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# Administrative and Judicial Review of Medicare Issues: A Guide Through The Maze

*Michael Neeley-Kvarme\**

Medicare<sup>1</sup> provides basic and supplementary health insurance to those over age 65.<sup>2</sup> In recent years, the health care industry and Medicare beneficiaries have grown increasingly dissatisfied with the procedures used to determine eligibility, reimbursement and coverage under the program.<sup>3</sup> The dissatisfaction of Medicare participants has highlighted the inadequacies of existing administrative and judicial review mechanisms.

This article examines administrative and judicial review within the Medicare program; more specifically: (1) the extent to which the government is required to provide administrative and judicial review; and (2) the degree to which particular procedures further the goals underlying the Medicare Act. The first section of the article outlines the framework of the Medicare system; the second section considers the adequacy of the administrative procedures for handling Medicare disputes. Finally, in the third section, the article examines the various means of obtaining judicial review.

## I. The Medicare Program

Medicare is designed to provide basic and supplementary health

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1 42 U.S.C. §§ 1395-1395rr (1976 & Supp. 1978). *See* 42 U.S.C.A. §§ 1395-1395ss (Supp. 1980) for amendments after 1978.

2 42 U.S.C. §§ 1395(c) [Part A], 1395j [Part B] (1976 & Supp. 1978).

3 It appears that in the future an increasing portion of the population will be eligible for Medicare benefits. Between 1970 and 1979, for instance, there was a drop in the percentage of the population under age 13 (decreases of 8.8% under age 5, and 16.4% between ages 5 and 13), while there was a significant increase in the number of people age 65 and over (increase of 23.5%). BUREAU OF THE CENSUS, U.S. DEP'T OF COMMERCE, CURRENT POPULATION REPORTS P-25, POPULATION ESTIMATES AND PROJECTIONS, PUB. NO. 874, 12 (1980) [hereinafter cited as POPULATION ESTIMATES]. In 1979, approximately 24.1 million aged persons and 2.9 million disabled beneficiaries were covered by Part A. H.R. DOC. NO. 333, 96th Cong., 2d Sess. 2 (1980). Similarly, 23.8 million aged and 2.7 million disabled persons elected Part B coverage in 1979.

insurance for those over age 65.<sup>4</sup> The program is divided into two parts: A and B. Part A is the basic national health plan covering hospitalization and post-hospital care. Part B is a supplementary insurance program covering physician and related health care services. While the two parts are largely independent, they at times overlap, causing accounting and conceptual difficulties.<sup>5</sup> Consideration of both parts is necessary to understand their interrelationship and to compare their respective review mechanisms.

### A. *Medicare Part A—The Basic Protection*

Medicare, Part A, "provides basic protection against the costs of hospital and related post-hospital services."<sup>6</sup> Part A beneficiaries include persons over 65 and disabled persons entitled to Social Security benefits.<sup>7</sup> Coverage is automatic for qualified individuals. The program is funded by employee wage and self-employment taxes.<sup>8</sup>

Part A reimburses qualified providers for the cost of health care services rendered to beneficiaries.<sup>9</sup> Qualified providers may include hospitals, skilled nursing facilities and home health agencies.<sup>10</sup> To qualify under Part A, the facility must meet the requirements of the Secretary of Health and Human Services (HHS)<sup>11</sup> and enter into the necessary agreements.<sup>12</sup> A qualified provider<sup>13</sup> is entitled to reim-

4 See note 2 *supra*. For a discussion of the operation of the Medicare program, see generally *Erika, Inc. v. United States*, 634 F.2d 580, 583 (Ct. Cl. 1980) (en banc), *cert. granted*, 101 S. Ct. 2312 (1981); *Faith Hosp. Ass'n v. United States*, 634 F.2d 526, 527-30 (Ct. Cl. 1980) (en banc); Butler, *An Advocate's Guide to the Medicare Program*, 8 CLEARINGHOUSE REV. 831 (1975) [hereinafter cited as Butler].

5 See, e.g., *Faith Hosp. Ass'n v. United States*, 634 F.2d 526, 528-30 (Ct. Cl. 1980). See also *Hospital San Jorge, Inc. v. Secretary of HEW*, 616 F.2d 580, 585-89 (1st Cir. 1980) (dealing with the Secretary's difficulty in determining under which program hospital-based physicians are properly reimbursed).

6 42 U.S.C. § 1395c (1976).

7 The statute provides health care for:

(1) individuals who are age 65 or over and are eligible for retirement benefits under subchapter II of this chapter or under the railroad retirement system, (2) individuals under age 65 who have been entitled for not less than 24 months to benefits under subchapter II of this chapter or under the railroad retirement system on the basis of a disability, and (3) certain individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease.

42 U.S.C.A. § 1395c (Supp. 1980).

8 42 U.S.C. § 1395i (1976), funded by taxes imposed by I.R.C. §§ 1401(b) (self-employment tax), 3101(b), 3111(b) (tax on wages).

9 42 U.S.C. §§ 1395c-1395f (1976).

10 *Id.* § 1395x(u).

11 Formerly Secretary of Health, Education and Welfare.

12 See 42 C.F.R. §§ 405.1011-.1230 (1980) (criteria for qualification).

bursement based upon the lesser of "reasonable costs" or "customary charges."<sup>14</sup>

Although Part A reimbursement is eventually paid by HHS from the Federal Hospital Insurance Trust Fund,<sup>15</sup> the provider has a choice between seeking reimbursement directly from HHS or from a fiscal intermediary. Most providers seek reimbursement from a fiscal intermediary,<sup>16</sup> usually a private insurance plan such as Blue Cross. The intermediary is under contract with the Secretary to determine eligibility and the reasonableness of costs, audit the provider, make payments, and provide assistance.<sup>17</sup> The intermediary acts as an "agent"<sup>18</sup> or "field service"<sup>19</sup> for the Secretary.

In order to provide the necessary cash-flow and to insure the continuing treatment of beneficiaries, intermediaries are authorized to make interim payments to providers throughout the fiscal year. The interim payments are based upon an estimate of the provider's costs.<sup>20</sup> At the end of the fiscal year, the provider must file an accounting which the intermediary reviews.<sup>21</sup> The intermediary determines the allowability and reasonableness of the costs.<sup>22</sup> The intermediary's costs are then apportioned between Medicare and non-Medicare patients in order to insure that Medicare pays only the

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13 42 U.S.C. § 1395cc (1976). *See* *Sacred Heart Hosp. v. United States*, 616 F.2d 477, 479 (Ct. Cl. 1980).

14 42 U.S.C. §§ 1395f(b), 1395x(v)(1)(A) (1976). *Sacred Heart Hosp. v. United States*, 616 F.2d 477, 483 (Ct. Cl. 1980). The majority of Medicare litigation has involved a determination of the amount of reimbursement to which a provider is entitled.

15 42 U.S.C. § 1395i (1976). *See* *Faith Hosp. Ass'n v. United States*, 634 F.2d 526, 528 (Ct. Cl. 1980) (en banc).

16 *Faith Hosp. Ass'n v. United States*, 634 F.2d 526, 527 (Ct. Cl. 1980). The Medicare program is structured to encourage the use of fiscal intermediaries as private administrators. In *St. Louis Univ. v. Blue Cross Hosp. Servs.*, 537 F.2d 283, 287 n.4 (8th Cir. 1976), the then responsible HEW conceded that using a fiscal intermediary conferred significant benefits on the provider.

17 42 U.S.C. § 1395h(a) (1976). *See generally* Homer & Platten, *Medicare Provider Reimbursement Disputes: An Analysis of the Administrative Hearing Procedures*, 63 GEO. L.J. 107 (1974) [hereinafter cited as Homer & Platten].

18 *Cf. Overlook Nursing Home, Inc. v. United States*, 556 F.2d 500, 501 (Ct. Cl. 1977) (fiscal intermediary constitutes an agent of the Secretary).

19 *Himmeler v. Califano*, 611 F.2d 137, 140 (6th Cir. 1979); *Martinez v. Richardson*, 472 F.2d 1121, 1123 (10th Cir. 1973).

20 42 U.S.C. § 1395g (1976); 42 C.F.R. § 405.1803 (1980). *See* *Moody Nursing Home, Inc. v. United States*, 621 F.2d 399, 400 (Ct. Cl. 1980).

21 42 C.F.R. § 405.406(b) (1980).

22 To be allowable, a cost must be incurred for a service covered by the insurance program. *See* 42 U.S.C. § 1395d (1976); 42 C.F.R. §§ 405.101-.196 (allowable), 405.301-.316 (nonreimbursable) (1980). The reasonable or customary charge question only arises for allowable costs. *See* 42 U.S.C. §§ 1395f, 1395x(v)(1)(A) (1976); 42 C.F.R. §§ 405.401-.554 (1980).

expenses relating to individuals covered by the program.<sup>23</sup> Finally, the intermediary adjusts future interim payments to compensate for any deficit or surplus accruing when past interim payments are compared with actual reimbursable costs.<sup>24</sup> The review provided for the various decisions in this process will be discussed in part II.

### B. Medicare Part B—Supplementary Coverage

Medicare Part B<sup>25</sup> is a government-subsidized health insurance plan providing supplementary coverage to Part A. Those eligible for Part A can elect to enroll in Part B and receive coverage upon the payment of monthly premiums.<sup>26</sup> Benefits are paid from the Federal Supplementary Medical Insurance Trust Fund which is administered by HHS and funded by patient premiums and matching federal grants.<sup>27</sup>

Generally, Part B pays 80% of the cost of physician services, related health services and prosthetic devices.<sup>28</sup> The beneficiary is reimbursed on the basis of the physician's reasonable charge rather than actual cost.<sup>29</sup> While the insurance covers the patient directly, Medicare allows the physician or the provider to take an assignment of the patient's rights and seek recovery.<sup>30</sup>

Part B resembles Part A in that HHS does not actually administer the program. Rather, HHS is empowered to contract with carriers who, like fiscal intermediaries, act as a field service.<sup>31</sup> Carriers are responsible for auditing providers, reviewing charges and paying

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23 42 U.S.C. § 1395x(v)(1)(A)(i) (1976).

24 42 C.F.R. § 405.405 (1980); *Faith Hosp. Ass'n v. United States*, 634 F.2d 526, 527 (Ct. Cl. 1980).

25 42 U.S.C. §§ 1395j-1395w (1976 & Supp. 1978).

26 *Id.* §§ 1395j, 1395p, 1395r. See generally *Erika, Inc. v. United States*, 634 F.2d 580 (Ct. Cl. 1980) (en banc), cert. granted, 101 S. Ct. 2312 (1981); *Cervoni v. Secretary of HEW*, 581 F.2d 1010 (1st Cir. 1978); *Drs. Russi, Griffin & Snell, Ltd. v. Matthews*, 434 F. Supp. 1036 (E.D. Va. 1977).

27 42 U.S.C. §§ 1395j, 1395t (1976). See generally *Faith Hosp. Ass'n v. United States*, 634 F.2d 526 (Ct. Cl. 1980) (emphasizing separate nature of Part A and Part B trust funds).

28 42 U.S.C. §§ 1395k(a)(1), 1395l, 1395x(s) (1976).

29 *Id.* § 1395l. See *Faith Hosp. Ass'n v. United States*, 634 F.2d 526 (Ct. Cl. 1980) (highlighting the importance of the difference in Part A-B context).

30 42 U.S.C. § 1395u(b)(3)(B)(ii) (1976). See *Cervoni v. Secretary of HEW*, 581 F.2d 1010, 1012 (1st Cir. 1978).

31 See *McClure v. Harris*, 503 F. Supp. 409 (N.D. Cal. 1980), prob. juris. noted sub nom. *Schweiker v. McClure*, 50 U.S.L.W. 3278 (U.S. Nov. 13, 1981), stay granted, [1981-1 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 31,089 (Rehnquist, Circuit Justice, June 12, 1981); *Drs. Russi, Griffin & Snell, Ltd. v. Matthews*, 438 F. Supp. 1036, 1042 (E.D. Va. 1977). See also notes 18-19 *supra*.

benefits.<sup>32</sup> The Secretary has designed review procedures for Part B but they are of a more limited scope than those under Part A. The procedures and their ramifications will be discussed in part II.

## II. Administrative Review

Due to congressional and administrative concern over the potential costs of Medicare litigation, administrative and judicial review has been limited within the Medicare system.<sup>33</sup> The limitations imposed vary within a maze of some five review schemes. The extent of review available to beneficiaries or providers ranges from the considerable protection afforded by the Provider Reimbursement Review Board (PRRB)<sup>34</sup> to the unreviewable actions taken by Utilization Review Committees.

The need for review within the Medicare system is demonstrated by the high reversal rate in Part A and Part B procedures which allow a reexamination of the initial administrative decision. Such decisions are reversed in 39 to 51 percent of all Part A hearings.<sup>35</sup> Similarly, Part B hearings reverse one-third of the cases brought.<sup>36</sup> One can only speculate as to the accuracy of the decisions

32 42 U.S.C. § 1395u (1976).

33 See 42 U.S.C. §§ 1395ff(b), 1395oo (1976). See also S. REP. NO. 1230, 92d Cong., 2d Sess. 213 (1972) (explaining the \$100 amount in controversy minimum required to establish entitlement to a hearing).

34 The PRRB was added in 1972 effective for fiscal years ending June 30, 1973 or later. Act of Oct. 30, 1972, Pub. L. No. 92-603, § 243(a) & (c), 86 Stat. 1420-22 (1972), now codified at 42 U.S.C. § 1395oo (1976).

35 BUREAU OF PROGRAM OPERATIONS, HEALTH CARE FINANCING ADMINISTRATION, PART A INTERMEDIARY APPEALS REPORT JULY-SEPT. 1980, at 3 (1980) (hereinafter cited as PART A REPORT).

36 BUREAU OF PROGRAM OPERATIONS, HEALTH CARE FINANCING ADMINISTRATION, PART B APPEALS ACTIVITY JAN.-MAR. 1980, at 4 (table 2) (1980). See also *Gray Panthers v. Schweiker*, [1981-1 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 30,746, at 9196 (D.C. Cir. Mar. 18, 1981); *McClure v. Harris*, 503 F. Supp. 409, 416 (N.D. Cal. 1980) *prob. juris. noted sub nom. Schweiker v. McClure*, 50 U.S.L.W. 3278 (U.S. Nov. 13, 1981), *stay granted*, [1981-1 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 31,089 (Rehnquist, Circuit Justice, June 12, 1981). In *McClure*, the court noted:

Defendants establish[ed] that between 1975 and 1978, carriers wholly or partially reversed, upon "review determination," their initial determinations in 51-57% of the cases considered. Of the adverse determination decisions brought before hearing officers, 42-51% of the carriers' decisions were reversed in whole or in part.

503 F. Supp. at 416 [1980 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 30,522, at 9991. Similarly, in *Gray Panthers*, the D.C. Circuit pointed out plaintiffs' contention that "approximately 50% of the formal hearings that are held on claims over \$100 result in adjustments of benefits in the claimant's favor . . . ." [1981 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 30,746, at 9196. The Secretary had contended that the reversal rate was only one-tenth of one percent based on comparing the number of reversals to the total denials for that year. Such comparisons can engender confusion, as the court stated, "[b]are statistics rarely provide

for which review is unavailable or inadequate.

Before analyzing individual review procedures it is useful to consider the statutory and constitutional constraints under which the Medicare system operates. The internal workings of the Medicare program are governed in part by the strictures of the Administrative Procedure Act (APA).<sup>37</sup> Informal rulemaking procedures must be followed by HHS in promulgating substantive and procedural rules.<sup>38</sup> Additionally, the APA provides guidance in determining the required procedures for administrative hearings.<sup>39</sup> A unique problem arises when the Secretary delegates rulemaking functions to intermediaries and carriers.<sup>40</sup> It has been held that standards and procedures promulgated on behalf of the Secretary by intermediaries and carriers constitute a form of informal rulemaking to which APA standards apply.<sup>41</sup>

Another constraint under which the Medicare system operates is the due process clause of the fifth amendment.<sup>42</sup> Essentially, procedural due process requires the government to provide a meaningful hearing to those whose life, liberty or property interests are affected by its actions.<sup>43</sup> Substantive due process prevents certain disparate treatment by the federal government.<sup>44</sup>

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a satisfactory measure of the fairness of a decisionmaking process." [1981-1 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 30,746, at 9210 n.23, *quoting* Mathews v. Eldridge, 424 U.S. 319, 346 (1976). The purpose of noting these statistics is to show the magnitude of the problem that exists.

37 5 U.S.C. §§ 701-706 (1976). The APA is not, however, an independent source of subject matter jurisdiction. *Califano v. Sanders*, 430 U.S. 99 (1977).

38 *Humana of South Carolina, Inc. v. Califano*, 590 F.2d 1070, 1080-84 (D.C. Cir. 1978). The court made this conclusion despite the arguable bar present in § 205(h). *See* section II *infra*. Although the court found Humana's complaint lacking, as a policy matter establishing review for APA violations makes the Secretary more responsive.

39 5 U.S.C. §§ 554, 556 (1976).

40 For example, the Provider Reimbursement manual (manual) is published by Blue Cross and HHS. At times, the government has attempted to enforce the manual's provisions as substantive regulations although they are not promulgated in accord with the APA. To date, the courts have rejected any substantive use of the manual. *See St. Elizabeth Hosp. v. United States*, 558 F.2d 8, 12-14 (Ct. Cl. 1977).

41 *See, e.g., Overlook Nursing Homes, Inc. v. United States*, 556 F.2d 500 (Ct. Cl. 1977).

42 U.S. Const. amend. V. *See generally* L. TRIBE, AMERICAN CONSTITUTIONAL LAW (1978) [hereinafter cited as TRIBE].

43 *See Mathews v. Eldridge*, 424 U.S. 319, 333 (1975).

