, 42 U.S.C. 405(h), made applicable to the Medicare Act by 42 U.S.C. 1395ii, makes those procedures the exclusive means of obtaining judicial review over final decisions of the Secretary:

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

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

2. Respondent is a trade association that represents approximately 200 nursing facilities that participate in both the Medicare and the Medicaid programs. App., *infra*, 14a. In May 1996, respondent filed suit in the United States District Court for the Northern District of Illinois seeking injunctive and declaratory relief and invoking the court's jurisdiction under 28 U.S.C. 1331, 1346 (1994 & Supp. II 1996), and 2201. The complaint

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[4] A facility may challenge the imposition of a civil money penalty by filing an action for judicial review in the court of appeals within 60 days. 42 U.S.C. 1395i-3(h)(2)(B)(ii) (incorporating 42 U.S.C. 1320a-7a). Although nursing facilities participating in the Medicaid program (see note 2, *supra*) may obtain an evidentiary hearing to contest a finding of a statutory or regulatory violation, 42 C.F.R. 431.153(i), the Medicaid Act itself does not contain its own provisions for judicial review of an enforcement action taken against a facility. See notes 5 and 11, *infra*.

alleges that the Secretary's regulations governing the enforcement of health and safety standards for nursing facilities are unconstitutionally vague, exceed the Secretary's statutory authority, and deprive facilities of their due process rights by limiting a provider's ability to contest an enforcement action. The complaint also alleges that a manual used by inspectors to survey providers is a substantive rule that must comply with the notice-and-comment rulemaking procedures of the Administrative Procedure Act (APA), 5 U.S.C. 553. See App., *infra*, 13a, 15a.

The district court dismissed the complaint for lack of subject matter jurisdiction. App., *infra*, 13a-21a. The court explained that 42 U.S.C. 405(h) forecloses jurisdiction under 28 U.S.C. 1331 and 1346 (1994 & Supp. II 1996) over the claims asserted on behalf of respondent's Medicare provider members, because those claims arise under the Medicare Act. App., *infra*, 15a-18a. The district court rejected respondent's reliance on this Court's decision in *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), which held that a federal district court had jurisdiction under Section 1331 to review a challenge to the validity of a Medicare regulation governing payments to physicians under Part B of the Medicare program. At that time, 42 U.S.C. 1395ff (1982) provided for a hearing and judicial review of challenges to the amount of payments made under Part A but not under Part B of the Medicare program. See 476 U.S. at 674 n.5 (quoting 42 U.S.C. 1395ff (1982)); *United States* v. *Erika, Inc.*, 456 U.S.201, 207-208 (1982). Relying on the "strong presumption that Congress intends judicial review of administrative action," the Court in *Michigan Academy* concluded that Section 405(h) did not preclude "challenges mounted against the *method* by which [the]

amounts [of Part B benefits] are to be determined rather than [challenges to] the [amount] *determinations* themselves." 476 U.S. at 670, 675. Given that statutory framework, the district court concluded that the decision in *Michigan Academy* is premised on the fact that the plaintiffs in that case had "no other avenue of judicial review" to challenge the Secretary's regulations. App., *infra*, 18a.

The district court pointed out that, after this Court's decision in *Michigan Academy*, Congress amended the Medicare Act to provide for administrative and judicial review of challenges to Part B amount determinations. See Pub. L. No. 99-509, § 9341(a)(1), 100 Stat. 2037 (1986) (codified at 42 U.S.C. 1395ff(1)). Thus, because both Part A and Part B participants "now have an avenue of judicial review," the district court concluded that the concern in *Michigan Academy* that agency action would be altogether immune from review "no longer exists." App., *infra*, 18a.

The district court further found that it lacked jurisdiction to consider respondent's claims under 42 U.S.C. 405(g), as incorporated into the Medicare Act for cases such as this by 42 U.S.C. 1395cc(h)(1). The district court explained that Section 405(g) imposes two requirements for obtaining judicial review: a nonwaivable requirement of presentment of the claim to the Secretary and a waivable requirement of exhaustion of administrative remedies. App, *infra*, 18a-19a. The district court concluded that because respondent "has not alleged or shown any attempt at presentment of [its] claims to the Secretary," the court lacks subject

matter jurisdiction over the claims arising under the Medicare Act. *Id.* at 19a.[5]

3. The court of appeals vacated and remanded for further proceedings. App., *infra*, 1a-12a. The court of appeals observed that this Court's decisions in *Heckler* v. *Ringer*, 466 U.S. 602 (1984), and *Weinberger* v. *Salfi*, 422 U.S. 749 (1975), "treat th[e] language [of 42 U.S.C. 405(h)] as channeling all claims to benefits through the administrative forum, no matter what legal theory underlies the claim." App., *infra*, 4a. Relying on *Michigan Academy*, however, the court of appeals concluded that Section 405(h) precludes a provider's challenge relating to a "request for reimbursement" but permits an "anticipatory challenge to implementing regulations." *Id.* at 4a, 5a. The court of appeals reasoned that, even though "[i]t may well be that the 1986 amendments [to Part B] remove the practical support for the distinction drawn by *Michigan Academy*" between "pre-enforcement challenges to Medicare regulations * * * and requests for reimbursement," "[u]ntil the Supreme Court tells us that it believes that the 1986 amendments require a change of direction

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[5] The district court dismissed respondent's claims brought under the *Medicaid* program. App., *infra*, 19a-20a. The court reasoned that "[b]y reaching the merits on the Medicaid claims, this court would effectively resolve the Medicare issues as well. This attempt to back-door the jurisdictional bar of the Medicare Act is impermissible." *Ibid.* In the court of appeals, the Secretary acknowledged that, because the Medicaid Act does not contain provisions comparable to 42 U.S.C. 405(g) and (h), see note 4, *supra*, the district court had subject matter jurisdiction under 28 U.S.C. 1331 over the claims brought on behalf of respondent's members participating *solely* in the Medicaid program, to the extent those claims were otherwise justiciable. App., *infra*, 2a-3a; Gov't C.A. Br. 15-16, 28-29. Seventy-five of respondents' members participate only in the Medicaid program. Amended Compl. ¶ 6.

* * *, we are obliged to follow the holding of *Michigan Academy*." *Id.* at 5a, 7a.[6]

The Secretary filed a petition for rehearing and suggestion of rehearing en banc. The court of appeals denied the petition, although three judges voted to grant rehearing en banc. App., *infra*, 22a-23a & n.2.