44 Substantive due process arises from the equal protection principles which apply to the federal government through the fifth amendment's due process clause. *See Department of Agriculture v. Moreno*, 413 U.S. 529, 532-38 (1973); *Department of Agriculture v. Murry*, 413 U.S. 508, 511-14 (1973); *Bolling v. Sharpe*, 347 U.S. 497, 499 n.11 (1971) (invalidating racial segregation in District of Columbia public schools as violative of due process rights guaranteed by fifth amendment). "[T]he concepts of equal protection and due process, both stemming from our American ideal of fairness are not mutually exclusive. . . .

Activation of the due process clause requires a determination that the affected person has a protected interest<sup>45</sup> and that state action rather than private action is involved.<sup>46</sup> To have a protected interest in a governmental benefit the party must have "more than an abstract need or desire for it. He must have more than a unilateral expectation of it. He must instead, have a legitimate claim of entitlement to it."<sup>47</sup>

In the Medicare context, the Supreme Court recently noted that Medicare beneficiaries have a protected interest in direct benefits.<sup>48</sup> Additionally, providers and Part B beneficiaries have contractual rights with the Secretary.<sup>49</sup> One commentator contends that a beneficiary's interest in the Medicare trust funds alone creates a protectable interest.<sup>50</sup>

The existence of state action in the Medicare context is clear. Where HHS makes the final decision regarding a beneficiary's eligibility, the government's involvement is not in doubt.<sup>51</sup> Where the final decision is made by a private insurer acting as a fiscal intermediary or carrier, the government's involvement, although not as apparent, is nonetheless present. Carriers, intermediaries and Utilization Review Committees all act on behalf of the Secretary in administering Medicare<sup>52</sup> and are thus the government's agents for purposes of the due process clause.<sup>53</sup>

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[D]iscrimination may be so unjustifiable as to be violative of due process." *Id.* at 499. *See also* *Buckley v. Valeo*, 424 U.S. 1, 93 (1976) ("equal protection analysis in the Fifth Amendment area is the same as that under the Fourteenth Amendment").

45 *Board of Regents v. Roth*, 408 U.S. 564, 569-72 (1971).

46 *Burton v. Wilmington Parking Auth.*, 365 U.S. 715 (1961); *Cospito v. Califano*, [1981-1 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 30,977, at 10,046-47 (D.N.J. Feb. 5, 1981).

47 *Board of Regents v. Roth*, 408 U.S. 564, 577 (1972).

48 *O'Bannon v. Town Court Nursing Center*, 447 U.S. 773 (1980). By contrast, the Court determined that patients did not have an interest in indirect benefits such as the certification of a provider.

49 42 U.S.C. §§ 1395h, 1395p-1395s (1976). *See* *Gray Panthers v. Schweiker*, [1981-1 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 30,746, at 23 (D.C. Cir. Mar. 18, 1981) (HHS "does not dispute that the claimants' interest in receiving the medical insurance benefits for which they have paid a monthly premium is a property interest . . ."). *See also* *Jones, Termination of Skilled Nursing Facility Medicaid Provider Agreements: Procedural Due Process Requirements*, 6 AM. J.L. MED. 451, 475 (1981) [hereinafter cited as *Jones*]. *But cf.* *Chelsea Community Hosp. v. Michigan Blue Cross*, 436 F. Supp. 1050, 1059 (E.D. Mich. 1977) (plaintiffs cannot complain of improper delegation to intermediaries since they chose that route).

50 *See* *Butler*, *supra* note 4, at 149.

51 *See, e.g.*, *O'Bannon v. Town Court Nursing Center*, 447 U.S. 773 (1980).

52 *See* notes 18, 19 & 31 *supra*.

53 In fact, most courts have assumed this conclusion or have not raised the issue. *Sacred Heart Hosp. v. United States*, 616 F.2d 477 (Ct. Cl. 1980) (Blue Cross Association an agent of the government while acting as intermediary); *Drs. Russi, Griffin & Snell, Ltd. v. Mathews*,



Given the presence of both state action and a protected interest, procedural due process requires a balancing of the governmental and private interests at stake.<sup>54</sup> The Supreme Court has stressed that there are no uniform procedural due process requirements.<sup>55</sup> In *Mathews v. Eldridge*,<sup>56</sup> the Court outlined the balancing approach which should be taken in applying the requirements of the due process clause to a particular situation.<sup>57</sup> The courts must consider the private interests at stake, the risk of erroneous deprivation, the value of additional safeguards, and the government's interest, including the burden which would be caused by the additional safeguards.<sup>58</sup> At a minimum, procedural due process seems to require notice and some form of hearing.<sup>59</sup> The ultimate test is whether a meaningful hearing is provided at a meaningful time.<sup>60</sup> Additionally, the courts have found due process to include a right to an impartial decisionmaker,<sup>61</sup> the right to present evidence, and the right to obtain a decision on the record.<sup>62</sup> The scope and nature of the requisite procedures must

438 F. Supp. 1036, 1042 (E.D. Va. 1977) (insurer constituted governmental agent for purposes of the fifth amendment). See *Gray Panthers v. Schweiker*, [1981-1 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 30,746 (D.C. Cir. Mar. 18, 1981) (dealing with constitutionality of carrier decisions); *McClure v. Harris*, 503 F. Supp. 409 (N.D. Cal. 1980) (examining impartiality of carrier hearing officers), *prob. juris. noted sub nom.* *Schweiker v. McClure*, 50 U.S.L.W. 3278 (U.S. Nov. 13, 1981), *stay granted*, [1981-1 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 31,089 (Rehnquist, Circuit Justice, June 12, 1981).

54 *Board of Curators v. Horowitz*, 435 U.S. 78, 86 n.20, 100, 103 (1978) (Marshall, J., concurring and dissenting); *Mathews v. Eldridge*, 424 U.S. 319 (1976); *Goldberg v. Kelly*, 397 U.S. 254, 263 (1970).

55 435 U.S. at 86.

56 424 U.S. 319 (1976).

57 424 U.S. at 334-35; 397 U.S. at 263. See generally Note, *Mathews v. Eldridge: A Fair Test on Balance*, 67 GEO. L.J. 1407 (1979).

58 424 U.S. at 334-35.

59 *Gray Panthers v. Schweiker*, [1981-1 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 30,746 (D.C. Cir. Mar. 18, 1981). Professor Tribe notes the recent Supreme Court trend to adopt a positivist theory whereby "the substantive right may [not] be viewed wholly apart from the procedure provided for its enforcement." TRIBE, *supra* note 42, at 534. If such a theory were adopted, Congress could conceivably eliminate all due process rights through limitations imposed in the creation of a governmental benefit. The better, and seemingly majority, rule is that once Congress establishes a governmental benefit, the Constitution protects an individual's rights regardless of any attempted limitations. A limitation is properly viewed as an expression of the government's interest to be taken into the balance. *Id.* at § 10-12.

60 424 U.S. at 333.

61 *McClure v. Harris*, 503 F. Supp. 409 (N.D. Cal. 1980) (Part B carrier decisions constitutionally invalid due to partiality of decisionmaker), *prob. juris. noted sub nom.* *Schweiker v. McClure*, 50 U.S.L.W. 3278 (U.S. Nov. 13, 1981), *stay granted*, [1981-1 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 31,089 (Rehnquist, Circuit Justice, June 12, 1981).

62 B. SCHWARTZ, ADMINISTRATIVE LAW § 67, at 192-93 (1976) [hereinafter cited as SCHWARTZ].

be determined for each particular situation. Moreover, the existence of judicial review can cure administrative failings.<sup>63</sup> The section which follows examines procedural questions as well as substantive restrictions in light of these general guidelines.

#### A. *Beneficiary Coverage—Provider Utilization Review Committees*

Medicare requires the institution of Provider Utilization Review Committees (UR Committees).<sup>64</sup> To qualify as a Medicare provider, an in-house UR Committee, composed of at least two physicians, must be established.<sup>65</sup> UR Committees determine the eligibility of Medicare beneficiaries. In addition, the Committee reviews the necessity, appropriateness, and quality of each patient's care.<sup>66</sup>

UR Committee decisions have a direct effect on the patient's right to receive Medicare benefits. Although patients and their doctors are entitled to prompt notice of UR Committee decisions,<sup>67</sup> the patient, as well as the intermediary and HHS, are bound by a Committee determination that the patient's care is not necessary.<sup>68</sup> In contrast, the intermediary and Secretary are not bound by a Committee determination that the patient is entitled to a particular health care service.<sup>69</sup>

When the UR Committee makes an adverse determination, the statute suspends the right to receive payment for any services provided more than three days after notice of the decision is received.<sup>70</sup> The patient has no right to appear or to present evidence before the UR Committee.<sup>71</sup> While the physician can ask for reconsideration of

63 *Gray Panthers v. Schweiker*, [1981-1 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 30,746 at 9206 n.9 (D.C. Cir. Mar. 18, 1981). See also *Mathews v. Eldridge*, 434 U.S. 319, 349 (1976) (contracted administrative procedures justified by the presence of extensive judicial review).

64 42 U.S.C. §§ 1395x(j)(8), 1395x(k) (1976). See generally Price, Katz & Provence, *An Advocate's Guide to Utilization Review*, 11 CLEARINGHOUSE REV. 307 (1977) [hereinafter cited as *Utilization Review*].

65 42 U.S.C. § 1395x(k)(2) (1976).

66 42 C.F.R. § 405.1035 (1980). See also *Moody Nursing Home, Inc. v. United States*, 621 F.2d 399 (Ct. Cl. 1980). UR Committees are designed to control the quality and cost of health care. 42 C.F.R. § 405.1035 (1979); *Utilization Review*, *supra* note 64, at 308.

67 42 U.S.C. § 1395f(a)(4) (1976).

68 Butler, *supra* note 4, at 843 n.156.

69 See *Utilization Review*, *supra* note 64, at 310; Butler, *supra* note 4, at 843.

70 42 U.S.C. § 1395f(a)(7) (1976).

71 42 C.F.R. § 405.1035(f) (1980). The Committee chooses relevant materials to examine. *Id.* § 405.1035(f)(1)(vi). The regulations only provide for the patient's physician to present his views. *Id.* § 405.1035(f)(5). This is consistent with the view that operation of the plans are a function of the medical profession. *Id.* § 405.1035(c).

the UR Committee decision, the patient has no right to seek review.<sup>72</sup> Moreover, no immediate agency or judicial review is available to challenge any decision or procedure.<sup>73</sup> The UR Committee procedure appears to violate the due process and equal protection guarantees of the fifth amendment<sup>74</sup> and possibly the patient's right to privacy.

The requirements of the due process clause apply to UR Committee decisions if the existence of state action and a protected interest are established.<sup>75</sup> Like intermediaries and carriers, the UR Committees are essentially agents of the government.<sup>76</sup> The Committees determine whether individuals are entitled to the benefits of a government program.<sup>77</sup> Thus, it appears that the state action requirement of the due process clause is met in this situation.<sup>78</sup>

In light of the Supreme Court's pronouncement in *O'Bannon v. Town Court Nursing Center*,<sup>79</sup> it is clear that UR Committee decisions affect a protected interest of the beneficiary. An adverse decision by the UR Committee denies the patient a direct governmental benefit. As the Supreme Court noted in *Goldberg v. Kelly*,<sup>80</sup> a protected interest exists for government welfare benefits where, as here, "[s]uch benefits are a matter of statutory entitlement for persons qualified to receive

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72 *Id.* § 405.1035(f)(5). In fact, if the attending physician does not testify, the final decision may be made by one physician rather than two. *Id.* § 405.1035(e)(4). See generally Butler, *supra* note 4, at 844.

73 See 42 C.F.R. § 405.1035 (1980). See also note 105 *infra*.

74 U.S. CONST. amend. V. See notes 43-44 *supra*.

75 See text accompanying notes 44-63 *supra*. See also *Drs. Russi, Griffin & Snell, Ltd. v. Mathews*, 438 F. Supp. 1036, 1042 (E.D. Va. 1977).

76 See *Sacred Heart Hosp. v. United States*, 616 F.2d 477, 479 (Ct. Cl. 1980) (Blue Cross Association considered an agent of the government while acting as intermediary); 438 F. Supp. at 1042 (insurer governmental agent for purposes of fifth amendment).

77 As one commentator analyzing this question has noted: "That decision [that continued institutional stay is not medically necessary] is the specific public function which the hospital performs, and in itself constitutes the governmental determination that Medicare will not pay." Butler, *supra* note 4, at 844.

78 At the same time, the delegation of HHS's authority to UR Committees increases the possibility that the administration of Medicare will be influenced by private interests. While some innate fairness is presumed when the government deals with its own citizens, the same assumption does not apply to private parties. Thus, the delegation of authority by HHS to UR Committees demands a more exhaustive inquiry into the fairness afforded the patient. See *McClure v. Harris*, 503 F. Supp. 409 (N.D. Cal. 1980) (holding that hearing officers appointed by carriers do not satisfy the requirements of due process), *prob. juris. noted sub nom. Schweiker v. McClure*, 50 U.S.L.W. 3278 (U.S. Nov. 13, 1981), *stay granted*, [1981-1 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 31,089 (Rehnquist, Circuit Justice, June 12, 1981).

79 447 U.S. 773 (1980).

80 397 U.S. 254 (1970).

them.”<sup>81</sup>

Given the activation of the due process clause, it is useful to compare UR Committee procedures with the guidelines set forth by the Supreme Court in *Goldberg v. Kelly*<sup>82</sup> and *Mathews v. Eldridge*.<sup>83</sup> In *Goldberg*, the Supreme Court held that welfare recipients were entitled to a trial-type evidentiary hearing prior to the termination of benefits.<sup>84</sup> In determining what procedural rights the recipients were entitled to, the Court stated: “The extent to which procedural due process must be afforded the recipient is influenced by the extent to which he may be ‘condemned to suffer a grievous loss’ . . . , and depends upon whether the recipient’s interest in avoiding that loss outweighs the government’s interest in summary adjudication.”<sup>85</sup> The Court noted that the termination of welfare payments could “deprive an eligible recipient of the very means by which to live . . . .”<sup>86</sup> The interests of the government in conserving fiscal and administrative resources were not considered to be overriding in the welfare context. The Court concluded that welfare recipients were entitled to an evidentiary hearing prior to termination of their benefits.<sup>87</sup>

In *Mathews v. Eldridge*<sup>88</sup> the Supreme Court held that an evidentiary hearing is not required prior to termination of Social Security disability benefits. *Eldridge* synthesized the approach to be taken in analyzing procedural due process requirements and set forth a balancing test requiring the consideration of three factors:

First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government’s interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.<sup>89</sup>

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81 *Id.* at 262.

82 397 U.S. 254 (1970).

83 424 U.S. 319 (1976).

84 397 U.S. at 264.

85 *Id.* at 262-63, *quoting* Joint Anti-Fascist Refugee Comm. v. McGrath, 341 U.S. 123, 168 (1951) (Frankfurter, J., concurring).

86 397 U.S. at 264.

87 *Id.* at 264-66. The Court stated in weighing the interests of governmental convenience and the recipient’s need: “Thus, the crucial factor in this context . . . is that termination of aid pending resolution of a controversy over eligibility may deprive an *eligible* recipient of the very means to live while he waits.” *Id.* In Medicare, the same life or death consequences may attach to the provision of health care services.

88 424 U.S. 319 (1976).

89 *Id.* at 335.

While some commentators have argued that *Eldridge* cut back on the procedural due process rights announced in *Goldberg*, the principles which guided the Court were essentially the same in both cases.<sup>90</sup> The major difference between the two cases was in the weighing of the interests at stake.<sup>91</sup> In *Eldridge* the court concluded that the recipients' interests in disability benefits were not as essential as the recipients' interests in welfare benefits in *Goldberg*.

The interests at stake in Medicare are more analogous to the right to welfare benefits in *Goldberg* than the right to disability benefits in *Eldridge*. Whether or not a beneficiary receives medical care could make the difference between life and death—just as the receipt of subsistence living allowances could.<sup>92</sup> Moreover, where death is a possibility, denial of Medicare could be an irreversible decision.<sup>93</sup> The government's interests in conserving fiscal and administrative resources are outweighed by the private interests at stake.<sup>94</sup> Therefore, Medicare beneficiaries should be entitled to protection similar to that granted the welfare recipients in *Goldberg*.

A comparison of the interests examined in *Eldridge* with the interests involved in UR Committee decisions further supports the conclusion that UR Committee procedures are unconstitutional. *Eldridge* considered whether a hearing was required prior to the termination of disability benefits. Although a property interest was found in the statutory right to benefits,<sup>95</sup> the Court considered the existing procedures sufficient to protect the individual's interests for several reasons. First, the Court distinguished disability payments from welfare payments because the former are not necessarily based upon need.<sup>96</sup> Second, the Court found that the decision to grant disability benefits can be made by reviewing existing medical treatment files whereas a determination of poverty requires an oral examination.<sup>97</sup> Finally, in disability decisions, the individual is entitled to

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90 See generally Note, *Mathews v. Eldridge: A Fair Test on Balance*, 67 GEO. L.J. 1407 (1979).

91 See *Board of Curators v. Horowitz*, 435 U.S. 78 (1978) (emphasizing the "flexible" nature of due process rights encompassed in the modern weighing process).

92 See, e.g., *Goldberg v. Kelly*, 397 U.S. at 264-66.

93 See *Jones*, *supra* note 49, at 469.

94 In *Chelsea Community Hosp. v. Michigan Blue Cross*, 630 F.2d 1131, 1136 (6th Cir. 1980), the Sixth Circuit flatly rejected the conservation of resources argument. The government had argued that these interests were sufficient to defeat review of constitutional questions.

95 *Mathews v. Eldridge*, 424 U.S. at 332.

96 *Id.* at 340.