REASONS FOR GRANTING THE PETITION

This case presents two questions at issue in *Your Home Visiting Nurse Services, Inc.* v. *Shalala*, No. 97-1489 (argued Dec. 2, 1998). Both this case and *Your Home* concern whether the preclusive language of Section 405(h) bars an action to review agency action under the Medicare program where subject matter jurisdiction is based on 28 U.S.C. 1331. Both cases also concern whether this Court's decision in *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), has continuing application when the Medicare Act itself affords a provider with an opportunity to obtain administrative and judicial review over agency action. As we note in our merits brief in *Your Home*, Gov't Br. 40-41 n.18, the court of appeals' decision in this case conflicts with the great weight of appellate authority. Because the Court's resolution in *Your Home* may govern the disposition of this case, the

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[6] The court of appeals dismissed as unripe respondent's vagueness challenge to the Secretary's regulations. App., *infra*, 10a-11a. The court of appeals observed that, "[i]n order to take advantage of *Michigan Academy*, [respondent] made its claim entirely abstract," by "not object[ing] to any evaluation of any particular nursing home or contend[ing] that a single one of its members has been ill used." *Id.* at 9a. The court of appeals also remanded to the district court respondent's due process and statutory claims for a determination whether those claims were justiciable, and further remanded respondent's APA notice-and-comment claim for consideration on the merits. *Id.* at 11a-12a.

petition in this case should be held pending the decision in *Your Home* and then disposed of in light of that decision.[7]

1. a. The principal question presented in *Your Home* is whether a fiscal intermediary's refusal to reopen a provider's annual reimbursement determination is subject to review by the Provider Reimbursement Review Board (PRRB) under 42 U.S.C. 1395*oo*(a), which in turn would result in a right to judicial review of the PRRB's final decision under 42 U.S.C. 1395*oo*(f). If the Court concludes in *Your Home* that the provider is not entitled to such administrative review, however, the Court will consider the *Your Home* petitioner's alternative contention that this Court's decision in *Michigan Academy* permits a federal district court, exercising jurisdiction under 28 U.S.C. 1331, to review (presumably pursuant to the APA) an intermediary's refusal to reopen a prior reimbursement determination. Pet. Br. 18-23.[8] The Secretary has argued in *Your Home* (Gov't Br. 36-42) that such jurisdiction is specifically precluded by the second and third sentences of Section 405(h), incorporated into the Medicare Act by 42 U.S.C. 1395ii, which provide that:

> No findings of fact or decision of the [Secretary] shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the [Secretary], or

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[7] We are providing counsel for respondent with a copy of our brief filed in *Your Home*.

[8] The petitioner in *Your Home* also contends that a federal court has subject matter jurisdiction under 28 U.S.C. 1361 and 5 U.S.C. 706 to review an intermediary's denial of a provider's reopening request. Pet. Br. 24-40. Those asserted bases for jurisdiction are not involved in this case.

> any officer or employee thereof shall be brought under section 1331 * * * of title 28 to recover on any claim arising under this subchapter.

42 U.S.C. 405(h). Section 405(h) equally bars respondent's suit in this case.

This Court has made clear that the preclusive language of Section 405(h) is "sweeping and direct and * * * states that *no* action shall be brought under § 1331." *Weinberger* v. *Salfi*, 422 U.S. 749, 757 (1975). Similarly, in *Heckler* v. *Ringer*, 466 U.S. 602 (1984), the Court held that "[t]he third sentence of 42 U.S.C. § 405(h) * * * provides that [42 U.S.C.] 405(g), to the exclusion of 28 U.S.C. § 1331, is the sole avenue for judicial review for all 'claim[s] arising under' the Medicare Act." *Id.* at 614-615 (quoting 42 U.S.C. 405(h)). The Court in *Ringer* explained that Section 405(h) "broadly" extends to "any claims in which 'both the standing and the substantive basis for the presentation' of the claims" is the Medicare Act. 466 U.S. at 615 (quoting *Salfi*, 422 U.S. at 761). The Court therefore concluded that all such claims must be brought under Section 405(g) by presenting the claims to the Secretary and exhausting administrative remedies, absent a waiver by the Secretary. 466 U.S. at 617; see also *Bowen* v. *City of New York*, 476 U.S. 467, 482-483 (1986); *Mathews* v. *Eldridge*, 424 U.S. 319, 327-328 (1976); *Salfi*, 422 U.S. at 763-767.[9]

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[9] As this Court observed in *Salfi*, 422 U.S. at 765, the purpose of requiring claimants to exhaust administrative remedies is to "prevent[] 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."

Those principles foreclose jurisdiction under 28 U.S.C. 1331 and 1346 (1994 & Supp. II 1996) over respondent's claims for declaratory relief.[10] Respondent seeks review of the validity of the Secretary's regulations that implement the statutory health and safety standards for nursing facilities participating in the Medicare program. The district court correctly concluded that, because respondent's claims asserted on behalf of Medicare providers arise under the Medicare Act, App., *infra*, 15a-18a, Section 405(h) bars a district court from exercising jurisdiction under Sections 1331 and 1346 to hear those claims.[11] Moreover, because respondent neither presented its claims to the Secretary nor exhausted its administrative remedies, the district court correctly concluded that it lacked jurisdiction under Section 405(g) to hear such claims.[12]

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[10] Although respondent also asserts that the Declaratory Judgment Act, 28 U.S.C. 2201, furnishes an alternative basis for the district court's subject matter jurisdiction (Amended Compl. ¶ 11), that provision is not an independent grant of jurisdiction. *Skelly Oil Co.* v. *Phillips Petroleum Co.*, 339 U.S. 667, 671-672 (1950).

[11] Sections 405(g) and 405(h) also foreclose the challenges brought by a provider that participates in *both* the Medicare and Medicaid programs because such claims also arise under the Medicare Act. Those providers are governed by essentially identical standards, 42 U.S.C. 1395i-3(a)-(d) and (g) (Medicare); 42 U.S.C. 1396r(a)-(d) and (g) (1994 & Supp. II 1996) (Medicaid), and dually participating providers are required to employ the administrative remedies set forth for the Medicare program. 42 C.F.R. 431.153(g). A contrary conclusion would circumvent Congress's intent in Sections 405(g) and 405(h) to require exhaustion of administrative remedies over claims arising under the Medicare Act. Cf. note 9, *supra*.

[12] The APA reinforces the exclusivity mandated by Sections 405(g) and 405(h). The APA expressly provides that "[t]he form of

In reaching the contrary conclusion, the court of appeals reasoned that "pre-enforcement review of a regulation's validity is not an action to 'recover on' a claim" within the meaning of Section 405(h). App., *infra*, 6a. This Court in *Ringer*, however, rejected as "superficially appealing but ultimately unavailing" the contention that Section 405(h) excepts from its breadth a challenge to a regulation that is divorced from a specific claim for benefits. 466 U.S. at 621. Rather, the Court found that federal courts lack jurisdiction under 28 U.S.C. 1331 to award declaratory and injunctive relief respecting the Secretary's policy not to cover a particular surgical procedure, even if a claimant has not undergone the surgery and therefore has no concrete claim for reimbursement on which he could recover. *Id.* at 621-626; compare *id.* at 631 n.9 (Stevens, J., concurring in part and dissenting in part) (arguing that such a claimant had "nothing on which he can recover" when he had not yet submitted a reimbursement claim). In short, the Court concluded that "[i]n the best of all worlds, immediate judicial access * * * might be desirable. But Congress, in § 405(g), and § 405(h), struck a different balance, refusing declaratory relief and requiring that administrative remedies be exhausted before judicial review of the Secretary's decisions takes place." *Id.* at 627. Thus, the court of appeals' decision conflicts with this Court's decision in

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proceeding for judicial review is the special statutory review proceeding relevant to the subject matter," 5 U.S.C. 703, and permits a district court action only if "there is no other adequate remedy in a court." 5 U.S.C. 704. Because Section 405(g) furnishes respondent and its Medicare-provider members a fully adequate remedy for challenges to enforcement actions and standards, review directly in the district court under the APA would not be available in any event.