97 *Id.* at 343-45. The court noted that an oral presentation in this situation was of much less value than in *Goldberg*.

extensive administrative review and, ultimately, judicial review.<sup>98</sup>

Admittedly, there are similarities between disability benefits and Medicare. Neither is necessarily based upon need and decisions regarding the eligibility of beneficiaries can be made on the basis of medical records.<sup>99</sup> In Medicare, however, the medical problem may arise on an emergency basis requiring immediate attention and precluding the development of an extensive medical history. The receipt of medical care is often of more immediate importance than the receipt of disability payments. Moreover, as the D.C. Circuit recently noted, *Eldridge* involved only an interruption of disability benefits, whereas in Medicare a permanent loss of benefits is at stake.<sup>100</sup>

The most important distinction between the disability benefit program and Medicare is the extent of administrative review available to the beneficiary. Prior to terminating disability benefits, a physician and a non-physician review the individual's file. The two reviewers examine medical reports as well as the interested party's submissions, and can order an independent medical examination when necessary.<sup>101</sup> After a decision is made, the individual is entitled to receive notice, to make a written response and to submit evidence. HHS reviews the decision and *de novo* reconsideration is provided. Ultimately, judicial review is available.<sup>102</sup> By contrast, in UR Committee decisions the patient has no right to appear, to present evidence or argument, or to be represented by counsel.<sup>103</sup> The present UR Committee procedures allow only the patient's doctor to challenge the decision.<sup>104</sup> Moreover, while reconsideration is provided, no immediate agency or judicial review is available.<sup>105</sup> When examined in light of the Supreme Court's analysis in *Goldberg* and *El-*

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98 *Id.* at 338-39. The beneficiary is entitled to review any denial, comment, and add evidence. *Id.* at 346. Additionally, an evidentiary hearing before a Social Security Administrative Law Judge is provided. *Id.* at 339.

99 The nature and depth of information collected on a short term basis for a UR Committee determination is arguably far less reliable than the medical files of the patient used in disability cases.

100 *Gray Panthers v. Schweiker*, [1981-1 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 30,746, at 9202 (D.C. Cir. Mar. 18, 1981).

101 424 U.S. at 337.

102 *Id.* at 338-39.

103 See text accompanying notes 71-73 *supra*.

104 42 C.F.R. § 405.1035 (1980).

105 *Id.* One commentator has argued that Medicare beneficiaries may be able to obtain review of adverse UR Committee decisions. See *Utilization Review*, *supra* note 62, at 317. Since activation of Part A hearing procedures requires a final determination, see 42 U.S.C. § 1395ff(b)(1) (1976), which does not include UR Committee decisions, beneficiaries may seek UR Committee reconsideration through the intermediary and then HHS review of any adverse intermediary decision. See *Utilization Review*, *supra* note 62, at 317; 42 C.F.R. § 405.704

*dridge*, the UR Committee procedures appear to violate the constitutional requirements of procedural due process.

The lack of procedural safeguards surrounding UR Committee decisions necessitates the institution of corrective measures. Initially, the patient should be notified of the UR Committee's intention to review his eligibility.<sup>106</sup> Some sort of pretermination hearing should be provided.<sup>107</sup> Additionally, the patient should be allowed to present evidence to the UR Committee. Since the UR Committee is required to review the medical file, allowing the submission of evidence should not be unduly burdensome.<sup>108</sup>

The review of UR Committee decisions should be expanded. As it now stands, the Secretary, but not the patient, has the right to obtain review of adverse UR Committee decisions. It is troubling that from the patient's perspective any final adverse adjudication is made by a private organization whereas the Secretary may seek additional review of decisions adverse to its position. This discrepancy violates our fundamental conceptions of fairness.<sup>109</sup> Several courts addressing the issue have determined that delegation of decisionmaking authority to a private organization is only appropriate if subsequent governmental review is available.<sup>110</sup> Compounding the

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(1980). This pathway cures some of the present defects because it eventually provides independent administrative review by the Secretary.

Two problems exist, however, with this interpretation. First, it violates the long-standing agency interpretation of the statute as prohibiting any reconsideration of HHS decisions denying patient coverage. Second, the timing is inappropriate. As the Tenth Circuit noted: "It may be possible through the administrative route to correct this practice . . . but it would be a long and tedious process, and by the time these elderly and infirm plaintiffs followed out this remedy they might no longer be with us." *Martinez v. Richardson*, 472 F.2d 1121, 1125 (10th Cir. 1973).

106 See, e.g., *O'Bannon v. Town Court Nursing Center*, 447 U.S. 773 (1980) ("The government cannot withdraw these direct benefits without giving the patients notice and an opportunity for a hearing on the issue of their eligibility for benefits."). As the D.C. Circuit recently stated in examining the Part B Medicare procedures, "it is universally agreed that adequate notice lies at the heart of due process." *Gray Panthers v. Schweiker*, [1981-1 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 30,746, at 9203 (D.C. Cir. Mar. 18, 1981).

107 The D.C. Circuit recently held that even in Part B cases involving less than \$100, an informal, pretermination oral hearing is required. *Gray Panthers v. Schweiker*, [1981-1 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 30,746, at 9197 (D.C. Cir. Mar. 18, 1981).

108 For instance, many medical symptoms are diagnosed by communicating with the patient. An interview could correct the inadequate records of the patient's physician.

109 See *International Shoe Co. v. Washington*, 326 U.S. 310, 316 (1945).

110 *St. Louis Univ. v. Blue Cross Hosp. Serv.*, 537 F.2d 283, 292-93 (8th Cir.), *cert. denied*, 429 U.S. 977 (1976); *McClure v. Harris*, 503 F. Supp. 409, 419 (N.D. Cal. 1980), *prob. juris. noted sub nom.* *Schweiker v. McClure*, 50 U.S.L.W. 3278 (U.S. Nov. 13, 1981), *stay granted*, [1981-1 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 31,089 (Rehnquist, Circuit Justice, June 12, 1981); *Association of Am. Physicians & Surgeons v. Weinberger*, 395 F. Supp. 125, 133 (N.D. Ill. 1975).

inadequacy of the present procedure is the probable absence of judicial review which may be constitutionally required.<sup>111</sup>

In both *Goldberg* and *Eldridge*, access to further administrative and judicial review was a factor supporting the constitutionality of less than full-scale hearing procedures.<sup>112</sup> The government's interest in preventing a flood of litigation concerning technical medical procedures must be balanced against the beneficiaries' interest in presenting their legal claims. It is essential that the courts be able to review any potential constitutional challenges.<sup>113</sup> Moreover, questions may be presented concerning the extent of statutory authority and the validity of regulations. Judicial review is the only mechanism which can insure that procedural due process irregularities are corrected.<sup>114</sup>

The review procedures available under Medicare may also violate equal protection principles.<sup>115</sup> The existing procedures give far more rights to providers of services than to recipients.<sup>116</sup> Since no suspect classification or protected interest is present, however, a rational basis for discrimination between these two classes is all that is necessary.<sup>117</sup> The government's rationale for giving providers greater rights is that their claims are more substantial than individuals and thus less taxing on fiscal and administrative resources.<sup>118</sup> The interests of the individual, however, seem weightier than those of the provider. If an individual is denied treatment by a UR Committee, he may be deprived of necessary medical care or even his life. As one commentator notes, distinctions on the reviewability of claims based on the potential amount in controversy are "insignificant for those persons who can [not] afford . . . service."<sup>119</sup> In fact, the distinction

111 *Gray Panthers v. Schweiker*, [1981-1 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 30,746, at 9206 n.9 (D.C. Cir. Mar. 18, 1981).

112 *Mathews v. Eldridge*, 424 U.S. 319, 339 (1976); *Goldberg v. Kelly*, 397 U.S. 254, 260 (1970).

113 See Part III and notes 250-51 *infra*.

114 See Gardner & Greenberger, *Judicial Review of Administrative Action and Responsible Government*, 63 GEO. L.J. 7, 30 (1974) (periodic judicial rulings would initiate reform and curb abuses) [hereinafter cited as Gardner & Greenberger].

115 *Bolling v. Sharpe*, 347 U.S. 497, 499 (1954). See *Richardson v. Belcher*, 404 U.S. 78, 81-82 (1971).

116 Compare 42 C.F.R. § 405.1035 (1980) with *id.* §§ 405.929-949 (1980) (Part A) and 42 U.S.C. § 1395oo (PRRB system). See also Butler, *supra* note 4, at 845; *Utilization Review*, *supra* note 62, at 329.

117 *Richardson v. Belcher*, 404 U.S. 78, 81-82 (1971); *Dandridge v. Williams*, 397 U.S. 471, 483-87 (1970); *Drs. Russi, Griffin, & Snell Ltd. v. Matthews*, 438 F. Supp. 1036, 1043 (E.D. Va. 1977).

118 438 F. Supp. at 1043.

119 See Butler, *supra* note 4, at 846. While the author is referring to the Part A/Part B



appears even less plausible when comparing the Part A beneficiary's rights with the provider's status. Medicare was designed to provide care for the beneficiary, yet the provider is given more extensive rights. In the UR Committee context, the distinction is carried to its most illogical extreme by giving the patient-beneficiary no rights and allowing the medical profession complete control over the decision. While the success of an equal protection challenge is doubtful, a persuasive argument can still be made.

Finally, one commentator has argued that inadequate review procedures may violate the patient's right to privacy.<sup>120</sup> Again, the extension of the right to privacy into the Medicare field is unlikely, but adding those facets of the patient's rights into the balance supports the argument for adequate due process protections.<sup>121</sup>

### B. *Beneficiary Appeals under Medicare Part B*

Medicare provides inadequate administrative and judicial review for beneficiary disputes under Part B. After a beneficiary has received services, a claim is submitted to the carrier for reimbursement.<sup>122</sup> The carrier makes an initial determination as to whether the treatment is covered and the amount that will be reimbursed.<sup>123</sup> Medicare requires the carrier to provide an appeals process.<sup>124</sup> A disappointed beneficiary may request an administrative review within six months of the initial determination<sup>125</sup> and submit additional evidence to the carrier.<sup>126</sup>

If the beneficiary or physician is dissatisfied with the review determination, either can request a hearing if the amount in controversy exceeds \$100.<sup>127</sup> The carrier is responsible for appointing an impartial hearing officer to conduct a full evidentiary hearing.<sup>128</sup> Although the beneficiary is allowed to present argument and evidence,

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distinction, her contentions should hold just as true where the distinction is within the same program.

120 See *Utilization Review*, *supra* note 64, at 329.

121 See *Roe v. Wade*, 410 U.S. 113 (1973) (dealing with a woman's right to privacy in pregnancy-related medical decisions).

122 42 U.S.C. § 1395n (1976); 42 C.F.R. § 405.250 (1980). The physician can take the beneficiary's claim by assignment.

123 42 C.F.R. § 405.803(a) (1980).

124 42 U.S.C. § 1395u(b)(3)(C) (1976); 42 C.F.R. § 405.801(a) (1980).

125 42 C.F.R. § 405.807 (1980).

126 *Id.* § 405.809.

127 42 U.S.C. § 1395u(b)(3)(C) (1976); 42 C.F.R. § 405.820-821 (1980).

128 42 C.F.R. § 405.823-830 (1980).

the hearing officer has no subpoena power to assist him.<sup>129</sup> Moreover, the hearing officer's decision is final and binding upon the parties with review neither to HHS nor, arguably, the courts.<sup>130</sup>

The requirements of the due process clause apply to beneficiary appeals under Part B if the existence of state action and a protected interest are established.<sup>131</sup> As in the UR Committee situation, the carrier's actions on behalf of the Secretary satisfy the state action requirement.<sup>132</sup> The protected interest of a Part B beneficiary arises from his statutory<sup>133</sup> and contractual<sup>134</sup> rights to receive Medicare benefits. Since both requirements are met, the Part B beneficiary is entitled to the protection afforded by the fifth amendment due process clause.

*Eldridge* requires the courts to consider the government's fiscal and administrative burdens when balancing the private and governmental interests involved in a due process question. Part B claims are potentially numerous and small.<sup>135</sup> Congress's concern over the potential costs of litigating these claims prompted the adoption of more perfunctory methods of deciding disputes.<sup>136</sup> Nonetheless, the potential cost of handling these disputes could not be much greater than for disability disputes for which the Supreme Court required far greater due process protections.<sup>137</sup> At present there are at least three due process problems in Part B beneficiary appeals, including: (1) the lack of an impartial hearing officer; (2) the unavailability of

129 *Id.* § 405.830. See Butler, *supra* note 4, at 845.

130 42 C.F.R. § 405.835 (1980). See Butler, *supra* note 4, at 846. But see Part III *infra*; Martinez v. Richardson, 472 F.2d 1121, 1124-26 (10th Cir. 1973) (pre-Salfi case finding jurisdiction to review Part B claims). The Medicare Act itself makes no provision for review of Part B amount in controversy questions. 42 U.S.C. § 1395ff (1976). Nevertheless, several courts have recently held that jurisdiction exists to review the legality of Part B decisions. See Erika, Inc. v. United States, 634 F.2d 580, 586-87 (Ct. Cl. 1980) (en banc), cert. granted, 101 S. Ct. 2312 (1981); Leduc v. Harris, 488 F. Supp. 588, 589-90 (D. Mass. 1980).

131 See notes 45-46 and accompanying text *supra*.

132 See notes 20, 21, 31 & 53 *supra*.

133 Goldberg v. Kelly, 397 U.S. 254, 262 (1970).

134 Part B is a quasi-private health plan in which the government has a substantial interest. The Part B beneficiary elects the plan and pays fees for coverage—almost surely without an understanding that there is no review process available.

135 See S. REP. NO. 404, 89th Cong., 1st Sess. 54-55, reprinted in [1965] U.S. CODE CONG. & AD. NEWS 1943, 1995; Erika, Inc. v. United States, 634 F.2d 580, 587 (Ct. Cl. 1980) (en banc), cert. granted, 101 S. Ct. 2312 (1981); Drs. Russi, Griffin & Snell, Ltd. v. Matthews, 438 F. Supp. 1036, 1043-44 (E.D. Va. 1977).

136 S. REP. NO. 404, 89th Cong., 1st Sess. 54-55, reprinted in [1965] U.S. CODE CONG. & AD. NEWS 1943, 1995.

137 Mathews v. Eldridge, 424 U.S. 319, 349 (1976). See also Chelsea Community Hosp. v. Michigan Blue Cross, 630 F.2d 1131, 1136 (6th Cir. 1980) (rejecting "that old workhorse, administrative convenience").

review for claims under \$100; and (3) a potential substantive due process violation.

### 1. Hearing Officer

Due process requires that a beneficiary receive an impartial hearing.<sup>138</sup> The only hearing provided for Part B disputes is conducted by a hearing officer designated by the carrier. Although a particular hearing officer may be unbiased, he is nonetheless employed by the carrier. Given the finality of the carrier's decision, the employment relationship constitutes a sufficient taint to invalidate the current procedure.

In *McClure v. Harris*,<sup>139</sup> the district court determined that vesting unreviewable decisionmaking power in carrier-appointed hearing officers failed to meet the requirements of procedural due process.<sup>140</sup> Applying the balancing test of *Eldridge*, the delegation of final authority to a suspect hearing officer violates the notion of impartiality central to procedural due process.<sup>141</sup> The cost of providing an impartial hearing will not be negligible. However, in light of existing safeguards for other Medicare issues, the government's added expense would be comparatively small.<sup>142</sup>

138 See generally SCHWARTZ, *supra* note 62, at § 67.

139 503 F. Supp. 409, 418 (N.D. Cal. 1980), *prob. juris. noted sub. nom.* Schweiker v. McClure, 50 U.S.L.W. 3278 (U.S. Nov. 13, 1981), *stay granted*, [1981-1 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 31,089 (Rehnquist, Circuit Justice, June 12, 1981).

140 *Id.* at 417. However, the court noted that the use of a biased privately appointed hearing officer at the preliminary stages of review may be constitutional. Subsequently, the court ordered HHS to provide all Medicare Part B beneficiaries dissatisfied with determinations made regarding their claims (on or after May 1, 1980) with *de novo* hearings conducted by an Administrative Law Judge of the Social Security Administration. *McClure v. Schweiker*, 4 MED. & MED. GUIDE (CCH) ¶ 31,066 (N.D. Cal., 1981) (order for stay denied). That decision was subsequently stayed by Circuit Justice Rehnquist. [1981-1 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 31,089 (June 12, 1981).

141 503 F. Supp. at 415-17.

142 The court stated:

The government clearly has a strong interest in controlling the costs associated with the Part B Medicare program. However, it is far from clear that the imposition of Part A [type] hearing procedures would entail substantial additional costs. As [the government] points out, more than 124 million Part B claims were processed by carriers in 1978. Only a fraction of those claimants pursue their currently available appeal remedies . . . . If an appeal to the Secretary is made available, there is no indication that anything but an even smaller group of claimants will actually pursue this additional remedy. Moreover, the cost of providing such additional remedy will be minimized by the fact that the Secretary already maintains an appeals procedure utilizing administrative law judges, for Part A claimants. . . . [T]hat would not be a cost-free change from the status quo, but neither should it be a costly one.

*Id.* at 416.

Both the Eighth Circuit and a district court have held that the final decision regarding a beneficiary's eligibility cannot be rendered by a private organization.<sup>143</sup> In *McClure* the district court stated: "With all due respect for the personal integrity of Part B hearing officers, this court finds that their impartiality is compromised by virtue of both prior involvement and pecuniary interests."<sup>144</sup> The court found that although hearing officers are disqualified if they have had prior involvement with a particular case, five out of seven hearing officers had been previously employed by the carrier.<sup>145</sup> Additionally, hearing officers are trained by the carrier.<sup>146</sup> As to pecuniary interests, although hearing officers are paid with federal funds, their incomes are "dependent upon the carrier's decision regarding whether, and how often, to call upon their services."<sup>147</sup>

A further reason to question the impartiality of carrier-appointed hearing officers is the inherent conflict of interest facing carriers and intermediaries. In *Faith Hospital Association v. United States*,<sup>148</sup> the Court of Claims held that a regulation dealing with the allocation of the cost of ancillary hospital services between Parts A and B<sup>149</sup> was both internally inconsistent<sup>150</sup> and, as applied, contrary to the Medicare laws.<sup>151</sup> The court found that the parties' erroneous interpretation of the regulation was partially attributable to the advice of the intermediary and carrier: "The 'fault' in this instance may also lie with the fiscal intermediary and carrier. . . . The problem could lie in the inherent conflict an insurer of both private [non-medicare] and public medical funds possesses."<sup>152</sup>

The carrier and intermediary are responsible for advising Medi-

143 *St. Louis Univ. v. Blue Cross Hosp. Serv.*, 537 F.2d 283, 293 (8th Cir.), *cert. denied*, 429 U.S. 977 (1976); *Association of Am. Physicians & Surgeons v. Weinberger*, 395 F. Supp. 125, 140 (N.D. Ill. 1975). *Cf.* *Davis v. Department of HEW*, 416 F. Supp. 448, 451-53 (S.D.N.Y. 1976) (not reaching question).

144 503 F. Supp. at 414.

145 *Id.* The court pointed out that such a connection would violate Canon 3-C of the Code of Judicial Conduct recognized by the Judicial Conference of the United States. *Id.* at 414-15.

146 *Id.* at 415.

147 *Id.* The Eighth Circuit stated in a similar context, "[t]he intangible effect of institutional loyalty must not be underestimated simply because it is difficult to quantify. As Justice Jackson commented, 'men are more often bribed by their loyalties and ambitions than by money.'" *St. Louis Univ. v. Blue Cross Hosp. Serv.*, 537 F.2d 283, 293 n.11 (8th Cir.), *cert. denied*, 429 U.S. 977 (1976).

148 634 F.2d 526 (Ct. Cl. 1980).

149 42 C.F.R. § 405.486 (1980).

150 634 F.2d at 536.

151 *Id.* at 537.

152 *Id.*

care participants and also adjudicating any violations—violations often caused by adhering to the advice given initially by the intermediary or carrier. Moreover, the carrier and intermediary, as private insurance companies, have an interest in expanding Medicare coverage.<sup>153</sup> If Medicare absorbs a greater portion of the overall medical costs, the amount which privately insured patients are charged should be reduced accordingly. To the extent that Medicare subsidizes privately insured patients, the insurance companies enjoy lower costs and higher profits. Hearing officers' decisions often determine the scope of Medicare coverage. The appointment of hearing officers by insurers with a direct pecuniary interest in their decisions adversely affects the impartiality required for a proper hearing.

The lack of an impartial hearing officer might be cured by independent agency or judicial review.<sup>154</sup> Agency review, however, is unobtainable. Even if it were available, several recent cases indicate that it would be inadequate.<sup>155</sup> The presence of judicial review is uncertain but probably more available for Part B decisions than for UR Committee decisions under Part A. Recently, several courts have held that jurisdiction exists to review Part B claims.<sup>156</sup> The government's interest in preventing extensive administrative or judicial review is to avoid the cost of extensive proceedings involving intricate medical decisions and factual problems. In the absence of more elaborate procedural safeguards, however, the Constitution requires the government to provide an independent, impartial hearing officer.<sup>157</sup>

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153 *Faith Hosp. Ass'n v. United States*, 585 F.2d 474 (Ct. Cl. 1978). For instance, in this previous *Faith Hospital* case, it appeared that the hospital was able to lower its overall medical costs due to the arrangement approved by the intermediary. Due to these lower costs, the intermediary should have been reimbursing its private insureds at a lower rate and making a greater profit.

154 See 1 K. DAVIS, *ADMINISTRATIVE LAW TREATISE* § 7.01, at 408 (1958). See also *Ingraham v. Wright*, 430 U.S. 651 (1977) (procedural due process satisfied by availability of common law remedies).

155 See *Sun City Community Hosp. v. United States*, 624 F.2d 997, 998-99 (Ct. Cl. 1980); *Sacred Heart Hosp. v. United States*, 616 F.2d 477, 484-85 (Ct. Cl. 1980). One district court determined that the plaintiffs failed to receive a fair hearing because the Secretary usurped the hearing officer's discretion by using unpromulgated yet internally controlling manuals and policies. *Leduc v. Harris*, 488 F. Supp. 588 (D. Mass. 1980). The Court of Claims has criticized this problem but avoided resolving it. *Sacred Heart Hosp. v. United States*, 616 F.2d 477, 485 n.10 (Ct. Cl. 1980); *Faith Hosp. Ass'n v. United States*, 585 F.2d 474, 482 n.9 (Ct. Cl. 1978). But see *St. Francis Memorial Hosp. v. United States*, [1981-1 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 31,047, at 10,264 n.19 (Ct. Cl. May 6, 1981).

156 *Erika, Inc. v. United States*, 634 F.2d 580 (Ct. Cl. 1980), *cert. granted*, 101 S. Ct. 2312 (1981); *Leduc v. Harris*, 488 F. Supp. 588, 589 (D. Mass. 1980).

157 A second procedural problem in Part B hearings is the failure to provide the hearing officer with subpoena power. Carrier, hospital or physician records may be relevant to the

## 2. Part A and B Claims of Less than \$100

For claims under both Part A and Part B amounting to less than \$100, HHS regulations provide for an initial determination by the intermediary or carrier.<sup>158</sup> Medicare claimants are given notice of that determination and a dissatisfied claimant may request review by a second intermediary or carrier employee.<sup>159</sup> No additional review is currently available.

In *Gray Panthers v. Schweiker*<sup>160</sup> the D.C. Circuit recently examined the constitutionality of these administrative procedures for claims of less than \$100. The court held that the current notice and paper hearing procedures were inadequate.<sup>161</sup> For delineation of the particular procedures required, however, the D.C. Circuit remanded the case for an application of the balancing test called for by *Eldridge*.<sup>162</sup>

The need for an oral hearing is discussed in *Gray Panthers*. The D.C. Circuit noted that oral hearings meet at least three policy goals: "the desire for accuracy, the need for accountability, and the necessity for a decisionmaking procedure which is perceived as 'fair.'" <sup>163</sup>

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beneficiary's case but unavailable without compulsion. The subpoena power is integral to the judicial process and most agency hearings allow for its use. SCHWARTZ, *supra* note 60, at § 47; Butler, *supra* note 4, at 845. Given the lack of independent HHS or judicial reviews, the provision of the subpoena power would improve present procedures with little cost resulting to the government.

158 See *Gray Panthers v. Schweiker*, [1981-1 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 30,746, at 9192 (D.C. Cir. Mar. 18, 1981).

159 *Id.* at 9208 n.16 (facsimile of form reprinted); 42 C.F.R. §§ 405.710-.717 (Part A), 405.807-.812 (Part B) (1980).

160 [1981-1 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 30,746 (D.C. Cir. May 18, 1981). The court also noted the statutory limitation prohibiting hearings on claims of less than \$100. Nevertheless, as the legislative history makes clear, that limitation was intended to preclude only full formal hearings.

161 *Id.* at 9194.

162 *Id.* "Experience under the program indicates that the holding of a full fair hearing is unwarranted in cases where the amount in controversy is relatively small." S. REP. NO. 1230, 92d Cong., 2d Sess. 213 (1972).

163 [1981-1 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 30,746, at 9192, 9205. In an analogous situation, the Supreme Court considered a paper review inadequate due to its lack of flexibility. *Goldberg v. Kelly*, 397 U.S. 254, 269 (1970). The Court stated:

Written submissions are an unrealistic option for most recipients, who lack the educational attainment necessary to write effectively and who cannot obtain professional assistance. Moreover, written submissions do not afford the flexibility of oral presentations; they do not permit the recipient to mold his argument to the issues the decision maker appears to regard as important.

*Id.* Though all Medicare beneficiaries are not necessarily poor as in *Goldberg*, as a general rule, the aged and disabled have less money than most citizens and significantly greater medical costs. Additionally, unlike the poor, the aged and disabled are likely to have communicational disabilities such as being blind, deaf, senile or unable to respond in writing due to

Medical diagnosis requires oral communication and many diagnoses or issues of reasonableness are not quantifiable on paper.<sup>164</sup> This need for a dialogue with the final decisionmaker extends throughout the Medicare system.

Even when the amount in controversy is less than \$100, vesting final decisionmaking power in a carrier or intermediary employee must be considered highly suspect. As exemplified by *Faith Hospital*, carriers and intermediaries have an inherent conflict of interest in the administration of Medicare.<sup>165</sup> The review of claims of less than \$100 is performed by employees of these organizations without even the semblance of independence present in *McClure*.<sup>166</sup> The cost of having an HHS administrative law judge perform a second paper review or an informal oral hearing would be minimal. Since HHS already pays for the costs of these reviews when they are made by carriers or intermediaries, there should be little added cost in having the review performed by an independent party.<sup>167</sup>

Finally, even for claims under \$100, the claimant should be provided with adequate notice of the reasons for any denial.<sup>168</sup> Adequate notice should delineate the issues sufficiently to allow the claimant to gather and present appropriate evidence. Detailed notice will often satisfy the claimant while a scant form notice may only raise the need for explanation. There would probably be little added cost in specifying the reasons for a denial.

### 3. Substantive Due Process

One commentator has argued that the different treatment accorded Parts A and B claimants violates substantive due process.<sup>169</sup> As outlined above, significantly lower levels of administrative and

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severe arthritis or muscular disorders. It is these very conditions, among others, which led to the enactment of Medicare. See Jones, *supra* note 49, at 484.

164 [1981-1 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 30,746, at 9205.

165 See text accompanying notes 148-57 *supra*.

166 See *McClure v. Harris*, 503 F. Supp. 409 (N.D. Cal. 1980), *prob. juris. noted sub nom. Schweiker v. McClure*, 50 U.S.L.W. 3278 (U.S. Nov. 13, 1981), *stay granted*, [1981-1 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 31,089 (Rehnquist, Circuit Justice, June 12, 1981).

167 The best procedure would be to have an administrative law judge review the claims in an informal setting rather than an HHS employee who is subject to greater institutional pressures that could sway the decision. See, e.g., *McClure v. Schweiker*, [1981-1 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 31,066 (N.D. Cal. May 1, 1981), *stay granted*, [1981-1 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 31,089 (Rehnquist, Circuit Justice, June 12, 1981). HHS already performs the review itself if no intermediary is chosen.

168 See *Gray Panthers v. Schweiker*, [1981-1 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 30,746 (D.C. Cir. Mar. 18, 1981).

169 See Butler, *supra* note 4, at 846.

judicial review are available under Part B. The justification for this disparity is that smaller sums are generally involved under Part B and therefore, the relative cost to the government of providing more extensive review would be greater.<sup>170</sup> Since Part B claimants pay for their subsidized insurance it can be argued that they should have greater rights than Part A beneficiaries. No "fundamental right"<sup>171</sup> or "suspect classification"<sup>172</sup> is involved, however, and therefore, the government is only required to show a rational basis for its distinction.<sup>173</sup> While such a level of scrutiny is low, it is not meaningless.<sup>174</sup> Nevertheless, the probability of success under a substantive due process argument is minimal.<sup>175</sup> The more troubling distinction between Part A and B is the potential preclusion of judicial review for legal and constitutional claims arising under Part B. As will be discussed in part III, such a limitation is of doubtful constitutional validity but for reasons beyond substantive due process.<sup>176</sup>

#### 4. A Practical Proposal

Generally, the distinction between Part A and Part B review is based on the supposition that Part A will give rise to substantially larger claims and, by comparison, Part B claims will be too costly to review.<sup>177</sup> Congress, however, has authorized physicians to take assignments from their patients and then collect from Medicare.<sup>178</sup> If a physician was allowed to aggregate the claims of several patients, the

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170 *Id.* at 846.

171 *See, e.g.*, *Shapiro v. Thompson*, 394 U.S. 618, 638 (1969) (right to travel). *See also* *TRIBE*, *supra* note 42, at § 16-7; *Barrett*, *Judicial Supervision of Legislative Classifications—A More Modest Role for Equal Protection?* 1976 B.Y.U. L. REV. 89 [hereinafter cited as *Barrett*].

172 *See, e.g.*, *Graham v. Richardson*, 403 U.S. 365, 371-72 (1971). *See also* *TRIBE*, *supra* note 42, at § 16-13.

173 *See, e.g.*, *Department of Agriculture v. Moreno*, 413 U.S. 528 (1973).

174 *Id.* The Court invalidated the provision differentiating between households of related persons which were allowed benefits and households containing unrelated persons which were denied benefits. The Court found the distinction irrational. The provision failed to further congressional nutrition goals and was aimed at unpopular political groups such as "hippies." *Compare* *Moore v. City of East Cleveland*, 431 U.S. 494 (1977) (dealing with family associational rights) *with* *Village of Belle Terre v. Boras*, 416 U.S. 1 (1974) (dealing with general associational interests). *See also* *Department of Agriculture v. Murry*, 413 U.S. 508 (1973).

175 It is useful to note Professor Tribe's argument that the Supreme Court in *Goldberg* implicitly recognized an underlying substantive right to subsistence once a welfare program has been established. *TRIBE*, *supra* note 42, at 1116-17. Thus, welfare recipients, including medicare beneficiaries have a quasi-fundamental right subject to protection. *But see Barrett*, *supra* note 171, at 90-93.

176 *See* notes 217-331 and accompanying text *infra*.

177 *See* notes 135-36 *supra*.

178 42 U.S.C. § 1395n (1976).



amount in controversy could equal or exceed the provider claims.<sup>179</sup> The government's interest in preventing piecemeal litigation could be furthered by making the physician responsible for litigating his aggregate claims rather than providing a series of hearings for the beneficiaries' smaller claims. To further this goal, HHS or Congress could set a dollar limitation to insure that fiscal and administrative burdens are minimized.<sup>180</sup>

Granting physicians greater rights when contesting aggregated claims possibly violates the beneficiary's substantive due process rights. There is, however, a legitimate, although not controlling, governmental interest in protecting fiscal and administrative resources. In addition, providing review of aggregated physician claims would arguably increase the availability of health care to beneficiaries and shift much of the risk of loss to physicians. When a physician refuses to take an assignment from the beneficiary, the latter is forced to make the initial payment. An elderly or indigent patient may thus be precluded from treatment.<sup>181</sup> Since many physicians refuse to take assignments,<sup>182</sup> Medicare beneficiaries would arguably receive better care if physicians had greater rights under the assignments and could seek fuller review of carrier decisions. Encouraging physicians to take assignments would also shift some of the financial responsibility for making medical judgments to the physician. In terms of new, less accepted treatments it would be the physician's rather than the beneficiary's responsibility to litigate the allowability of the treatment and its cost with the carrier.<sup>183</sup> Thus, greater review for aggregated claims by physicians should be encouraged and placed on a par with provider reimbursement disputes.

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179 See *Berdict v. United States*, 612 F.2d 533 (Ct. Cl. 1980); *Cervoni v. Secretary of HEW*, 581 F.2d 1010 (1st Cir. 1978); *Kechjian v. Califano*, 458 F. Supp. 159 (D.R.I. 1978); *Drs. Russi, Griffin & Snell, Ltd. v. Matthews*, 438 F. Supp. 1036 (E.D. Va. 1977).

180 Dollar limitations have been imposed on provider review. See 42 U.S.C. § 1395oo (1976) (setting forth provider limits). Aggregate claims for physicians under Part B might be set at a lower limit.

181 See *Martinez v. Richardson*, 472 F.2d 1121, 1124-26 (10th Cir. 1973).

182 See *Butler*, *supra* note 4, at 143 n.46.

183 See *Sacred Heart Hosp. v. United States*, 616 F.2d 477 (Ct. Cl. 1980). Although it involves Part A charges, *Sacred Heart* provides an excellent example of the type of claim requiring aggregation. The hospital had completely reorganized the administration of its inhalation therapy department along new, unconventional lines. Despite a dramatic reduction in overall inhalation therapy costs, the fiscal intermediary *denied* the administrative costs because they were not in line with other, albeit more expensive, hospitals. It is unlikely that each beneficiary could have litigated the issues involved. Fortunately, the provider had sufficient economic interest and expertise to challenge the fiscal intermediary and to prove its point. Similarly, in terms of economics and proof, a heart specialist who performs a new operation on several patients can more readily challenge a carrier or HHS.

### C. *Beneficiary Appeals—Part A*

After a beneficiary receives services under Part A, the fiscal intermediary must determine whether the service is covered by Medicare.<sup>184</sup> The beneficiary is entitled to notice of adverse decisions<sup>185</sup> and can request a redetermination.<sup>186</sup> A beneficiary dissatisfied with the redetermination can request a hearing before an administrative law judge (ALJ) if the amount in controversy exceeds \$100.<sup>187</sup>

At the hearing, the beneficiary is allowed to appear, present evidence and make oral arguments.<sup>188</sup> The ALJ has the power to issue subpoenas, take evidence and swear witnesses.<sup>189</sup> The ALJ must make a decision based on the record which is reviewable only on the facts.<sup>190</sup> An adverse decision may be presented to the Appeals Council<sup>191</sup> which can take new evidence and render a decision.<sup>192</sup> The decisions of the Appeals Council are considered final administrative actions<sup>193</sup> and reviewable in district court if the amount in controversy exceeds \$1,000.<sup>194</sup>

While the Part A beneficiary appeals procedure is considerably more thorough than either the UR Committee or Part B review procedures, several problems do exist. As in Part B review proceedings, an irrational distinction is made between the reviewability of facts and law. Although Congress intended to prevent overwhelming the courts with examinations of individual factual questions, it did not mean to prevent review of the legality of agency decisions. Since this is a problem primarily associated with judicial review, it will be considered further in part III.<sup>195</sup>

In a Part A review the ALJ is not associated with the private intermediary so a direct conflict of interest does not arise. Additionally, independent judicial review is available for substantial disputes.

184 42 C.F.R. § 405.702 (1980).