Ringer, which construed the plain text of Section 405(h) to preclude "all 'claim[s] arising under' the Medicare Act," 466 U.S. at 615 (quoting 42 U.S.C. 405(h)).

b. The court of appeals also erred in relying on this Court's decision in *Michigan Academy* to permit respondent to bypass the Medicare Act's specific administrative and judicial remedies. In *Michigan Academy*, the Court permitted plaintiffs to invoke the district court's jurisdiction under Section 1331 to challenge the validity of reimbursement regulations under Part B of the Medicare program at a time when 42 U.S.C. 1395ff (1982) provided for a hearing and judicial review of challenges to the amount of payments made under Part A but not Part B of the program. 476 U.S. at 674 n.5 (quoting 42 U.S.C. 1395ff (1982)); *United States* v. *Erika, Inc.*, 456 U.S. 201, 207-208 (1982). Rejecting what it termed the "extreme" position taken by the government that Congress intended Section 405(h) to foreclose "all" judicial review of facial challenges to the Secretary's regulations, the Court held that Section 405(h) did not preclude "challenges mounted against the *method* by which [the] amounts [of Part B benefits] are to be determined." 476 U.S. at 675, 680.

Michigan Academy does not support jurisdiction over respondent's claims outside the specific review provisions of the Medicare Act. Unlike the situation in *Michigan Academy*, in which jurisdiction under Section 1331 was the *sole* jurisdictional basis for obtaining judicial review of administrative action under Part B of the program as it then existed, Section 405(g), as incorporated into the Medicare Act by 42 U.S.C. 1395cc(h)(1), explicitly affords respondent an avenue to challenge the Secretary's regulations. Thus, Section 405(g) expressly confirms the district court's power to "review * * * the validity of [the Secretary's]

regulations" when it reviews the Secretary's final decision. Because judicial review of regulations is available, the presumption of judicial review underlying the decision in *Michigan Academy* is not "implicate[d]." *Thunder Basin Coal Co.* v. *Reich*, 510 U.S. 200, 207 n.8 (1994); see also *McNary* v. *Haitian Refugee Ctr., Inc.*, 498 U.S. 479, 498 (1991) ("Inherent in our analysis [in *Michigan Academy*] was the concern that absent such a construction of the * * * statute, there would be 'no review at all of substantial statutory and constitutional challenges to the Secretary's administration of Part B of the Medicare program.'") (quoting *Michigan Academy*, 476 U.S. at 680). Accordingly, under Section 405(h) and this Court's decisions in *Ringer* and *Salfi*, the Medicare Act is the sole means of obtaining judicial review over claims arising under the Act.

2. In holding that Medicare providers may bring a pre-enforcement APA challenge to the Secretary's' regulations by invoking the district court's jurisdiction under 28 U.S.C. 1331, the court of appeal's decision departs from the great weight of appellate authority.

In *Michigan Ass'n of Homes & Services for the Aging, Inc.* v. *Shalala*, 127 F.3d 496 (1997), the Sixth Circuit rejected the attempt by an association of nursing facilities to invoke a district court's jurisdiction under Section 1331 to raise claims that are virtually identical to the those asserted by respondent. *Id.* at 498-499. The Sixth Circuit held that under the express terms of Section 405(h), and this Court's decisions in *Ringer* and *Salfi*, judicial review under Section 405(g) is the sole means to challenge the Secretary's regulations, and providers therefore may not invoke the jurisdiction of a district court under Section 1331 to circumvent Section 405(g)'s requirements of presentment to the Secretary and exhaustion of administrative remedies.

Id. at 499-501. The Sixth Circuit further held that *Michigan Academy* did not support the assertion of federal question jurisdiction. The court reasoned that "[a]dministrative review—and so long as * * * sections 405(g) and (h) are fulfilled, judicial review—is available any time a sanction is actually imposed." *Id.* at 501.

The Sixth Circuit's decision therefore squarely conflicts with the court of appeals' decision in this case. The court of appeals' decision similarly is inconsistent with the Third Circuit's decision in *St. Francis Medical Center* v. *Shalala*, 32 F.3d 805, 812-813 (1994), cert. denied, 514 U.S. 1016 (1995), which holds that the administrative and judicial review provisions of the Medicare Act are the sole means of obtaining review of provider reimbursement claims arising under Part A of the Medicare program. See also *Westchester Management Corp.* v. *HHS*, 948 F.2d 279, 282 (6th Cir. 1991) (court lacked jurisdiction under Sections 1331 and 1346 to consider provider's APA, statutory, and constitutional challenge to Medicare regulation), cert. denied, 504 U.S. 909 (1992).

Moreover, the court of appeals' decision conflicts with the decisions of those courts of appeals that have applied *Michigan Academy* in light of subsequent legislative changes to Part B of the Medicare program. As the Seventh Circuit recognized in this case (App., *infra*, 4a-6a), Congress amended 42 U.S.C. 1395ff in 1986 to provide for administrative and judicial review of challenges to carrier determinations concerning the amount of payments made under Part B of the program. Pub. L. No. 99-509, § 9341(a)(1), 100 Stat. 2037. In light of that amendment, the courts of appeals have held that Part B claimants must pursue the specific review procedures under Section 405(g), and that Section 405(h)

bars federal courts from exercising jurisdiction under 28 U.S.C. 1331 to review claims arising under Part B of the Medicare program, including the type of facial challenges to regulations at issue in *Michigan Academy*. See *American Academy of Dermatology* v. *HHS*, 118 F.3d 1495, 1497-1501 (11th Cir. 1997); *Farkas* v. *Blue Cross & Blue Shield*, 24 F.3d 853, 855-860 (6th Cir. 1994); *Abbey* v. *Sullivan*, 978 F.2d 37, 41-44 (2d Cir. 1992); *National Kidney Patients Ass'n* v. *Sullivan*, 958 F.2d 1127, 1130-1134 (D.C. Cir. 1992), cert. denied, 506 U.S. 1049 (1993).[13] Thus, disregarding the express terms of Section 405(h), the court of appeals' decision in this case conflicts with the substantial body of appellate authority that has held that Medicare providers may not invoke the jurisdiction of a federal district court under Section 1331 to circumvent the administrative and judicial review procedures prescribed by the Medicare Act.