185 *Id.*

186 *Id.* § 405.710.

187 *Id.* § 405.720; 20 C.F.R. § 404.929 (1981). See text accompanying notes 158-68 *supra* for discussion concluding more adequate procedures must be provided for claims involving less than \$100 under Part A.

188 See 20 C.F.R. § 404.949 (1981).

189 *Id.*

190 *Id.* § 404.953 (1981).

191 *Id.* § 404.967 (1981).

192 *Id.* §§ 404.976, .979 (1981). Although the beneficiary technically has a right to appear before the Appeals Council, this right is largely theoretical since the Council only meets in Arlington, Virginia. See Butler, *supra* note 4, at 143.

193 20 C.F.R. § 404.981 (1981).

194 42 U.S.C. § 1395ff(b)(1) (1976).

195 See notes 217-331 and accompanying text *infra*.

Subpoena power is also available so that a beneficiary can compel the production of witnesses and evidence.

The provision of these procedural safeguards for Part A beneficiaries raises the question of whether the lack of similar safeguards for Part B beneficiaries is a denial of substantive due process. While the two groups substantially overlap, less protection is given to Part B beneficiaries who have paid for the insurance coverage. The Medicare program thus insulates many decisions which would be reviewable in the private insurance and health care system. If impartial administrative review can be provided for all Part A beneficiary claims involving more than \$100, and further judicial review for claims greater than \$1,000, there is no rational reason for denying the same procedural due process to Part B beneficiaries. Both programs deal with equally important liberty and property interests. In fact, the Part B beneficiary's property interest is greater because he makes a direct contribution of insurance premiums.

The availability of judicial review is a factor to consider in assessing the adequacy of administrative review. In *Eldridge*, the Supreme Court intimated that the lack of procedural safeguards surrounding the termination of beneficiaries' disability payments was counterbalanced by the availability of independent judicial review.<sup>196</sup> When judicial review is seriously limited or unavailable, administrative review mechanisms should be required to provide greater protection of the beneficiaries' due process rights. Given the direct provision of judicial review for Part A beneficiaries and the apparent absence of review for Part B beneficiaries, the lack of minimal procedural safeguards in Part B is particularly suspect.

#### D. *Provider Reimbursement*

Providers are reimbursed throughout the year based on an estimate of their reasonable costs. Final adjustments are made to their reasonable cost reimbursement based upon an audit of their year-end fiscal reports.<sup>197</sup> Disputes involving the amount of provider reimbursement are handled by a two-level administrative review system.<sup>198</sup>

196 *Mathews v. Eldridge*, 424 U.S. 319, 339 (1976). Compare *Weinberger v. Salfi*, 422 U.S. 749, 762 (1975) (judicial review available) with *Johnson v. Robinson*, 415 U.S. 361, 373 (1974) (no judicial review provided in statutes).

197 42 C.F.R. § 405.1803 (1980).

198 The existing review system provides one level of review for claims of \$1,000 to \$10,000, see note 199 *infra*, and another for claims above \$10,000. See notes 208-09 *infra*. No review is provided for claims of less than \$1,000. This raises some of the questions previously discussed

## 1. Claims of \$1,000 to \$10,000

For claims of \$1,000 to \$10,000, upon receiving notice of an adverse determination, the provider may request a hearing from the intermediary.<sup>199</sup> The intermediary appoints a hearing officer or panel to hear the dispute.<sup>200</sup> While discovery is available, subpoenas are not.<sup>201</sup> The decision must be on the record and is final.<sup>202</sup> Nevertheless, judicial review is arguably available in the Court of Claims and district courts.<sup>203</sup> While judicial review cures certain defects, the better approach would be to reform the administrative system.

Review by intermediary-appointed hearing officers infringes upon the provider's right to a fair and impartial hearing.<sup>204</sup> As *Faith Hospital* indicated, intermediaries have an inherent conflict of interest in their advising and review functions.<sup>205</sup> Similarly, the district court in *McClure* concluded that carrier-appointed hearing officers were not sufficiently impartial to make a final decision.<sup>206</sup> Thus, the provision of a second, independent review process is necessary to fulfill due process requirements.<sup>207</sup>

## 2. Provider Reimbursement Review Board—Claims of \$10,000 or More

For claims of at least \$10,000, Congress has established the Provider Reimbursement Review Board (PRRB)<sup>208</sup> to handle disputes. If a group of providers have aggregate claims exceeding \$50,000,

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regarding review of minimal claims. See text accompanying notes 158-68 *supra*. In contrast to beneficiaries, however, providers have less important interests since only their property rights are at stake.

199 42 U.S.C. § 1395oo(a)(1)(B); 42 C.F.R. §§ 405.1803-.1813 (1980). See generally Butler, *supra* note 4, at 835-36. Medicare contains no specific mechanism to review provider claims of less than \$1,000. Many of the same considerations examined in connection with beneficiary claims of less than \$100 are applicable to provider claims of less than \$1,000.

200 42 C.F.R. § 405.1817 (1980).

201 Butler, *supra* note 4, at 845.

202 42 C.F.R. § 405.1831-.1833 (1980).

203 See *Sacred Heart Hosp. v. United States*, 616 F.2d 477, 482 (Ct. Cl. 1980) (Court of Claims assumed jurisdiction over post-1973 provider claim because no other avenue of relief available at the time the claim was filed).

204 See text accompanying notes 138-57 *supra*.

205 See text accompanying notes 151-61 *supra*.

206 See text accompanying notes 141-50 *supra*.

207 Judicial review of the applicable legal standards seems imperative. Note the recent Court of Claims cases where the hearing officer properly followed the Medicare provisions only to be improperly revised by HHS. *Sun City Community Hosp. v. United States*, 624 F.2d 997, 1002 (Ct. Cl. 1980); *Sacred Heart Hosp. v. United States*, 616 F.2d 477 (Ct. Cl. 1980).

208 42 U.S.C. § 1395oo(a)(2) (1976).

which contain common questions of law and fact, then PRRB review is also available.<sup>209</sup> The provider has the right to appear, be represented by counsel, present evidence and witnesses, and use PRRB subpoena power. The PRRB is comprised of five members, at least three of whom have no relationship with the intermediaries.<sup>210</sup> The PRRB makes a *de novo* determination of the issues and facts.<sup>211</sup> The decision is final unless modified or reversed by the Secretary, and judicial review is available in the district courts.<sup>212</sup>

The presence of the PRRB for Part A providers suggests the possibility of giving similar protections to the aggregated claims of Part B physicians. The PRRB procedure allows for a streamlined, independent review of the factual difficulties inherent in Medicare cases, yet allows for important judicial review of the procedures used and law applied by the board and HHS.

The PRRB procedure meets all due process requirements.<sup>213</sup> Thus, it provides an excellent model for review in other Medicare areas. UR Committee decisions, Part B beneficiary disputes and Part A issues could all be made ultimately appealable to an independent board or to the PRRB. The due process problems encountered in using intermediaries and carriers to adjudicate disputes would thus be substantially reduced. In addition, the legal issues presented should be ultimately appealable to the judiciary.

Throughout the Medicare area, little direct review is provided for legal issues.<sup>214</sup> In precluding judicial review of legal issues, Congress allows the agency to self-define its limits and role.<sup>215</sup> While there may be a legitimate governmental interest in minimizing the extent to which factual questions are reviewed—particularly in

209 *Id.* § 139500(b). See *Glendale Adventist Medical Center v. Schweiker*, [1980-81 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 30,988 (9th Cir. Apr. 3, 1981) (providers can aggregate cost reports from more than one year to meet the \$50,000 requirement). *Cleveland Memorial Hosp., Inc. v. Califano*, 594 F.2d 993 (4th Cir. 1979) (The PRRB refused to review a group claim aggregating \$50,000 from several fiscal years because the regulations required that aggregated claims must all arise in the same year. The court reversed based on legislative history indicating aggregation could be from more than one year.)

210 42 U.S.C. § 139500(h) (1976); 42 C.F.R. § 405.1845 (1980). The lack of an independent review raises a due process question as to whether the provider is receiving an impartial, and hence constitutional, hearing. See *McClure v. Harris*, 503 F. Supp. 409 (N.D. Cal. 1980), *prob. juris. noted sub nom.* *Schweiker v. McClure*, 50 U.S.L.W. 3278 (U.S. Nov. 13, 1981), *stay granted*, [1981-1 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 31,089 (Rehnquist, Circuit Justice, June 12, 1981).

211 42 U.S.C. § 139500(d) (1976); 42 C.F.R. §§ 405.1869-.1871 (1980).

212 42 U.S.C. § 139500(f) (1976); 42 C.F.R. §§ 405.1875-.1877 (1980).

213 *But see* *Homer & Platten*, *supra* note 17, at 123-32 (criticizing the PRRB regulations).

214 See 42 U.S.C. §§ 405(g), 405(h), 1395ff, 1395oo (1976).

215 See *Gardner & Greenberger*, *supra* note 114.

technical fields such as medicine—even in those circumstances, the usual standard of administrative review must apply to prevent arbitrary or capricious agency action.<sup>216</sup> As the next section will detail, judicial review of Medicare issues is confusing, uncertain and badly in need of congressional revision.

### E. Summary

A survey of the administrative review available to Medicare providers and beneficiaries reveals significant due process inadequacies and a maze of confusing procedures through which claimants must maneuver. Congress, in enacting Medicare, elected to use private insurers to augment administration of the program. The inherent dual role and conflict of interest of these insurers necessitates independent review. Recognizing the importance of medical care and the advanced age of most beneficiaries, independent review should not be so far removed as to make it unrealistic. Additionally, a disparity exists between the extent and nature of the review available to beneficiaries and providers. Generally, the individual is sacrificed rather than the institution. Given the grave nature of the interests at stake and the government's ability to provide review for many Medicare claims, such irrational distinctions should be eliminated.

### III. Judicial Review

The inadequacy of Medicare's administrative procedures creates the need for an efficient judicial review mechanism.<sup>217</sup> Whether by design or oversight,<sup>218</sup> however, Congress limited the availability of

216 See, e.g., *Sun City Community Hosp. v. United States*, 624 F.2d 997, 1001 (Ct. Cl. 1980); *Sacred Heart Hosp. v. United States*, 616 F.2d 477 (Ct. Cl. 1980).

217 The need for judicial review is exemplified by the frequent beneficiary and provider challenges to agency actions in light of the regulations, e.g., *Hospital San Jorge Inc. v. Secretary of HEW*, 616 F.2d 580 (1st Cir. 1980); statutory authority, e.g., *Faith Hosp., Inc. v. United States*, 634 F.2d 526 (Ct. Cl. 1980); and the Constitution, e.g., *St. Louis Univ. Hosp. v. Blue Cross Hosp.*, 537 F.2d 283, 291-93 (8th Cir. 1976) (decision by private Provider Appeals Committee). As a practical matter, decisions delegated to private organizations may constitute "final decisions" by the Secretary. Thus they are reviewable by the courts. At least one court has specifically recognized this finality where a constitutional question was presented but no jurisdictional questions raised. *Gray Panthers v. Schweiker*, [1981-1 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 30,746, at 9195. *Pushkin v. Califano*, 600 F.2d 486 (5th Cir. 1979) (equal protection claim by optometrists); *Leduc v. Harris*, 4 MED. & MED. GUIDE (CCH) ¶ 30,721 (D. Mass., Jan. 9, 1980) (due process challenge in Part B); *Caylor-Nickel Hosp., Inc. v. Califano*, 4 MED. & MED. GUIDE (CCH) ¶ 30,718 (N.D. Ind. 1979).

218 See, e.g., *Chelsea Community Hosp. v. Michigan Blue Cross Ass'n*, 630 F.2d 1131 (6th Cir. 1980).

judicial review of Medicare issues.<sup>219</sup> The Medicare Act itself provides judicial review only for: (1) the Secretary's final decisions on individual eligibility;<sup>220</sup> (2) Part A benefit determinations involving more than \$1,000;<sup>221</sup> and (3) PRRB cost reimbursement decisions involving at least \$10,000.<sup>222</sup>

Congress also incorporated into the Medicare Act section 205(h)

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219 Congress's primary concern in regulating the scope of judicial review was to prevent overburdening the Secretary and the courts with small claims involving factual and technical medical issues. S. REP. NO. 404, 89th Cong., 1st Sess. 54-55, *reprinted in* [1965] U.S. CODE CONG. & AD. NEWS 1943, 1995. *See also* 118 CONG. REC. 33992 (1972). *See generally* Erika, Inc. v. United States, 634 F.2d 580, 588 (Ct. Cl. 1980) (en banc), *cert. granted*, 101 S. Ct. 2312 (1981).

As a practical matter, however, nearly all the cases have dealt with traditionally reviewable questions of agency compliance with the law or Constitution. *See, e.g.*, Chelsea Community Hosp. v. Michigan Blue Cross Ass'n, 630 F.2d 1131 (6th Cir. 1980) (whether Secretary could delegate final adjudicatory power to a private body); Faith Hosp., Inc. v. United States, 634 F.2d 526 (Ct. Cl. 1980) (regulation arbitrary and capricious).

220 42 U.S.C. § 1395ff (1976) provides:

(a) Entitlement to and amount of benefits

The determination of whether an individual is entitled to benefits under part A or part B, and the determination of the amount of benefits under part A, shall be made by the Secretary in accordance with regulations prescribed by him.

(b) Appeal by individuals

(1) Any individual dissatisfied with any determination under subsection (a) of this section as to—

(A) whether he meets the conditions of section 426 or section 426a of this title, or

(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this subchapter, or section 1395i-2 of this title, or section 1819, or

(C) the amount of benefits under part A (including a determination where such amount is determined to be zero)

shall be entitled to a hearing thereon by the Secretary 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.

(2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than \$100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than \$1,000.

(c) Appeal by institutions or agencies

Any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination described in section 1395cc(b)(2) of this title, shall be entitled to a hearing thereon by the Secretary (after reasonable notice and opportunity for hearing) 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.

221 *Id.*

222 *Id.* § 1395oo. Congress added the PRRB in 1973. A group of providers with an aggregate claim of \$50,000 or more may also seek review if common questions of law or fact are involved. *See generally* Homer & Platten, *supra* note 17; Butler, *supra* note 4.

of the Social Security Act<sup>223</sup> "as applicable."<sup>224</sup> Section 205(h) reads:

The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under sections 1331 or 1346 of title 28 to recover on any claim arising under this subchapter.<sup>225</sup>

Under section 205(g) of the Social Security Act,<sup>226</sup> all final decisions of the Secretary are ultimately reviewable.<sup>227</sup> Section 205(g), however, was not included in the Medicare Act. Consequently, uncertainty exists concerning the scope of section 205(h) and the availability of judicial review for Medicare issues not addressed by the statutes.<sup>228</sup> Thus, courts have had to struggle with the effect of section 205(h) on their ability to review Medicare disputes under traditional bases of jurisdiction such as federal question jurisdiction,<sup>229</sup> mandamus,<sup>230</sup> the Administrative Procedure Act,<sup>231</sup> and the Tucker

223 42 U.S.C. § 405(h) (1976).

224 *Id.* § 1395ii.

225 *Id.* § 405(h).

226 *Id.* § 405(g).

227 The section provides:

Any individual, after any final decision of the Secretary 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.

The findings of the Secretary as to any fact, if supported by substantial evidence, shall be conclusive, and where a claim has been *denied* by the Secretary 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 Secretary, 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 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.

42 U.S.C. § 405(g) (1976).

228 Examples of issues left unaddressed by the Medicare review provisions include Part B amount determinations, pre-1973 provider reimbursement claims and post-1973 claims of less than \$10,000. There is also no provision for review of the Secretary's failure to make a "final decision." This problem is particularly common when authority is delegated to private parties. *See, e.g.*, *St. Louis Univ. Hosp. v. Blue Cross Hosp.*, 537 F.2d 283, 291-93 (8th Cir. 1976). At least one court has held that a delegation of a decision to a private organization may constitute a "final decision." *See Gray Panthers v. Schweiker*, [1981-1 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 30,746 (D.C. Cir. Mar. 18, 1981).

229 28 U.S.C. § 1331 (1976).

230 *Id.* § 1361.



Act.<sup>232</sup>

This section of the article will examine the major Supreme Court decision concerning judicial review under section 205(h) and the questions left unanswered by that decision. The section will conclude with analyses of the availability of judicial review in the Court of Claims and district courts.

### A. Weinberger v. Salfi

In 1974, the Supreme Court considered the effect of section 205(h) on judicial review in *Weinberger v. Salfi*.<sup>233</sup> The case involved a claim for widows' and childrens' Social Security benefits.<sup>234</sup> The Social Security Act contained an irrebuttable presumption that wives or step-children of less than nine months were not entitled to dependents benefits.<sup>235</sup> A widow who had been married to the deceased wage earner for six months brought suit challenging the irrebuttable presumption as unconstitutional.<sup>236</sup> A three-judge district court concluded that it had federal question jurisdiction and that the statute was unconstitutional.<sup>237</sup> The Supreme Court reversed, holding that the district court was barred from taking federal question jurisdiction by section 205(h).

Until *Salfi*, most courts considered section 205(h) merely to require an exhaustion of administrative remedies.<sup>238</sup> The Supreme Court focused, however, on the third sentence of 205(h) which reads: "[N]o action against the United States, the Secretary or any officer or employee thereof shall be brought under [sections 1331 and 1361] of Title 28 to recover on any claim [arising under Title II of the Social Security Act]."<sup>239</sup> Justice Rehnquist stressed that the phrase "no action" was "sweeping and direct" and covered any action under Title II.<sup>240</sup> According to the Court, any other construction would render section 205(h) superfluous since the first two sentences of section

231 5 U.S.C. §§ 701-706 (1976).

232 28 U.S.C. § 1491 (1976).

233 422 U.S. 749 (1974).

234 42 U.S.C. §§ 402(d) (children's benefits), 402(g)(1) (widow's benefits) (1976).

235 *Id.* § 416(c), (e).

236 422 U.S. at 753.

237 *Salfi v. Weinberger*, 373 F. Supp. 961 (N.D. Cal. 1974), *rev'd*, 422 U.S. 749 (1974).

238 373 F. Supp. at 964. *See Kingsbrook Jewish Medical Center v. Richardson*, 486 F.2d 663 (2d Cir. 1973); *Aquavella v. Richardson*, 437 F.2d 397 (2d Cir. 1971); *Cappadora v. Celebrezze*, 356 F.2d 1 (2d Cir. 1966).

239 42 U.S.C. § 405(h) (1976).

240 422 U.S. at 757.

205(h) assured administrative exhaustion.<sup>241</sup> Thus, the Court concluded that only those claims cognizable under section 205(g) could be reviewed in district court.<sup>242</sup>

*Salfi* also raised the question of the extent to which Congress can preclude judicial review of constitutional questions. Plaintiff argued that her claim was not barred by section 205(h) because it arose under the Constitution, and not under Title II of the Social Security Act.<sup>243</sup> Plaintiff's argument was based, in part, on *Johnson v. Robinson*,<sup>244</sup> in which the Court had concluded that a Veteran's Act section comparable to section 205(h) did not bar review of constitutional issues.<sup>245</sup>

Justice Rehnquist avoided *Johnson* by concluding that the claims were based solely on Title II. The Court stated, "[N]ot only is it Social Security benefits which appellees seek to recover, but it is the Social Security Act which provides both the standing and the substantive basis for the presentation of their constitutional contentions."<sup>246</sup> The Court also specifically distinguished *Johnson*. The Court noted that the statute in *Johnson* only precluded review of the Administrator's decisions, whereas the plaintiff's challenge in that case was to an act of Congress. By contrast, in *Salfi*, section 205(h) was held to preclude judicial consideration of any action to recover on a claim.<sup>247</sup>

The more important distinction between *Salfi* and *Johnson* is that in *Johnson*, if the statute were read differently, no judicial review would be available on constitutional questions. By contrast, a liti-

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241 *Id.*

242 42 U.S.C. § 405(g).

243 *Weinberger v. Salfi*, 422 U.S. 749, 760 (1974). In some respects, *Salfi* represented a triumph for the positivist theory noted by Professor Tribe in the due process area. *TRIBE*, *supra* note 42, at § 10-12. The positivist approach would allow Congress to limit the constitutional protection accorded to rights it creates. This is not yet the majority position. *Id.* at § 10-13. Moreover, it raises substantial constitutional questions involving the proper balance of power in our government.

244 415 U.S. 361 (1974).

245 The statute considered in *Johnson* reads:

[T]he decisions of the [Veterans'] Administrator on any question of law or fact under any law administered by the Veterans' Administration providing benefits for veterans . . . shall be final and conclusive and no other official or any court of the United States shall have power to review any such decision by an action in the nature of mandamus or otherwise.

38 U.S.C. § 211(a) (1976).

246 422 U.S. at 760-61.

247 *Id.* at 761-62. The Court's distinction seems contrived. Both cases involved challenges to the constitutionality of a statute. A more realistic distinction is the availability of review in *Salfi* compared to the availability of review in *Johnson*.

gant could secure relief regarding the Social Security Act under section 205(g). It is this last distinction which is most important in Medicare because judicial review is not directly provided in many areas.<sup>248</sup>

Importantly, both in *Johnson* and *Salfi*, the Court said that it would require "clear and convincing evidence" of a congressional intent to preclude constitutional review.<sup>249</sup> Serious constitutional questions would arise if a statute precluded review of claimed constitutional violations.<sup>250</sup> Although the Supreme Court has never addressed this specific issue, it is doubtful whether any statute which totally precluded review of constitutional questions would be found valid.<sup>251</sup>

The federal courts retain jurisdiction to determine whether withdrawal of jurisdiction is permissible.<sup>252</sup> Moreover, jurisdictional

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248 *Erika, Inc. v. United States*, 634 F.2d 580 (Ct. Cl. 1980), *cert. granted*, 101 S. Ct. 2312 (1981); *Chelsea Community Hosp. v. Michigan Blue Cross Ass'n*, 630 F.2d 1131 (6th Cir. 1980); *Hopewell Nursing Home, Inc. v. Califano*, [1981-1 Transfer Binder] MED. & MED. GUIDE (CCH) ¶ 30,701 (D.S.C. 1980).

249 422 U.S. at 762; 415 U.S. at 373. Justice Brennan considered *Johnson* to control the outcome in *Salfi* for several reasons. 422 U.S. at 786. He considered § 205(h) to bar review only of eligibility determinations and cases requiring application of the statutes to particular sets of facts. For cases challenging the validity of statutes and regulations, he argued, the Court was imposing a futile administrative review. Moreover, the plaintiffs' claims were based on the Constitution and did not arise under the Social Security Act.

250 See generally P. BATOR, P. MISHKIN, D. SHAPIRO & H. WESCHLER, HART AND WESCHLER'S THE FEDERAL COURTS AND THE FEDERAL SYSTEM 313-75 (2d ed. 1973) [hereinafter cited as THE FEDERAL COURTS]; K. DAVIS, ADMINISTRATIVE LAW OF THE SEVENTIES § 28.09 (1976); J. MASHAW & R. MERRILL, INTRODUCTION TO THE AMERICAN PUBLIC LAW SYSTEM 853-55 (1975); Hart, *The Power of Congress to Limit the Jurisdiction of Federal Courts: An Exercise in Dialecting*, 66 HARV. L. REV. 1362 (1953) (hereinafter cited as Hart).

251 See R. BORK, CONSTITUTIONALITY OF THE PRESIDENT'S BUSING PROPOSALS (American Enterprise Inst. 1972); Hart, *supra* note 247; Eisenberg, *Constitutional Authority to Restrict Lower Federal Court Jurisdiction*, 83 YALE L.J. 498 (1974) [hereinafter cited as Eisenberg]; Harzenski, *Jurisdictional Limitations and Suspicious Motives: Why Congress Cannot Forbid Court-Ordered Busing*, 50 TEMPLE L.Q. 14, 25 (1976); Redish & Woods, *Congressional Power to Control the Jurisdiction of Lower Federal Courts: A Critical Review and a New Synthesis*, 124 U. PA. L. REV. 45 (1975); Comment, *Congressional Power Over State and Federal Court Jurisdiction: The Hill-Burton and Trans-Alaska Pipeline Examples*, 49 N.Y.U. L. REV. 131 (1974). See also *Ex parte Yeager*, 75 U.S. (8 Wall.) 85 (1869) (attempt by Congress to limit federal court jurisdiction to circumvent a substantive judicial interpretation of the Constitution was itself unconstitutional); *Marbury v. Madison*, 5 U.S. (1 Cranch) 137 (1803) ("It is emphatically the province and duty of the [courts] to say what the law is."). *Accord*, *United States v. Nixon*, 418 U.S. 683, 705 (1974). But see *Ex parte McCardle*, 74 U.S. (7 Wall.) 506 (1869).

252 See THE FEDERAL COURTS, *supra* note 250: "If the court finds that what is being done [by the government] is invalid, its duty is simply to declare the jurisdictional limitation invalid also, and then proceed under the general grant of jurisdiction." *Id.* at 348. Thus, so long as federal courts have federal question jurisdiction, they always have the power to decide the constitutionality of any congressional jurisdictional limitation. As one court observed, "A

statutes operating in violation of substantive provisions of the Constitution would themselves be unconstitutional.<sup>253</sup> Thus, an attempt to withdraw jurisdiction over constitutional questions might well be ineffective. Given such a problem, it is the duty of the courts to interpret a statute, such as section 205(h), in a manner which avoids an unconstitutional result.

Following *Salfi*, the lower courts have been forced to deal with the various issues *Salfi* left open or created. Since *Salfi* did not specifically overrule *Johnson*, the latter case may control in particular instances. Finally, the Supreme Court's statement that the issues in *Salfi* arose under Title II of the Social Security Act rather than the Constitution seems overbroad and difficult to apply where procedural due process has been violated. Therefore, it is worth examining how the lower courts have struggled with these issues and the various solutions devised.

### B. *Court of Claims*

The most consistent and well-established avenue for judicial review of Medicare disputes has been through the Court of Claims under the Tucker Act.<sup>254</sup> In *Whitecliff, Inc. v. United States*,<sup>255</sup> the Court of Claims established that it had jurisdiction under the Tucker Act to review Medicare issues, thus reaffirming its pre-*Salfi* order in *Goldstein v. United States*.<sup>256</sup> The court also examined the effect of *Salfi* and reconsidered the scope of section 205(h).

The plaintiff-provider in *Whitecliff* sued to recoup an alleged un-

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basic and inherent function of the judicial branch of a government built upon a constitution is to set aside void action by government officials. . . . In our jurisprudence, no Government action which is void under the Constitution is exempt from judicial power." *Eisentrager v. Forrestal*, 174 F.2d 961, 964 (D.C. Cir. 1949) (citations omitted), *rev'd on other grounds sub nom. Johnson v. Eisentrager*, 339 U.S. 763 (1950). See also R. BERGER, CONGRESS V. THE SUPREME COURT 282 (1969) (quoting THE FEDERALIST No. 82 (A. Hamilton)).

253 See *Eisenberg*, *supra* note 251, at 523.

254 Both houses of Congress have recently passed bills creating a new United States Court of Appeals for the Federal Circuit. S. 21, 97th Cong., 1st Sess. (1981); H. R. 2405, 97th Cong., 1st Sess. (1981). Those bills merge the present Court of Claims with the Court of Customs and Patent Appeals to form the new circuit. The Court of Claims Trial Division will be reconstituted as the United States Claims Court. The Claims Court will have Tucker Act jurisdiction plus some additions. *Id.* §§ 132(a) and 126(d) respectively. Appeals from the Claims Court will then go to the new Circuit Court. Much of the analysis under this section will remain the same. It should be noted that Congress in reenacting the new Claims Court jurisdiction was aware of the assumption of Medicare jurisdiction. Additionally, the bills grant declaratory relief and injunctive powers to the Claims Court which will eliminate the current disadvantage of litigating in the Court of Claims.

255 536 F.2d 347 (Ct. Cl. 1976), *cert. denied*, 430 U.S. 969 (1977).

256 201 Ct. Cl. 888, *cert. denied*, 414 U.S. 947 (1973).

derpayment withheld by Blue Cross Association's Medicare Provider Appeals Committee. Since the claims arose prior to 1973, there was no express provision for provider review. The court declined to extend *Salfi* to bar Court of Claims jurisdiction because to do so

would be to prevent all review of very large categories of cases and issues, including constitutional questions, and to accord absolute finality to adjudications by private organizations like the BCA. Such a result would be of doubtful constitutional validity and would undermine the normal presumption in favor of judicial review.<sup>257</sup>

The *Whitecliff* court reaffirmed the standard of review established in pre-*Salfi* cases. The Court of Claims' review is limited to determining "compliance with the Constitution, statutory provisions, and regulations, . . . , as well as [an examination] for the taint of arbitrariness, capriciousness, or lack of support in substantial evidence."<sup>258</sup> Evidentiary review is allowed only to assure procedural due process in decisionmaking. This standard of review meets Congress's goal of avoiding extensive judicial review of the technical questions presented in Medicare.<sup>259</sup> At the same time, the Secretary and HHS agents are prevented from unlawfully depriving Medicare participants of their constitutional or statutory rights.

Later developments have supported the conclusion that Medicare and the Tucker Act confer jurisdiction on the Court of Claims.<sup>260</sup> In *Chelsea Community Hospital v. Michigan Blue Cross*,<sup>261</sup> the Sixth Circuit adopted the Court of Claims' view and stressed a point only intimated in *Whitecliff*. The *Chelsea* court concluded that the *Whitecliff* decision properly adhered to the maxim of statutory con-

257 536 F.2d at 350.

258 *Sacred Heart Hosp. v. United States*, 616 F.2d 477, 483 (Ct. Cl. 1980).

259 *See, e.g.*, notes 135-36 *supra*. *See also* *St. Louis Univ. v. Blue Cross Health Servs.*, 357 F.2d 283, 289 (8th Cir. 1976).

260 The two acts must be considered together to find jurisdiction. Surprisingly, none of the cases considering the Court of Claims jurisdiction in Medicare cases deal with the limitations inherent in suing the sovereign and concomitant scope of the Tucker Act. In the seminal case detailing the scope of the Court of Claims jurisdiction under the Tucker Act, *United States v. Testan*, 424 U.S. 392 (1976), the Supreme Court noted that the Tucker Act is only a jurisdictional statute and does not create any substantive rights. The right to recover in the Court of Claims, *Testan* holds, "depends upon whether any federal statute 'can fairly be interpreted as mandating compensation . . .'" *Id.* at 400. Medicare claimants fall into the group of cases resting upon an express right to payment under a federal statute—the Medicare Act. *See Eastport S.S. Corp. v. United States*, 372 F.2d 1002, 1007-08 (Ct. Cl. 1967). Medicare claimants are suitable litigants in the Court of Claims because the Medicare Act provides a right to money, and the Tucker Act provides a waiver of sovereign immunity.

261 630 F.2d 1131 (6th Cir. 1980).

struction that courts should seek to interpret statutes so as to avoid constitutional questions.<sup>262</sup> Additionally, the Sixth Circuit noted Justice Powell's comment in *Califano v. Sanders*<sup>263</sup> that *Salfi* "merely adhered to the well-established principle that when constitutional questions are in issue, the availability of judicial review is presumed."<sup>264</sup> Thus, *Califano* indicates that where, as in *Johnson*, constitutional review is seemingly precluded by a literal reading of the statute, the courts must avoid such a construction.

The presumption in favor of judicial review generally requires "clear and convincing evidence" of congressional intent to preclude review.<sup>265</sup> As one judge of the Court of Claims has noted, if section 205(h) is a bar to Court of Claims jurisdiction, it requires finding an implied intent on the part of Congress to partially repeal the Tucker Act.<sup>266</sup> Such a construction does not seem to meet the requirement of "clear and convincing evidence" of congressional intent necessary to preclude review.

In *Erika, Inc. v. United States*,<sup>267</sup> the Court of Claims reexamined its jurisdiction over Medicare issues. *Erika* involved a claim for benefits under Part B. The government argued that Congress's failure to provide for Part B review under section 1395h indicated an intent to

262 "We adopt the view of the Court of Claims, for it is a 'cardinal principle' that we should seek statutory constructions which avoid constitutional doubts." *Id.* at 1135.

263 430 U.S. 99 (1977).

264 *Id.* at 109, quoted in 630 F.2d at 1134.

265 See, e.g., *Trinity Memorial Hosp. v. Associated Hosp. Serv.*, 570 F.2d 660, 665 (7th Cir. 1977) (finding review in Court of Claims). The Court of Claims also specifically adopted this standard in *Erika, Inc. v. United States*, 634 F.2d 580, 587 (Ct. Cl. 1980), cert. granted, 101 S. Ct. 2312 (1981). The principle that preclusion of judicial review requires "clear and convincing evidence" of congressional intent was established in *Abbott Labs. v. Gardner*, 387 U.S. 136, 141 (1967). Professor Davis argues that the standard is too high in prohibiting preclusion by implication and cites six cases with less restrictive dicta. See K. DAVIS, *ADMINISTRATIVE LAW OF THE SEVENTIES* § 28.09 (1976 & Supp. 1980). The *Abbott* decision, however, seems to be the better view and is still good law. When the preclusion of judicial review is intended, at a minimum Congress should be required to be explicit. An implied repeal of the jurisdiction of the Tucker Act should not be given effect. See note 266 *infra*.

266 *Erika, Inc. v. United States*, 634 F.2d at 592 (Ct. Cl. 1980) (Nichols, J., concurring). Judge Nichols suggested that partial repeals of the Tucker Act by implication have been favored, but continued:

There is, however, a big difference between an implied partial repeal of the Tucker Act in course of providing a seemingly adequate remedy elsewhere than in this court (actuated, perhaps, by a commendable desire to guarantee us an easy life with long vacations) and such an implied partial repeal in course of expressly denying relief elsewhere. Much will depend on facts, but I do not think the Supreme Court has yet said or done anything to disable us from requiring defendant to show us express repeal of the Tucker Act in such circumstances.

*Id.* Thus, even assuming repeal by implication is accepted, it cannot be presumed here.

267 634 F.2d 580 (Ct. Cl. 1980) (en banc), cert. granted, 101 S. Ct. 2312 (1981).

partially limit the Court of Claims' Tucker Act jurisdiction.<sup>268</sup> Chief Judge Friedman, writing for the court, expressly relied on *Johnson* and a line of Court of Claims cases allowing review of final decisions. The Chief Judge concluded:

If, as those cases hold, the courts may entertain constitutional and statutory challenges to administrative action even where the governing statute explicitly bars judicial review, *a fortiori*, the courts may do so where, as here, the alleged bar to judicial review is merely implicit in the statutory language and structure.<sup>269</sup>

To find section 205(h) a bar to Tucker Act jurisdiction requires a tortuous construction. The third sentence of section 205(h) barring judicial review only refers to district court jurisdiction and does not refer to the Tucker Act.<sup>270</sup> While the Sixth Circuit argues that the second sentence of section 205(h) could be read to preclude Court of Claims review, such a reading would make the third sentence superfluous.<sup>271</sup> A better construction would be that section 205(h) accords finality to the Secretary's factual determinations, but also allows the Court of Claims review of the underlying legal issues and the methods used in arriving at the decision.

Jurisdiction to review Medicare issues is well established in the Court of Claims. Unfortunately, the court is limited in the breadth of relief it can grant.<sup>272</sup> For litigants seeking declaratory and injunctive relief, the district courts are the appropriate forum if review is available. One declaratory judgment deciding the legality of a regu-

268 634 F.2d at 585-86.

269 *Id.* at 587.