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[13] Indeed, the Seventh Circuit itself has acknowledged that, because "the *Michigan Academy* distinctions drawn between 'amount of payment' and 'validity of the statute and regulations' challenges are no longer meaningful or necessary," the review provisions of Section 405(g) "now provide the full authority for exercising jurisdiction over Part A and Part B disputes." *Martin* v. *Shalala*, 63 F.3d 497, 503 (1995).

CONCLUSION

The petition for a writ of certiorari should be held pending the decision in *Your Home Visiting Nurse Services, Inc.* v. *Shalala*, No. 97-1489 (argued Dec. 2, 1998), and then disposed of as appropriate in light of the decision in that case.

Respectfully submitted.

SETH P. WAXMAN
Solicitor General

JANUARY 1999

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

No. 97-2315

ILLINOIS COUNCIL ON LONG TERM CARE INC.,
PLAINTIFF-APPELLANT

v.

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., DEFENDANTS-APPELLEES

[Argued: Dec. 5, 1997
Decided: May 8, 1998]

Before: EASTERBROOK, DIANE P. WOOD, and EVANS, Circuit Judges

EASTERBROOK, Circuit Judge.

Nursing homes that want reimbursement under the Medicare or Medicaid programs must comply with regulations specifying minimum health and safety standards. Statutory criteria were enacted in 1987, see 42 U.S.C. § 1395i- 3(a) to (d) (Medicare), § 1396r(a) to (d) (Medicaid), but implementing regulations were not issued until 1994, and did not take effect until July 1, 1995. 59 Fed.Reg. 56,116 (1994). An association of nursing homes, the Illinois Council on Long Term Care,

tells us that before these new regulations were adopted about 6% of its members had been directed to change their operations in order to meet applicable standards, while more recent inspections have found 70% of nursing homes to be deficient. Regulators attribute this to tougher substantive rules that nursing homes have yet to satisfy; the nursing homes attribute the jump to vague rules that leave too much discretion in the hands of inspection teams.

The Council filed this suit on behalf of its members and asked the court to declare that the new regulations violate the due process clause of the fifth amendment because they are too vague and do not provide adequate opportunities to be heard before financial penalties take effect. The Council also argued that a manual used by inspection teams has the effect of a regulation and therefore could be adopted only after notice-and-comment rulemaking under § 3 of the Administrative Procedure Act, 5 U.S.C. § 553. The Secretary of Health and Human Services, the principal defendant in the case, asked the district court to distinguish between the Medicare and Medicaid aspects of the suit. According to the Secretary, objections to implementation of the Medicare Act are barred by 42 U.S.C. § 1395ii, incorporating 42 U.S.C. § 405(h), which makes an application for benefits (and review of the Secretary's final decision), the sole route to judicial review. None of the Council's members has obtained a final decision, and § 1395ii forbids jumping the gun on legal issues that will be relevant to the administrative decision, the Secretary contended. *See Heckler v. Ringer*, 466 U.S. 602, 104 S. Ct. 2013, 80 L.Ed.2d 622 (1984). Although most of the Council's theories are based on the Constitution and the APA rather than any incompatibility between

the regulations and the Medicare Act, *Weinberger v. Salfi*, 422 U.S. 749, 95 S. Ct. 2457, 45 L.Ed.2d 522 (1975), holds that a claim is subject to the review-channeling provision in § 405(h) when the end in view is receipt of federal payments. Claims under the Medicaid Act should be handled otherwise, the Secretary submitted, because that statute does not incorporate § 405(h) and lacks any comparable restriction. A challenge to Medicaid regulations therefore is proper under 28 U.S.C. § 1331 and 5 U.S.C. § 702—but, the Secretary added, should be dismissed in large measure as unripe. Only the Medicaid providers' APA challenge to the handbook is mete for decision, the Secretary concluded. The district judge accepted the first part of this argument—that § 1395ii postpones review of claims by Medicare providers—but extended it to the entire case, stating: "The issues are the same, the only difference being that the first three counts arise under the Medicaid Act whereas the latter three arise under the Medicare Act. By reaching the merits on the Medicaid claims, this court would effectively resolve the Medicare issues as well. This attempt to back-door the jurisdictional bar of the Medicare Act is impermissible." 1997 WL 158347 at *3, 1997 U.S. Dist. Lexis 3982 at *9-10. After the Council filed its notice of appeal, the sixth circuit reached the same conclusion in an essentially identical case. *Michigan Association of Homes & Services for the Aging, Inc. v. Shalala*, 127 F.3d 496 (6th Cir.1997).

Section 1395ii makes § 405(h) applicable to Medicare cases "to the same extent as" it applies to Social Security disability cases. Section 405(h) provides in part: "No findings of fact or decision of the [Secretary] shall be reviewed by any person, tribunal, or governmental

agency except as herein provided. No action against the United States, the [Secretary], or any officer or employee thereof shall be brought under § 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter." The word "herein" refers to the rest of § 405, and in particular to § 405(g), which permits judicial review only after a final decision by the Secretary. *Ringer* and *Salfi* treat this language as channeling all claims to benefits through the administrative forum, no matter what legal theory underlies the claim. But *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667, 678-81, 106 S. Ct. 2133, 2140-41, 90 L.Ed.2d 623 (1986), holds that § 1395ii does not foreclose Medicare providers' anticipatory challenge to implementing regulations. Bypassing the question whether § 405(h) would prevent such a challenge to a regulation implementing the Social Security disability program, the Court held that § 1395ii addresses only "amount determinations" (476 U.S. at 680, 106 S. Ct. at 2141)—that is, calculations of reimbursements by the fiscal intermediaries 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 courts of law." *Ibid.* (emphasis in original).

According to the Secretary, *Michigan Academy* ceased to have any precedential force a few months after it was issued. The Secretary reads *Michigan Academy* as creating an exception to § 1395ii for claims that otherwise could not reach the courts. Shortly after the Court decided *Michigan Academy*, Congress amended the Medicare Act to give providers an avenue to judicial review of amount determinations, 42 U.S.C.

§ 1395ff(b)(1), thus overturning the result of *United States v. Erika, Inc.*, 456 U.S. 201, 102 S. Ct. 1650, 72 L.Ed.2d 12 (1982). Once that occurred, the argument concludes, the basis of *Michigan Academy* disappeared, and with it the Court's holding. The district court, and the sixth circuit in *Michigan Association*, 127 F.3d at 500-01, accepted this line of argument. But if something important happened in 1986, the point has been lost on the Supreme Court, which in 1991 reiterated its conclusion that § 1395ii does not affect regulatory challenges that are detached from any request for reimbursement. *McNary v. Haitian Refugee Center, Inc.*, 498 U.S. 479, 497-98, 111 S. Ct. 888, 898-99, 112 L.Ed.2d 1005 (1991). And it has been lost on us too, for we have since 1986 drawn a distinction between preenforcement challenges to Medicare regulations (allowed) and requests for reimbursement (postponed until after the Secretary has made a final decision). *E.g., Martin v. Shalala*, 63 F.3d 497, 503-05 (7th Cir.1995); *Bodimetric Health Services, Inc. v. Aetna Life & Casualty*, 903 F.2d 480, 483-87 (7th Cir.1990).