270 See Reviser's Note, 42 U.S.C. § 405(h) (1976); *Weinberger v. Salfi*, 422 U.S. 749, 756 n.3 (1974).

271 *Chelsea Community Hosp. v. Michigan Blue Cross Ass'n*, 630 F.2d 1131, 1135-36 (6th Cir. 1980). The court stated:

If § 405(h) does apply to the present controversy, it is binding on *all* courts; the plain language of § 405(h) provides that "[n]o findings of fact or decision of the Secretary shall be reviewed by *any* person, tribunal, or governmental agency except as herein provided" (emphasis added). We could not in good conscience hold this section applicable and still transfer the present case to the Court of Claims; however, we do not think that § 405(h) is applicable in any way to pre-1973 provider-reimbursement claims. *Salfi* is distinguishable: the statutory review provision present in *Salfi*, and essential to *Salfi*'s logic, is missing here. This is the interpretation adopted by the Court of Claims.

*Id.* at 1135.

272 The Court of Claims can grant declaratory relief only if the declaratory judgment is tied to an award of monetary damages. See *United States v. King*, 395 U.S. 1, 2 (1969); *Gentry v. United States*, 546 F.2d 343, 345 (Ct. Cl. 1976); *Austin v. United States*, 206 Ct. Cl. 719, 722-23 (1975). The court is also not empowered to grant injunctive relief. *United States v. Testan*, 424 U.S. 392, 398 (1976).

lation is more economical than having numerous litigants bringing claims based on the same faulty regulation to the Court of Claims.<sup>273</sup> Moreover, Court of Claims decisions have national precedential value. Thus, Congress might do well to reevaluate the existing limitations to granting full relief in the Court of Claims.<sup>274</sup>

#### D. District Courts

Medicare participants attempting to bring suit in federal district court must first find a jurisdictional basis. The Supreme Court has eliminated the Administrative Procedure Act<sup>275</sup> as an independent source of jurisdiction.<sup>276</sup> Similarly, the Declaratory Judgment Act<sup>277</sup> cannot be used as a jurisdictional basis.<sup>278</sup> There has been little case law developed on mandamus jurisdiction,<sup>279</sup> and thus most litigation has focused on the availability of federal question jurisdiction. Due to section 205(h) and *Salafi*, however, federal question jurisdiction for Medicare claims has remained uncertain.

The majority of courts have found section 205(h) to be at least a partial bar to judicial review of Medicare decisions.<sup>280</sup> The crucial

273 See Gardner & Greenberger, *supra* note 114, at 27-30.

274 Congress recently passed legislation granting these powers to the new United States Claims Court. See note 254 *supra*.

275 5 U.S.C. §§ 701-706 (1976).

276 *Califano v. Sanders*, 430 U.S. 99 (1977). The Court stated that "the APA is not to be interpreted as an implied grant of subject-matter jurisdiction to review agency decisions." *Id.* at 105. See *Rhode Island Hosp. v. Califano*, 585 F.2d 1153, 1156 n.1 (1st Cir. 1978). Cf. *Humana of South Carolina, Inc. v. Califano*, 590 F.2d 1070, 1080-82 (D.C. Cir. 1978) (§ 1331 jurisdiction to review violation of APA notice and comment requirements).

277 28 U.S.C. §§ 2201-2202 (Supp. 1980).

278 *Aetna Life Ins. Co. v. Haworth*, 300 U.S. 227 (1937).

279 The only real discussion of the availability of mandamus jurisdiction is dictum by the D.C. Circuit that mandamus may exist in certain circumstances. See *Association of Am. Medical Colleges v. Califano*, 569 F.2d 101, 112-14 (D.C. Cir. 1977). Although mandamus was never a part of § 41, the court found § 205(h) a bar where administrative procedures existed. Nonetheless, the court suggested that mandamus might be appropriate to compel the Secretary to act administratively.

280 See *Hospital San Jorge, Inc. v. Secretary of HEW*, 598 F.2d 684, 686 (1st Cir. 1979); *Rhode Island Hosp. v. Califano*, 585 F.2d 1153 (1st Cir. 1979); *Humana of South Carolina, Inc. v. Califano*, 590 F.2d 1070 (D.C. Cir. 1978); *American Ass'n of Councils of Medical Staffs of Private Hosp., Inc. v. Califano*, 575 F.2d 1367 (5th Cir. 1978); *Dr. John T. MacDonald Foundation, Inc. v. Califano*, 571 F.2d 328, 331 (5th Cir.) (en banc), *cert. denied*, 439 U.S. 893 (1978); *Trinity Memorial Hosp., Inc. v. Associated Hosp. Serv., Inc.*, 570 F.2d 660 (7th Cir. 1977); *Association of Am. Medical Colleges v. Califano*, 569 F.2d 101, 105-13 (D.C. Cir. 1977); *Milo Community Hosp. v. Weinberger*, 525 F.2d 144, 146-47 (1st Cir. 1975); *Unihealth Servs. Corp. v. Califano*, 464 F. Supp. 811, 813-17 (E.D. La. 1979); *Kechijian v. Califano*, 458 F. Supp. 159, 161-62 (D.R.I. 1978), *aff'd*, 621 F.2d 1 (1st Cir. 1980); *John Muir Memorial Hosp., Inc. v. Califano*, 457 F. Supp. 848, 852-56 (N.D. Cal. 1978) (§ 205h bars if claim "arises under" Medicare Act); *Lodi Memorial Hosp. v. Califano*, 451 F. Supp. 651, 655



question, then, is how much of a bar Congress intended, or the courts will allow, section 205(h) to be. In particular, when and to what extent can courts review constitutional, procedural and substantive issues raised in the Medicare context?

As a starting point, it is worthwhile to consider the minimally acceptable interpretation of section 205(h) and *Salafi* in the Medicare context. While *Salafi* held that section 205(h) is not merely a codification of the exhaustion of administrative review doctrine, litigants are at least required to exhaust the administrative and judicial review procedures provided in the Medicare Act.<sup>281</sup> Review is prohibited if a constitutional cause of action exists merely because of a failure to pursue administrative remedies.<sup>282</sup> The courts have not been receptive to the argument that administrative review of constitutional claims is futile.<sup>283</sup> The courts have also noted that the agency can avoid the constitutional question by deciding the case on another ground.<sup>284</sup> Further, where the problem involves an agency interpretation of a statute or regulation, the Secretary may be able to correct the situation. Where no secretarial review exists for administrative

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(D.D.C. 1978); *Hazelwood Chronic & Convalescent Hosp., Inc. v. Califano*, 450 F. Supp. 1158, 1161 (D. Ore. 1978); *Trustees of Ind. Univ. v. Blue Cross Ass'n*, 445 F. Supp. 617 (S.D. Ind. 1977) (later transferred to the Court of Claims); *Cleveland Memorial Hosp., Inc. v. Califano*, 444 F. Supp. 125, 127 (E.D.N.C. 1978) (dicta; jurisdiction existed under § 1395oo), *aff'd*, 594 F.2d 993 (4th Cir. 1979); *St. Elizabeth Hosp. v. Califano*, 441 F. Supp. 158 (E.D. Ky. 1977); *Cervoni v. HEW*, 440 F. Supp. 750, 751 (D.P.R. 1977), *aff'd*, 581 F.2d 1010 (1st Cir. 1978); *Pacific Coast Medical Enterprises v. Califano*, 440 F. Supp. 296, 302 (C.D. Cal. 1977), *modified*, 633 F.2d 123 (9th Cir. 1980); *Daytona Beach Gen. Hosp., Inc. v. Weinberger*, 435 F. Supp. 891 (M.D. Fla. 1977); *Medical Center v. Califano*, 433 F. Supp. 837, 841 (W.D. Mo. 1977); *Hillside Community Hosp. v. Mathews*, 423 F. Supp. 1168, 1172 (N.D. Cal. 1976) (but court found APA jurisdiction prior to *Sanders v. Califano*); *Aristocrat South, Inc. v. Mathews*, 420 F. Supp. 23, 26 (D.D.C. 1976); *Simoncelli v. Weinberger*, 418 F. Supp. 87 (E.D. Pa. 1976). *See also* *St. Louis Univ. Hosp. v. Blue Cross Servs.*, 537 F.2d 283 (6th Cir.), *cert. denied*, 429 U.S. 977 (1976) (while § 205h bars, would allow for constitutional question).

281 *Humana of South Carolina, Inc. v. Califano*, 590 F.2d 1070 (D.C. Cir. 1978); *Rhode Island Hosp. v. Califano*, 585 F.2d 1153 (1st Cir. 1978) (provider challenge brought under § 1331 improper for failure to pursue available § 1395ff(o) remedies); *Association of Am. Medical Colleges v. Califano*, 569 F.2d 101 (D.C. Cir. 1977) (failure to challenge via PRRB, even where challenge was futile, barred under § 205(h) and *Salafi*); *Milo Community Hosp. v. Weinberger*, 525 F.2d 144, 146-47 (1st Cir. 1975); *John Muir Memorial Hosp., Inc. v. Califano*, 457 F. Supp. 848, 855 (N.D. Cal. 1978) (Muir has a constitutional cause of action only because it failed to pursue its administrative remedies); *Medical Center v. Califano*, 433 F. Supp. 837, 841 (W.D. Mo. 1977) (1970-72 claims appeal still pending before Blue Cross Ass'n); *Aristocrat South, Inc. v. Mathews*, 420 F. Supp. 23 (D.D.C. 1976) (PRRB could decide if regulation was arbitrary and capricious so review was not fruitless).

282 *John Muir Memorial Hosp., Inc. v. Califano*, 457 F. Supp. 848, 855 (N.D. Cal. 1978).

283 *Humana of South Carolina, Inc. v. Califano*, 590 F.2d 1070, 1078 (D.C. Cir. 1978); *Aristocrat South, Inc. v. Mathews*, 420 F. Supp. 23 (D.D.C. 1976).

284 420 F. Supp. at 23.

decisions, however, direct review by the courts should be provided.<sup>285</sup>

The most extreme judicial interpretation of *Salfi* and section 205(h) is that there is no review of any Medicare issues except as explicitly provided for in the Medicare Act. Courts accepting such an interpretation have focused on the Supreme Court's statement that section 205(h) "is sweeping and direct" and "states that no action shall be brought under [section] 1331."<sup>286</sup> This interpretation ignores the context of the statement and remainder of the opinion. First, the Supreme Court made the statement while refuting the contention that section 205(h) merely codified the exhaustion doctrine.<sup>287</sup> Second, finding section 205(h) a complete bar to review is contrary to *Johnson*<sup>288</sup> and to the Supreme Court's attempt to distinguish it in *Salfi*.<sup>289</sup> Just as with the disability program considered in *Johnson*, the Medicare Act does not always provide for judicial review and where constitutional questions are presented review is presumed or may exist regardless of Congress's actions. *Johnson* is the appropriate precedent where no judicial review exists for particular Medicare questions but review is not explicitly barred.

The absurdity of finding section 205(h) an absolute bar to Medicare review is exemplified in *Pacific Coast Medical Enterprises v. Califano*.<sup>290</sup> A provider challenged the Secretary's denial of reimbursement for 1970 to 1973 costs involving the purchase of a hospital's stock. The court found the Secretary's actions unreasonable, arbitrary, capricious and in clear error.<sup>291</sup> Nevertheless, the court found it had no jurisdiction to remedy these violations for 1970 to 1972 due to section 205(h). As to the 1973 period, the court remanded to the PRRB. Even assuming the provider could get relief in the Court of Claims, the decision is contrary to Congress's goal of economical resolution of disputes.

Most courts have found section 205(h) to constitute only a par-

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285 An example of such a situation is presented by a case where no review was available because the PRRB had not yet been established. See *Sacred Heart Hosp. v. United States*, 616 F.2d 477 (Ct. Cl. 1980). As Congress noted in forming the PRRB, the problem was that there were no specific procedures to obtain administrative or judicial review. See S. REP. NO. 1230, 92d Cong., 1st Sess. 51 (1972).

286 *Weinberger v. Salfi*, 422 U.S. 749, 757 (1975). See, e.g., *Trustees of Ind. Univ. v. Blue Cross Ass'n*, 445 F. Supp. 617, 618-19 (S.D. Ind. 1977) (later transferred to the Court of Claims). The court stated: "The holding in *Salfi* provides an absolute bar to judicial review unless specifically provided for within the Social Security Act." *Id.* at 618.

287 422 U.S. at 757.

288 415 U.S. 361, 373 (1974).

289 422 U.S. at 761-62.

290 440 F. Supp. 296 (C.D. Cal. 1977), *modified*, 633 F.2d 123 (9th Cir. 1980).

291 440 F. Supp. at 307.

tial bar to federal question jurisdiction after *Salfi*.<sup>292</sup> The majority of these courts have avoided the *Salfi-Johnson* question of whether Congress could preclude review either by noting the existence of review in the Court of Claims<sup>293</sup> or determining that no constitutional claim was presented.<sup>294</sup> These courts have relied on the Supreme Court's statement that a statute precluding review of constitutional questions would itself pose serious constitutional questions.<sup>295</sup> Moreover, the availability of judicial review of constitutional claims is presumed, absent clear and convincing evidence that Congress intended otherwise.<sup>296</sup> The Fifth Circuit stated that it could "happily" avoid both questions because they were raised only if *no* avenues of relief were available.<sup>297</sup> Since the Court of Claims has held that it has jurisdic-

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292 See text accompanying note 280 *supra*.

293 *Hospital San Jorge v. Secretary of HEW*, 598 F.2d 684, 686 (1st Cir. 1979) (the court noted a possible exception if review of constitutional questions is precluded; however, plaintiff failed to present a colorable claim to challenge the administrative procedures); *American Ass'n of Councils of Medical Staffs v. Califano*, 575 F.2d 1367, 1373 (5th Cir. 1978) (§ 205(h) bars suits and this bar does not violate due process); *Dr. John T. MacDonald Foundation v. Califano*, 571 F.2d 328, 332 (5th Cir. 1978) (en banc) (all avenues of relief are not foreclosed since the Court of Claims has declared its jurisdiction); *Trinity Memorial Hosp. v. Associated Hosp. Serv.*, 570 F.2d 660, 667-68 (7th Cir. 1977) (no question of Court of Claims jurisdiction since § 41 of title 28 did not include § 1491); *South Windsor Convalescent Home, Inc. v. Mathews*, 541 F.2d 910, 914 (2d Cir. 1976) (jurisdiction lies exclusively in the Court of Claims) (but see *MacDonald* questioning ability to so "hold"). See also *Humana of South Carolina, Inc. v. Califano*, 590 F.2d 1070, 1076 n.46 (D.C. Cir. 1978); *St. Louis Univ. Hosp. v. Blue Cross Hosp. Serv.*, 537 F.2d 283 (6th Cir.) (review available for constitutional questions, however, none were presented), *cert. denied*, 429 U.S. 977 (1976); *Hazelwood Chronic & Convalescent Hosp., Inc. v. Califano*, 450 F. Supp. 1158, 1161 (D. Ore. 1978) (stating Court of Claims jurisdiction); *Trustees of Ind. Univ. v. Blue Cross Ass'n*, 445 F. Supp. 617 (S.D. Ind. 1977) (finding § 205(h) an absolute bar but transferring the case to the Court of Claims). Cf. *Daytona Beach Gen. Hosp., Inc. v. Weinberger*, 435 F. Supp. 891 (M.D. Fla. 1977) (*Salfi* barred § 1331 jurisdiction, including Court of Claims jurisdiction, but court could review due process violation); *Rhode Island Hosp. v. Califano*, 585 F.2d 1153, 1159 (1st Cir. 1978) (contrasts *St. Louis Hosp.* where no review available); *Cervoni v. Secretary of HEW*, 581 F.2d 1010, 1015-17 (1st Cir. 1978) (no constitutional problem because no constitutional question presented).

294 See *Cervoni v. Secretary of HEW*, 581 F.2d 1010, 1015-17 (1st Cir. 1978) (no constitutional problem because no constitutional question presented). But see *Chelsea Community Hosp. v. Michigan Blue Cross Ass'n*, 630 F.2d 1131, 1137 (6th Cir. 1980) (criticizing the assumption of review to decide constitutional questions).

295 *Weinberger v. Salfi*, 422 U.S. 749, 762 (1975); *Dr. John T. MacDonald Foundation v. Califano*, 571 F.2d 328, 332 (5th Cir. 1978) (en banc); *Association of Am. Medical Colleges v. Califano*, 569 F.2d 101, 107 n.55 (D.C. Cir. 1977).

296 *Califano v. Sanders*, 430 U.S. 99, 109 (1977); *Johnson v. Robison*, 415 U.S. 361, 366-67 (1974).

297 *Dr. John T. MacDonald Foundation, Inc. v. Califano*, 571 F.2d 328, 332 (5th Cir. 1978) (en banc).

tion to review questions of law,<sup>298</sup> the courts have, "happily," been able to avoid the hard questions. The Second and Seventh Circuits have even gone so far as to hold that the Court of Claims has jurisdiction over Medicare claims.<sup>299</sup>

While it is tempting to ignore the problem presented by section 205(h), resort to the Court of Claims is not entirely satisfactory. Litigants are usually able to fashion their claims for relief in terms of monetary claims, but such claims may waste both litigant and court time. Because the Court of Claims is unable to provide equitable or declaratory relief,<sup>300</sup> challenges to the promulgation of regulations<sup>301</sup> or to procedural defects must all wind their way through administrative procedures and the Court of Claims. Such challenges often could be decided much earlier by mandamus or declaratory judgment. Furthermore, not all courts recognize jurisdiction in the Court of Claims, and some have refused to transfer cases.<sup>302</sup>

Avoiding the jurisdictional question by determining that no viable substantive problem is presented for review seems a poor analytical choice. In *Hospital San Jorge, Inc. v. Secretary of Health, Education & Welfare*,<sup>303</sup> the First Circuit indicated that it had no jurisdiction over a provider's reimbursement suit unless a viable constitutional claim was presented. The court assumed, without deciding, that the hospital had a protected property right but found no constitutional violation.<sup>304</sup> As the Sixth Circuit has noted, this practice of hypothesizing jurisdiction cannot provide a meaningful review of constitutional questions.<sup>305</sup>

298 *Whitecliff, Inc. v. United States*, 536 F.2d 347, 351 (Ct. Cl. 1976), *cert. denied*, 430 U.S. 969 (1977).