It may well be that the 1986 amendments remove the practical support for the distinction drawn by *Michigan Academy*. The panel in Martin said as much. 63 F.3d at 502-03. *Michigan Academy* emphasized, 476 U.S. at 670-73, 106 S. Ct. at 2135-37, the presumption that Congress has allowed some avenue of judicial review, and the Justices read the statutes then in effect with that presumption in mind. Now that Congress has authorized review of amount determinations through § 1395ff(b)(1), that part of *Michigan Academy's* rationale is gone—the invalidity of regulations would be a good reason for a reviewing court to upset an amount determination. This led the district court to write that

"the *Michigan Academy* exception does not apply." Both the Secretary and the district court thus treat the Supreme Court's opinion as an "exception" to a statute—as if the Court claimed the power to treat statutes no differently from the common law, and to make "exceptions" to Acts of Congress based on judicially created presumptions. Cf. Guido Calabresi, *A Common Law for the Age of Statutes* (1982). To the contrary, the Court has disavowed such power. E.g., *Bank of Nova Scotia v. United States*, 487 U.S. 250, 255, 108 S. Ct. 2369, 2373-74, 101 L.Ed.2d 228 (1988). *Michigan Academy* does not say that a presumption of judicial review justifies an "exception" to § 1395ii. It says, rather, that § 1395ii, read in light of its 1972 legislative history, affects only "amount determinations". 476 U.S. at 678-81, 106 S. Ct. at 2140-41. The key language from this perspective is "recover on" in the sentence: "No action against the United States, the [Secretary], or any officer or employee thereof shall be brought under § 1331 or [§] 1346 . . . to recover on any claim arising under this subchapter." As the Court read § 1395ii and therefore § 405(h) in *Michigan Academy*, pre-enforcement review of a regulation's validity is not an action to "recover on" a claim, even when per *Salfi* a constitutional objection to the regulation is a "claim arising under this subchapter."

Neither this critical language from § 405(h) nor the history of § 1395ii changed in 1986. Had Congress written a new statute, we would need to decide what the new language means, rather than what *Michigan Academy* said some bygone language meant. But when Congress amended § 1395ff it left § 1395ii alone. Section 1395ii was amended in 1994 (see § 108(c)(4) of Pub.L. 103-296, 108 Stat. 1485), but that change was

designed only to make it clear that a bureaucratic reorganization (the removal of the Commissioner of Social Security from the Department of Health and Human Services) had no substantive effects. The operative language is the same now as it was when *Michigan Academy* came down. The Supreme Court is jealous of its powers and insists that the inferior courts are not authorized to declare the reasoning of its opinions outdated and their holdings passe. See *State Oil Co. v. Khan*, —— U.S. ——, 118 S. Ct. 275, 284, 139 L.Ed.2d 199 (1997); *Rodriguez de Quijas v. Shearson/American Express, Inc.*, 490 U.S. 477, 484, 109 S. Ct. 1917, 1921-22, 104 L.Ed.2d 526 (1989); *Thurston Motor Lines, Inc. v. Jordan K. Rand, Ltd.*, 460 U.S. 533, 535, 103 S. Ct. 1343, 1344, 75 L.Ed.2d 260 (1983). Until the Supreme Court tells us that it believes that the 1986 amendments require a change of direction with respect to § 1395ii, we are obliged to follow the holding of *Michigan Academy*.

Although this conclusion makes it unnecessary to discuss in detail the distinctions between the Medicare and Medicaid programs, the possibility that this case may find its way to a higher tribunal leads us to record our disagreement with the district court's conclusion that challenges to Medicaid regulations are barred whenever the decision has implications for Medicare regulations. The Medicaid Act contains nothing comparable to § 405(h) or § 1395ii. The general federal-question jurisdiction under § 1331 therefore supplies the avenue of judicial review, and it has been understood for a long time that courts are not to invent novel obstacles to the use of this jurisdiction. See *Colorado River Water Conservation District v. United States*, 424 U.S. 800, 817, 96 S. Ct. 1236, 1246, 47 L.Ed.2d 483

(1976). We have entertained challenges to Medicaid regulations without hinting that a district court should dismiss the case (effectively abstaining) if a similar problem could arise under the Medicare Act or its regulations. See *Woodstock/Kenosha Health Center v. Schweiker*, 713 F.2d 285, 288-89 (7th Cir.1983); *Illinois Department of Public Aid v. Schweiker*, 707 F.2d 273 (7th Cir.1983). The district court did not mention these cases; instead it relied on an earlier decision, *Rhode Island Hospital v. Califano*, 585 F.2d 1153, 1162-63 (1st Cir.1978), that is incompatible with the law of this circuit. The Medicare and Medicaid programs have many substantive and procedural differences; it is not as if they were twins, so that a court should struggle to avert the possibility of allowing judicial review at different times or through different mechanisms. Nursing homes that participate in the Medicaid program are not limited to the Medicare procedures. If some nursing homes may litigate on their own, they may litigate through their trade association; we don't see why the fact that other members of the Council have potential Medicare claims should cut off associational representation and compel independent litigation.

Thus we disapprove the sixth circuit's decision in *Michigan Association* across the board, for it is inconsistent with *Woodstock/Kenosha*, and similar cases in this circuit, none of which the sixth circuit cited. *Michigan Association* claimed to follow *Health Equity Resources Urbana, Inc. v. Sullivan*, 927 F.2d 963 (7th Cir.1991), which it read for the proposition that the Medicaid Act's incorporation of 42 U.S.C. § 405(g) via 42 U.S.C. § 1396i(b)(2) is independently sufficient to prevent anticipatory judicial review of regulations. Any interpretative exercise that makes multiple

sections of the United States Code meaningless—and this one would dispense with at least § 405(h) and § 1395ii—and requires a federal court to renounce its own jurisdiction into the bargain, is more than a little suspect. It is not at all what our opinion in *Health Equity Resources* was about. That Medicaid provider commenced an administrative proceeding under § 405(g) and § 1396i(c)(2) to contest an "amount determination" by a fiscal intermediary. Dissatisfied with how things were going, the provider attempted to initiate a suit before the administrative proceeding was over. Applying standard doctrines of exhaustion of administrative remedies, *Health Equity Resources* nixed the maneuver. We did not hold then, and decline to hold now, that a Medicaid provider is forbidden to bring a pre-enforcement challenge to a Medicaid regulation under § 1331.

It follows from what we have said so far that the district court should have resolved on the merits the Council's argument that the manual is a regulation for which notice-and-comment rulemaking was essential. For the most part, however, the Council's victory on the jurisdictional issue does it little good. In order to take advantage of *Michigan Academy*, the Council made its claim entirely abstract. It does not object to any evaluation of any particular nursing home or contend that a single one of its members has been ill used. Such arguments would have played into the Secretary's hands by making it easier to contend that this is just a disguised effort to contest "amount determinations" and therefore postponed (by § 1395ii and *Ringer*) until after the administrative process has run its course. But by making the claim so abstract, the

Council set up the Secretary's contention that the suit is unripe.

One aspect of the Council's attack is assuredly premature. The nursing homes contend that the regulations are void for vagueness. But this is not a first amendment case. It is about conditions attached to a federal subsidy; none of any nursing home's substantive constitutional rights is in jeopardy. That makes it impossible to mount a "facial" attack on the rules. If a rule "implicates no constitutionally protected conduct, [the court] should uphold the challenge only if the enactment is impermissibly vague in all of its applications. A plaintiff who engages in some conduct that is clearly proscribed cannot complain of the vagueness of the law as applied to the conduct of others. A court should therefore examine the complainant's conduct before analyzing other hypothetical applications of the law." *Hoffman Estates v. The Flipside, Hoffman Estates, Inc.*, 455 U.S. 489, 494-95, 102 S. Ct. 1186, 1191, 71 L.Ed.2d 362 (1982) (footnote omitted). In other words, "vagueness challenges . . . which do not involve First Amendment freedoms must be examined in the light of the facts of the case at hand." *United States v. Mazurie*, 419 U.S. 544, 550, 95 S. Ct. 710, 714, 42 L.Ed.2d 706 (1975). Having crafted a litigation strategy to avoid § 405(h) and § 1395ii, the Council finds itself with no "facts of the case at hand" and therefore without any hope of success on a claim that the regulations are unconstitutionally vague. It is indeed hard to see how regulations under a social welfare program could be condemned out of hand as Delphian. Agencies may use ambiguous standards that acquire meaning through the process of application, just as the common law does. See, e.g., *Parker v. Levy*, 417 U.S. 733, 94 S. Ct. 2547, 41

L.Ed.2d 439 (1974); *NLRB v. Bell Aerospace Co.*, 416 U.S. 267, 294, 94 S. Ct. 1757, 1771-72, 40 L.Ed.2d 134 (1974); *CSC v. Letter Carriers*, 413 U.S. 548, 93 S. Ct. 2880, 37 L.Ed.2d 796 (1973). An industry subject to a battery of new regulations cannot ask for an all-at-once review but must wait until the agency has worked through the process of adding detail in administrative adjudication. See *Machinists Union v. NLRB*, 133 F.3d 1012, 1015-17 (7th Cir.1998).

To the extent the Council complains that the manual and accompanying survey forms are unauthorized by the 1987 legislation, these claims may be mooted by a decision on the APA theory. Other aspects of this line of argument may be inappropriate for pre-enforcement review given the standards of *Babbitt v. United Farm Workers*, 442 U.S. 289, 298-99, 99 S. Ct. 2301, 2308-09, 60 L.Ed.2d 895 (1979); *Gardner v. Toilet Goods Association*, 387 U.S. 167, 87 S. Ct. 1526, 18 L.Ed.2d 704 (1967); and *Abbott Laboratories v. Gardner*, 387 U.S. 136, 87 S. Ct. 1507, 18 L.Ed.2d 681 (1967). For example, the Council insists that the regulations and manual will not assure that remedies are consistently applied to similarly situated nursing homes, which 42 U.S.C. § 1395i-3(g)(2)(D) requires the Secretary to do. But how could a court determine, without examining how the system works in practice, whether remedies have been applied consistently? Some other arguments based on the 1987 statute do not appear to present situations in which lack of pre-enforcement review will put the plaintiffs to costly choices—and if anticipatory review is not essential to avoid hardship, then courts should defer review, in order to obtain the benefits of the more focused presentation made possible by a concrete application of the rules. See *Texas v. United*

States, —— U.S. ——, 118 S. Ct. 1257, 140 L.Ed.2d 406 (1998).

Finally, to the extent the Council believes that the regulations fail to provide pre-deprivation hearings at the times (and in the form) the Constitution demands, the claim may be ripe for decision. But because the appellate papers leave us unsure just what this claim entails and how it affects any particular nursing home, it is best to leave to the district court the resolution of the Secretary's ripeness objection to this aspect of the Council's suit.

In sum: the APA-based objection to adoption of the manual is within the district court's jurisdiction and should be addressed on the merits; the vagueness challenge is not ripe for decision and should be dismissed; the due process objection to the timing and structure of opportunities to be heard, and the arguments based on the 1987 statute, may or may not be ripe for decision, and the district court should require the parties to flesh out these claims before deciding which, if any, is justiciable. The judgment is vacated, and the case is remanded for further proceedings consistent with this opinion.

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS

No. 96 C 2953

ILLINOIS COUNCIL FOR LONG TERM CARE, INC.,
PLAINTIFF,

vs.

DONNA E. SHALALA, ET AL., DEFENDANTS

[March 31, 1997]

MEMORANDUM AND ORDER

LINDBERG, District Judge.

Plaintiff, Illinois Council for Long Term Care, has filed a complaint requesting injunctive and declaratory relief against defendants, Secretary Donna Shalala of the Department of Health and Human Services; Anthony J. Tirone, in his capacity as Deputy Director of the United States Office of Survey and Certification, Health Standards and Quality Bureau, Health Care Financing Administration; and John R. Lumpkin, M.D., as Director of the Illinois Department of Public Health (IDPH). Defendants have moved to dismiss all claims pursuant to Fed.R.Civ.P. 12(b)(1) and 12(b)(6).

Plaintiff represents approximately two-hundred nursing homes. Approximately 75 of these members participate only in Medicare. The remaining members participate in either Medicaid or both Medicare and Medicaid. Plaintiff's case arises from the following facts.

The Department of Health and Human Services (HHS) has given the Health Care Financing Administration (HCFA) the responsibility to establish a set of requirements of participation. 42 C.F.R. § 483.1(b). A nursing home must be in compliance with these requirements in order to receive Medicare and Medicaid reimbursements for its patients. In Illinois, the IDPH conducts annual surveys of nursing homes in order to determine whether they are in substantial compliance.

HCFA has developed regulations and distributed Standard Operating Manuals to state agencies such as the IDPH. The IDPH uses them as a guide for surveys and imposing penalties when a nursing home is found to be in non-compliance. In 1987, the Congress amended the Social Security Act with the Omnibus Budget Reconciliation Act (OBRA) in an attempt to improve upon the health, safety, and rights of participants. The amendments called for stricter guidelines and more severe penalties. The first set of HCFA's regulations used the pre-1987 OBRA amendments as its enforcement guidelines. Under these regulations, only 6% of nursing homes in Illinois were found to be in non-compliance. In 1995, HCFA's new set of regulations went into effect. These regulations took into account the 1987 OBRA amendments. Nearly 70% of nursing homes in Illinois were found to be in non-compliance under these new regulations.