299 *Trinity Memorial Hosp., Inc. v. Associated Hosp. Serv., Inc.*, 570 F.2d 660, 667 (7th Cir. 1977); *South Windsor Convalescent Home, Inc. v. Mathews*, 541 F.2d 910, 914 (2d Cir. 1976). *See also* *Hazelwood Chronic & Convalescent Hosp., Inc. v. Califano*, 450 F. Supp. 1158, 1161 (D. Ore. 1978). *But see* *Chelsea Community Hosp. v. Michigan Blue Cross Ass'n*, 630 F.2d 1131, 1135 (6th Cir. 1980) (questioning the Fifth Circuit's power to "hold" that the Court of Claims has jurisdiction).

300 *See* note 272 *supra*.

301 *See, e.g.*, *Faith Hosp. Ass'n v. United States*, 634 F.2d 526 (Ct. Cl. 1980).

302 *See* *Pacific Coast Medical Enterprises v. Califano*, 440 F. Supp. 296 (C.D. Cal. 1977), *modified*, 633 F.2d 123 (9th Cir. 1980).

303 598 F.2d 684 (1st Cir. 1979).

304 *Id.* at 687. *See also* *Cervoni v. Secretary of HEW*, 581 F.2d 1010, 1017-19 (1st Cir. 1978).

305 *Chelsea Community Hosp. v. Michigan Blue Cross Ass'n*, 630 F.2d 1131, 1137 (6th Cir. 1980). The court stated: "[W]e must note that the practice of assuming jurisdiction arguendo cannot provide a meaningful review of constitutional claims." *Id. Accord*, *Rogers, A Way Out of the Social Security Jurisdictional Tangle*, 21 ARIZ. L. REV. 689, 714 (1979) [hereinafter cited as *Rogers*].

The best reasoned decisions appear to be Sixth Circuit and Eighth Circuit decisions holding that the courts have the power to review all constitutional challenges. In *St. Louis University v. Blue Cross Hospital Service*,<sup>306</sup> the Eighth Circuit held that review of a reimbursement amount was barred by section 205(h)<sup>307</sup> but that consideration of due process violations was not.<sup>308</sup> The provider challenged the constitutionality of the Provider Appeals Committee, the private organization responsible for determining the proper amount of reimbursement. While eventually finding the committee structure permissible, the court thoroughly analyzed its jurisdiction to make that determination. Judge Bright, writing for the court, indicated that serious problems would be raised by the preclusion of judicial review.<sup>309</sup> He then noted three distinctions from the Social Security situation in *Salfi*. First, while the litigants in *Salfi* sought recovery of a claim, the provider's primary goal in *St. Louis University* was to obtain an adequate hearing which had no direct bearing on the amount of reimbursement owed. Second, unlike the situation in *Salfi*, the Medicare Act does not otherwise provide a means of review and the "plain words" of section 205(h) do not preclude constitutional challenges. Finally, section 205(h) is only incorporated into Medicare "as applicable." Since such a statute is meant to give force and effect to the incorporating statute, it should be read to avoid constitutional uncertainty.<sup>310</sup>

The Sixth Circuit reached a similar result in *Chelsea Community Hospital v. Michigan Blue Cross Association*.<sup>311</sup> The court focused on discerning legislative intent and employed the presumptions favoring judicial review. The court considered the availability of judicial review for all Social Security issues a crucial factor in the *Salfi* decision. Thus, it adopted the Court of Claims interpretation that review was not entirely precluded by section 205(h) because "it is a 'cardinal principle' that we should seek statutory constructions which avoid

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306 537 F.2d 283 (8th Cir. 1976).

307 *Id.* at 287-89. The court noted that amount determinations were the type of technical questions which Congress intended to preclude from review. Thus, to the extent the provider sought payments under the Medicare Act, jurisdiction was barred by § 1331. *Id.* at 289. Of course, for years after 1973, Congress specifically provided review through the Provider Reimbursement Review Board. 42 U.S.C. § 1395oo (1976).

308 537 F.2d at 292.

309 *Id.* at 291-92.

310 *Id.* at 292.

311 630 F.2d 1131 (6th Cir. 1980). See also *Arkansas Soc'y of Pathologists v. Harris*, 4 MED. & MED. GUIDE (CCH) ¶ 30,706 (E.D. Ark. 1980) (similar decision).

constitutional doubts."<sup>312</sup> Several lower courts have also determined that federal question jurisdiction was available as a basis for constitutional review where no alternative means existed.<sup>313</sup> The Sixth Circuit, however, is the first court to realize the practical effects of any other decision. Participation in Medicare is voluntary and, as the Sixth Circuit noted, "making provider reimbursements unreviewable would doubtless chill the provision of care to beneficiaries, or perhaps worse, would encourage providers to cheapen the care given to Medicare patients."<sup>314</sup>

The Sixth and Eighth Circuits fall somewhat short of the Court of Claims interpretation of section 205(h) because purely substantive claims were not considered. While either the Secretary's failure to conform to a regulation, or the application of an invalid regulation, are arguably reviewable under procedural due process, the review of legal issues should be explicit and direct. As the Eighth Circuit noted, Congress was intent on barring the courts from considering the "complex interplay" between facts and technology in determining the appropriate amount of reimbursement.<sup>315</sup> Congress is also concerned that private enterprise participate in the Medicare program.<sup>316</sup> Program participation is discouraged if the Secretary is not required to abide by the governing law or if there is no means of challenging the Secretary's interpretations.

312 630 F.2d at 1135.

313 *Northeast Emergency Medical Assocs. v. Califano*, 470 F. Supp. 1111, 1119 (E.D. Pa. 1979); *Pacemaker Monitor Corp. v. United States*, 440 F. Supp. 473, 477 (S.D. Fla. 1977); *Daytona Beach Gen. Hosp., Inc. v. Weinberger*, 435 F. Supp. 891, 899 (M.D. Fla. 1977) (no general jurisdiction but ability to review due process violation); *Russi v. Matthews*, 438 F. Supp. 1036, 1041 (E.D. Va. 1977) (jurisdiction under § 1331 to review due process and equal protection claims); *Columbia Heights Nursing Home & Hosp., Inc. v. Weinberger*, 380 F. Supp. 1066 (M.D. La. 1974); *Temple Univ. v. Associated Hosp. Serv.*, 361 F. Supp. 263 (E.D. Pa. 1973).

314 630 F.2d at 1136. The court stated:

We cannot believe that Congress intended in 1965 that Medicare providers would be "entitled" to whatever reimbursement the Secretary (or fiscal intermediary) granted, be it high or low, fairly or unfairly set. The Medicare Act does not, of course, show any legislative intent to aid providers of care for their own sakes. *E.g.*, *Green v. Cashman*, 605 F.2d 945, 946 (6th Cir. 1979). The Congressional concern was rather for the Act's beneficiaries. *Id.* Yet making provider reimbursements unreviewable would doubtless chill the provision of care to beneficiaries, or perhaps worse, would encourage providers to cheapen the care given to Medicare patients. More scrupulous providers might choose to offset insufficient Medicare reimbursements by charging higher fees to non-Medicare patients. This would contravene one objective of the Act, which is that "the costs of services of [sic] individuals covered by the program will not be borne by individuals not covered . . . ."

315 537 F.2d at 289.

316 *See* 42 U.S.C. § 1395b (1976).

The D.C. Circuit added another dimension to Medicare jurisdiction when it concluded that section 205(h) was not a bar to a provider's challenge that the Secretary had failed to follow the APA rulemaking methodology.<sup>317</sup> The provider alleged that the Secretary failed to give notice and allow comment. Since review was otherwise unavailable, the court held federal question jurisdiction allowed consideration.

One commentator has suggested a path out of the present morass based upon the type of situation presented.<sup>318</sup> Analyzing provider reimbursement claims, the author concludes that while section 205(h) bars claims brought purely for reimbursement,<sup>319</sup> procedural claims collateral to reimbursement claims are reviewable, as the District of Columbia and Eighth Circuits have concluded.<sup>320</sup> Courts other than the Court of Claims should review "substantive constitutional claims."<sup>321</sup> Unfortunately, this analysis does not make appro-

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317 *Humana of South Carolina, Inc. v. Califano*, 590 F.2d 1070, 1080 (D.C. Cir. 1978).

318 Note, *Federal Question Jurisdiction over Medicare Provider Appeals after Weinberger v. Salfi: Toward a Principled Construction of the Statutory Bar*, 65 VA. L. REV. 1383, 1384 (1979) [hereinafter cited as *Federal Question Jurisdiction*].

319 *Id.* at 1389-90. The Note concludes that all claims challenging the amount of reimbursement are barred by § 205(h). This conclusion is more appropriately reached by recognizing that questions of fact are not reviewable by the courts due to § 205(h). Additionally, for many amount determination claims, administrative review is provided. If the plaintiff fails to exhaust administrative remedies, judicial review is precluded.

320 *Id.* at 1391-95. The author determines that *Humana of South Carolina, Inc. v. Califano*, 590 F.2d 1070 (D.C. Cir. 1978), and *St. Louis Univ. v. Blue Cross Hosp. Servs.*, 537 F.2d 283 (8th Cir.), *cert. denied*, 429 U.S. 977 (1976), correctly concluded that procedural constitutional claims were reviewable. That conclusion is inappropriate if administrative review is available. In other words, administrative review must be exhausted. The Note also improperly criticizes the Seventh Circuit's decision to transfer cases to the Court of Claims. *Trinity Memorial Hosp., Inc. v. Associated Hosp. Serv., Inc.*, 570 F.2d 660 (7th Cir. 1977). The author comments that since the Court of Claims has jurisdiction only over claims against the United States it cannot decide disputes between claimants and the fiscal intermediaries or carriers. *Federal Question Jurisdiction*, *supra* note 318, at 1392 n.58. That is incorrect. The private organizations involved in the Medicare Act constitute agents of the United States government and their actions confer jurisdiction against the United States. *Sacred Heart Hosp. v. United States*, 630 F.2d 1131 (Ct. Cl. 1980). Further, the Court of Claims is not necessarily a less familiar or more geographically distant forum than other federal courts of appeals. *Federal Question Jurisdiction*, *supra* note 318, at 1393 n.63. First, for initial decisions the relevant comparison is between district courts and the Court of Claims trial division which sits where the dispute is centered. Second, the Court of Claims is becoming the "familiar" forum for litigating Medicare disputes due to its own decisions and the decisions of the circuit courts. Moreover, the Court of Claims is able to render decisions with national coverage obviating the inter-circuit conflicts now found in Medicare law. Thus, the question remains whether other federal courts must transfer procedural claims, which of necessity involve a claim for reimbursement, to the Court of Claims.

321 *Federal Question Jurisdiction*, *supra* note 318, at 1395-1400. The term "substantive constitutional claims" is of minimal analytic utility. The only purely constitutional claims a Medi-

priate allowance for the Court of Claims' function.<sup>322</sup> Moreover, it focuses only on provider claims whereas individual and Part B claims are equally important.<sup>323</sup> The appropriate decision is made by analyzing three factors: (1) the availability of review encompassed in the Medicare Act; (2) whether questions of fact or law are presented, and (3) whether the issues are "raised under" the Medicare Act or other federal provisions.

Analyzing these factors, it is clear that review is absolutely precluded under federal question jurisdiction whenever the Medicare Act expressly provides for review in a particular manner and the litigant fails to follow the required procedures. If no review of constitutional questions can be obtained, however, federal question jurisdiction and Tucker Act jurisdiction are available. It must also be recognized that review of purely substantive issues is necessary.

Congress has made it clear that it considers factual questions in Medicare generally inappropriate for review by the federal courts.<sup>324</sup> Thus, even a private organization's determinations of fact are not reviewable.<sup>325</sup> The redetermination of basic factual issues is even barred where legal questions are involved, although not necessarily the application of law to established facts.<sup>326</sup> Consequently, in cases requiring a reapplication of law and finding of new facts, a remand to the Secretary is proper.<sup>327</sup>

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care claimant could raise are: (1) a fifth amendment taking due to the failure to reimburse, *see, e.g.*, *Humana of South Carolina, Inc. v. Califano*, 590 F.2d 1070 (D.C. Cir. 1978); (2) substantive (i.e., equal protection) or procedural due process claims; and (3) whether § 205(h) can constitutionally bar review. Unfortunately, *Salfi* has broad dicta indicating that all claims stemming from involvement in the Medicare program arise under the statute and not under the Constitution. *Weinberger v. Salfi*, 422 U.S. 749, 760-61 (1975); *John Muir Memorial Hosp., Inc. v. Califano*, 457 F. Supp. 848, 853 (N.D. Cal. 1978). Thus, the initial question remains whether a constitutional question involving a Medicare issue can be reviewed and, if so, in which forum.

322 *See* note 316 *supra*.

323 While most claims involve providers, those are now covered by the PRRB. A provider can now obtain review where the amount in controversy exceeds \$10,000. A more general analysis is required for lesser claims, Part B issues or questions involving other statutes. *E.g.*, *American Ass'n of Councils of Medical Staffs of Private Hosps. v. Califano*, 575 F.2d 1367 (5th Cir. 1978), *cert. denied*, 439 U.S. 1114 (1979) (violation of APA).

324 *See* 42 U.S.C. § 405(g) (1976); *St. Louis Univ. v. Blue Cross Hosp. Serv.*, 537 F.2d 283, 289 (8th Cir.), *cert. denied*, 429 U.S. 977 (1976).

325 *See Cervoni v. Secretary of HEW*, 581 F.2d 1010 (1st Cir. 1978). Contrast, however, due process challenges to the private organization's or the agency's fact finding. The question, however, is not the ability of those two agencies to sift and weigh the facts but the manner in which it is done.

326 *See, e.g.*, *Faith Hosp. v. United States*, 634 F.2d 526 (Ct. Cl. 1980) (court reapplied law to the given facts).

327 The Court of Claims is particularly lax in this regard, having failed to remand any



Further, cases involving Medicare but "arising under" another act are cognizable. For instance, the District of Columbia Circuit held that a suit challenging the Secretary's adherence to the APA was reviewable under federal question jurisdiction.<sup>328</sup> Similarly, a suit involving a Freedom of Information Act request would not seem barred by section 205(h).

Finally, when Medicare participants have legitimate constitutional claims which are not directly reviewable under existing administrative procedures, judicial review must be available. Section 205(h) should not be considered a bar to the presentation of constitutional issues. As the Supreme Court indicated in both *Johnson* and *Salfi*, constitutional review should not be precluded in the absence of clear and convincing evidence that Congress intended to do so.<sup>329</sup> The courts should interpret section 205(h) in a manner which is both consistent with Supreme Court precedent and avoids possible constitutional violations. One commentator has argued for the same result by suggesting that purely constitutional questions should not be considered to "arise under" Medicare thereby escaping the bar of section 205(h).<sup>330</sup>

Uncertainty concerning Medicare jurisdiction presently exists from circuit to circuit. To further confuse potential litigants, the district courts hear some cases and the Court of Claims others. Two institutions are at fault. The Supreme Court should establish in which instances federal question jurisdiction is available and resolve inter-circuit conflicts. More importantly, Congress should thoroughly examine the jurisdictional situation and decide specifically what courts should review which issues. It may be constitutionally acceptable to bar reconsideration of factual decisions,<sup>331</sup> but review of substantive and constitutional claims should be provided, particu-

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cases for redetermination. Apparently, that decision is made to eliminate the "needless" task of having an administrative decision made where a judicial judgment is easily rendered. The more appropriate, and innovative, procedure is for the court to affirm the original fact finding of a lower administrative tribunal and to declare the subsequent agency reversal contrary to the law, *see* *Sacred Heart Hosp. v. United States*, 616 F.2d 477 (Ct. Cl. 1980), *followed in* *Sun City Community Hosp. v. United States*, 624 F.2d 997 (Ct. Cl. 1980), or to remand the case to the agency, 28 U.S.C. § 1491 (1976). *See also* *Shrader v. Harris*, 631 F.2d 297 (4th Cir. 1980) (no jurisdictional bar in § 405(g) & (h) to determining whether claimant's mental illness negated res judicata effect of prior decisions).

328 *Humana of South Carolina, Inc. v. Califano*, 590 F.2d 1070 (D.C. Cir. 1978).

329 *Johnson v. Robison*, 415 U.S. at 373; *Weinberger v. Salfi*, 422 U.S. at 762.

330 Rogers, *supra* note 305, at 722-26.

331 Again the distinction must be made between the actual finding of fact—which may be unreviewable—as opposed to the procedure used to find the facts—which undoubtedly is reviewable.

larly if Congress wants to encourage the continued involvement of private organizations in the administration of the Medicare system.

#### IV. Conclusion

Elderly patients, their physicians and other members of the health care system with potential Medicare grievances face a confusing administrative and judicial mechanism for resolution of their disputes. Administratively, there are five different systems of review complying with the Constitution in varying degrees but generally according greater rights to institutions than to the individual for whom the Medicare system was designed. Assuming the potential litigant negotiates the administrative maze, a new challenge awaits in attempting to secure judicial review. Under the present system, the Court of Claims is available to review claims derived from illegal administrative actions by the agency. Additionally, the district courts can review most issues using federal question jurisdiction despite the bar imposed by section 205(h).

All told, the Medicare system is in need of change. Greater administrative review must be provided for individuals. Given the administrative delegation to private insurers, the courts should provide full review for fundamental legal questions. The added burden to the judiciary would be minimal and greater protection of individual rights would be afforded.