Plaintiff claims that this drastic change in the rate of non-compliance is because the new regulations and Standard Operating Manuals are unconstitutionally vague, that the new regulations and Standard Operating Manuals were enacted in violation of the Administrative Procedure Act, and that the lack of a sufficient appeals process is a violation of due process.

Defendants, pursuant to Fed. R. Civ. P. 12(b)(1), move to dismiss for lack of subject matter jurisdiction. "The general rule . . . is that absent clear direction to the contrary by Congress, the federal courts have the power to award any appropriate relief in a cognizable cause of action brought pursuant to a federal statute." *Franklin v. Guinnett County Public Schools*, 503 U.S. 60, 70-71, 112 S. Ct. 1028, 117 L.Ed.2d 208 (1992). This jurisdictional issue must be resolved first.

Plaintiff contends that this court has subject matter jurisdiction under 28 U.S.C. §§ 1331, 1346 and 2201. Defendants argue that this court lacks subject matter jurisdiction under §§ 1331 and 1346. This is because plaintiff's claims arise under the Medicare Act. This court has jurisdiction over a complaint arising under the Medicare Act only after the plaintiff has satisfied the requirements of § 405(g) which is incorporated into the Medicare Act by 42 U.S.C. §§ 1395cc(h)(1). Defendants contend that plaintiff has not satisfied the § 405(g) requirements.

Plaintiff contests this court has jurisdiction for four separate reasons. First, the claims do not arise under the Medicare Act. Second, an administrative appeals tribunal cannot hear constitutional and statutory challenges. Third, there is no other avenue of judicial

review for plaintiff's due process claims and thus the exception noted in *Michigan Academy v. Bowen*, 476 U.S. 667, 106 S. Ct. 2133, 90 L.Ed.2d 623 (1986), applies to them. Fourth, Counts I through III allege claims under the Medicaid Act which unlike the Medicare Act does not incorporate the 42 U.S.C. §§ 405(g) and 405(h) jurisdictional provisions of the Social Security Act. Plaintiff is incorrect and the complaint will be dismissed for lack of subject matter jurisdiction.

Plaintiff first argues that its claims do not arise under the Medicare Act and are thus not barred by the jurisdictional requirements of 42 U.S.C. §§ 405(g) and 405(h).

Under § 405(h)(which is incorporated into the Medicare Act by 42 U.S.C. § 1395ii), federal courts do not have subject matter jurisdiction under § 1346 and § 1331 over claims arising under the Medicare Act. *Michigan Association v. Donna Shalala*, 931 F.Supp. 1339, 1342 (E.D.Mich.1996) (quoting *Livingston Care Center, Inc. v. United States*, 934 F.2d 719, 721 (6th Cir.1991)). Section 405(h)'s "claims arising under" language has been defined to "include any claims in which both the standing and the substantive basis for the presentation of the claims is the Medicare Act." *Id.* (quoting *Heckler v. Ringer*, 466 U.S. 602, 615, 104 S. Ct. 2013, 80 L.Ed.2d 622 (1984)).

Count V of plaintiff's complaint alleges defendants did not satisfy their duties under a specific Medicare Act provision. 42 U.S.C. § 1395i-3(g)(2)(D). This count is barred by § 405(h) because it is directly based on a Medicare Act provision.

The resolution of the claims alleged in Counts IV, VI, and VII largely depends on an analysis of various Medicare Act provisions. Plus, any resolution will have a direct impact on the applicability and enforceability of the Medicare Act. Thus, Counts IV, VI, and VII are also barred by § 405(h) because they are substantively based on the Medicare Act. *Id.*

Plaintiff next contends that its constitutional and statutory challenges cannot be brought before an administrative appeals body. Under 42 C.F.R. § 488.408, the Secretary of HHS will not hear appeals concerning the manner and method of the surveys and the choice of remedy. However, § 405(h) allows for and requires that constitutional and statutory challenges satisfy the jurisdictional requirements of § 405(g) before a complaint can be brought to court. 42 U.S.C. § 405(h). This gives 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. *Weinberger v. Salfi*, 422 U.S. 749, 95 S. Ct. 2457, 45 L.Ed.2d 522 (1975). Therefore, it is not only constitutional, but reasonable to have constitutional and statutory challenges go through the jurisdictional requirements of the Medicare Act. *Id.*

Also, at the heart of plaintiff's case, is a claim for benefits. This is evidenced by the relief sought by plaintiff. Plaintiff seeks continuation of Medicare payments and reimbursement for past due payments incurred by the patients at the nursing homes. Thus, the issue here is whether or not the nursing homes are entitled to benefits. Plaintiff may not circumvent the Medicare Act by attempting to bring what is essentially

a claim for benefits as a facial constitutional challenge. *Id. Heckler*, 466 U.S. at 616.

Plaintiff next argues that even if the claims arise under the Medicare Act and the Secretary has jurisdiction over the constitutional and statutory challenges, §§ 405(g) and 405(h) do not apply because of the exception noted in *Michigan Academy*, 476 U.S. 667, 106 S. Ct. 2133, 90 L.Ed.2d 623 (1986).

In *Michigan Academy*, the Supreme Court was addressing Medicare Part B. Defendant contended that the Supreme Court's jurisdiction was barred by § 405(h). At the time, HHS did not offer an appeals process for its Part B participants. It was because the plaintiff had "no other avenue of judicial review" that the Court ruled §§ 1331 and 1346 gave federal courts jurisdiction over the Part B claims despite the jurisdictional bars of the Medicare Act.

The Medicare Act has now been amended to provide Part A and Part B participants the right to appeal within HHS. 42 U.S.C. § 405(h); 42 C.F.R. § 488.408(g). Section 405(h) allows plaintiff to appeal any dispute to the Secretary. Thus, the concern noted in *Michigan Academy* no longer exists because all participants now have an avenue of judicial review within HHS.

Having established that this case falls under the Medicare Act and that the *Michigan Academy* exception does not apply, it is now necessary to look at the jurisdictional requirements of the Act.

Under § 405(g), a Medicare participant must satisfy two requirements before bringing a case to court. The

first is a non-waivable requirement of presentment to the Secretary of HHS. The second is a waivable requirement of exhaustion of remedies. 42 U.S.C. § 405(g); *Martin v. Shalala*, 63 F.3d 497, 503 (7th Cir. 1995).

The first requirement has not been satisfied. Plaintiff has not alleged or shown any attempt at presentment of his claims to the Secretary. Therefore, it is unnecessary to even reach the second requirement.

As stated above, plaintiff's claims arise under the Medicare Act. Therefore, under § 405(h), HHS has jurisdiction over all of plaintiff's claims, including its constitutional and statutory challenges. The exception to § 405(h) noted in *Michigan Academy* does not apply since an avenue of judicial review exists for plaintiff. Therefore, failure by plaintiff to satisfy the presentment requirement of § 405(g) means this court lacks subject matter jurisdiction over the claims in plaintiff's complaint.

Plaintiff also represents nursing homes which only receive Medicaid benefits. The Medicaid Act does not contain any jurisdictional restrictions similar to those contained in §§ 405(g) and 405(h). Therefore, plaintiff argues, this Court has jurisdiction over the first three counts of their complaint which arise under the Medicaid Act.

This court does not agree. Counts I through III of the Complaint mirror Counts IV through VI. The issues are the same, the only difference being that the first three counts arise under the Medicaid Act whereas the latter three arise under the Medicare Act. By

reaching the merits on the Medicaid claims, this court would effectively resolve the Medicare issues as well. This attempt to back-door the jurisdictional bar of the Medicare Act is impermissible. *Rhode Island v. Califano*, 585 F.2d 1153, 1162-63 (lst Cir. 1978).

In *Rhode Island v. Califano*, the court held that federal courts lacked subject matter jurisdiction over Medicaid claims under circumstances similar to those at bar. In so ruling, the court reasoned that the Medicaid claims were not sufficiently separate and distinct from the Medicare claims. Any resolution of the Medicaid issues would unavoidably touch upon substantive Medicare issues. This, the court ruled, cannot be allowed under § 405(h).

Further, the Medicaid issues will be addressed when the Medicare claims are appealed to and heard by the Secretary. *Rhode Island*, 585 F.2d. at 1163. The result of such an appeal will have the same impact on both the Medicare and Medicaid claims because the Secretary's decision is based on regulations which provide a single set of requirements that both Medicare and Medicaid participants must satisfy. *Michigan Association*, 931 F.Supp. at 1345, 42 C.F.R. § 483. 1(b). Thus, the counts arising under the Medicaid Act have the same avenue of judicial review within HHS as the counts arising under the Medicare Act. As stated above, this appeals process must be completed before this court has jurisdiction over the claims plaintiff alleges in its complaint.

For the foregoing reasons, all claims against defendants will be dismissed for lack of subject matter jurisdiction.

ORDERED: The motion to dismiss of defendants, Donna E. Shalala, Anthony J. Tirone, and John R. Lumpkin [13-1] is granted. All counts of the complaint of plaintiff, Illinois Council for Long Term Care, are dismissed. Defendants' alternative motion for summary judgment [13-2] is denied as moot. Plaintiff's motion for a preliminary injunction [19-1] is denied as moot. The document being recorded in the docket as a motion for summary judgment by American Health Care Association [27-2] is a mislabeled memorandum and so is administratively terminated.

/s/ GEORGE W. LINDBERG
GEORGE W. LINDBERG
District Judge

APPENDIX C

UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT
CHICAGO, ILLINOIS 60604

No. 97-2315
No. 96 C 2923

ILLINOIS COUNCIL ON LONG TERM CARE
INC., PLAINTIFF-APPELLANT

v.

DONNA E. SHALALA, SECRETARY OF HEALTH AND
HUMAN SERVICES, ET. AL., DEFENDANTS-APPELLEES

APPEAL FROM THE UNITED STATES
DISTRICT COURT FOR THE NORTHERN DISTRICT
OF ILLINOIS, EASTERN DIVISION

[August 13, 1998]

BEFORE: HON. FRANK H. EASTERBROOK,
Circuit Judge
HON. DIANE P. WOOD, Circuit Judge
HON. TERENCE T. EVANS, Circuit Judge

ORDER

Federal defendants-appellees filed a petition for rehearing and suggestion of rehearing en banc on June 22, 1998. All of the judges on the panel have voted to deny rehearing. A judge in active service called for a vote on suggestion of rehearing en banc,* but a majority** of the active judges voted to reject the suggestion. The petition for rehearing is therefore denied, and the suggestion for rehearing en banc is rejected.

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* Judge Flaum did not participate in the consideration of the suggestion for rehearing en banc.

** Judges Ripple, Manion and Rovner voted to grant rehearing en banc.

APPENDIX D

1. Section 405(g) of Title 42, United States Code, provides:

Judicial review

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 commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Commissioner of Social Security may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides, or has his principal place of business, or, if he does not reside or have his principal place of business within any such judicial district, in the United States District Court for the District of Columbia. As part of the Commissioner's answer the Commissioner of Social Security shall file a certified copy of the transcript of the record including the evidence upon which the findings and decision complained of are based. The court shall have power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Commissioner of Social Security, with or without remanding the cause for a rehearing. The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive, and where a claim has been denied by the Commissioner of Social Security or a decision is rendered under subsection (b) of this section which is adverse to an individual who was a party to the hearing before the Commissioner of Social Security, because of failure of

the claimant or such individual to submit proof in conformity with any regulation prescribed under subsection (a) of this section, the court shall review only the question of conformity with such regulations and the validity of such regulations. The court may, on motion of the Commissioner of Social Security made for good cause shown before the Commissioner files the Commissioner's answer, remand the case to the Commissioner of Social Security for further action by the Commissioner of Social Security, and it may at any time order additional evidence to be taken before the Commissioner of Social Security, but only upon a showing that there is new evidence which is material and that there is good cause for the failure to incorporate such evidence into the record in a prior proceeding; and the Commissioner of Social Security shall, after the case is remanded, and after hearing such additional evidence if so ordered, modify or affirm the Commissioner's findings of fact or the Commissioner's decision, or both, and shall file with the court any such additional and modified findings of fact and decision, and a transcript of the additional record and testimony upon which the Commissioner's action in modifying or affirming was based. Such additional or modified findings of fact and decision shall be reviewable only to the extent provided for review of the original findings of fact and decision. The judgment of the court shall be final except that it shall be subject to review in the same manner as a judgment in other civil actions. Any action instituted in accordance with this subsection shall survive notwithstanding any change in the person occupying the office of Commissioner of Social Security or any vacancy in such office.

2. Section 405(h) of Title 42, United States Code, provides:

Finality of Commissioner's decision

The findings and decision of the Commissioner of Social Security after a hearing shall be binding upon all individuals who were parties to such hearing. 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.

3. Section 1395cc of Title 42, United States Code, provides in relevant part:

(h) Dissatisfaction with determination of Secretary; appeal by institutions or agencies; single notice and hearing

(1) Except as provided in paragraph (2), an institution or agency dissatisfied with a determination by the Secretary that it is not a provider of services or with a determination described in subsection (b)(2) of this section shall be entitled to a hearing thereon by the Secretary (after reasonable notice) to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title, except that, in so applying such sections and in applying section 405(*l*) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

(2) An institution or agency is not entitled to separate notice and opportunity for a hearing under both section 1320a-7 of this title and this section with respect to a determination or determinations based on the same underlying facts and issues.

4. Section 1395ii of Title 42, United States Code, provides:

Application of certain provisions of subchapter II

The provisions of sections 406 and 416(j) of this title, and of subsections (a), (d), (e), (h), (i), (j), (k), and (*l*) of section 405 of this title, shall also apply with respect to this subchapter to the same extent as they are applicable with respect to subchapter II of this chapter, except that, in applying such provisions with respect to this subchapter, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.